CHAPTER-I

INTRODUCTION

1.1 Background

Nepal is one of the mountainous and landlocked countries with the area of 147141 sq. km lies between two big neighbouring countries India and China. The northern part of Nepal is covered with high mountains covered with snowy peaks called mountain region which covers 35 percent of the total area of Nepal. According to the 2001 census, the region accommodates 7.3 percent of the country. The middle part is hill region. This region covers 42 percent of the total area of Nepal. The life style of this region is very hard due to the lack of transportation, communication, education and opportunities. The southern part of Nepal is terai, covers 23 percent of the total area of Nepal. According to the 2001 census, the total area of Nepal. According to the 2001 census the share of population of this region is 48.4. This region is very importation region of the nation because it directly supports for the national economy of Nepal.

All over these regions of Nepal different heterogeneous cultural and different group, stage of people are living together. The different stages of human life cycle is divided into different period and different name as childhood, adolescent, young, youth, old age etc.

The life cycle's one of the important stage is adolescence. At that time most of the people are at secondary and higher secondary school level.

Adolescence is a period of transition from childhood to adulthood in which physical, social, psychological, emotional and behavioural changes take place. It is also known as "the teenage years". This is also a period of a "milestone" for everyone. This is a time of preparation for undertaking greater responsibilities. Adolescents health is the outcomes of several factors such as socio-economic status, environment in which they live and grow, good guidance: UNFPA, UNICEF and WHO defined "youth people" as a between the ages of 10 to 24, "young people" between the age of 15-25 and

"Adolescents" as the population 10-19 years. This adolescent also divided into two state early adolescents 10-14 years and late-adolescents 15-19 years. (UNFPA, 1998).

Psychologically, adolescence 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 insight this integration into adult socially has many aspects. In this stage a person not only to achieve interaction into the social relationship of adults, but also develop the phenomena of responsibility and feeling of being a important part of own society.

Sexually transmitted disease (STDs) are the diseases, which are transmitted through sexual contact during the unprotected intercourse. They are also transmitted from mother to child before or during the birth and through unsafe blood transfusion as well as through semen, vaginal, secretion and breast-feeding. During the post decades, there has been a wide spread out of STDs wide both in number of infectious agent and range of human population affected. More than twenty micro organism are known to be transmittable through sexual intercourse. Some of the major diseases of STDs are gonorrhea, syphilis, cancroids, Chlamydia, Trichomonoiasis and AIDS.

Human Immune Deficiency Virus (HIV) is an infection agent that cause Acquired Immune Deficiency Syndrome (AIDS) which destroy immune system of the body of the body natural ability to fight against various diseases. The infected person may lose weight and become ill with disease like persistent, serve diarrhea, fever, skin disease, pneumonia, TB or tumor. At this stage, he or she developed AIDS (WHO). Therefore, AIDS is the last stage or life threatening state of HIV infection. The full form of AIDS is:

A = Acquired = not born with

I = Immune = body defense system

D= Deficiency = not working properly, and

S= Syndrome = group of signs and symptoms

It is believed that the adolescents, especially of those aged 15-19 years are believed to engaged in high level of unprotected sexual activity both within and outside marriage

leaving them exposed to risk of unplanned and unwanted pregnancies and contracting STI including HIV. Such behaviour often resulting in early out of wedlock pregnancy constitutes a major threat to health of those adolescents as well as retarding their potential education, career and economic development (William and Nasirv, 1999).

The adolescent are at greater risk of STI/ HIV infection due to ignorance, risk behaviour and lack of information and severices, menstrual hygiene the main purpose of reproductive and sexual health education is to make young people aware of the various mental physical and emotional changes at the period of adolescence furthermore, they should emphasize on providing knowledge about the disadvantage of early intercourse especially unsafe sex.

AIDS (Acquired Immune Deficiency Syndrome) is not one disease, but a set of diseases (Upretric 1998) caused by the human immune deficiency virus (HIV) that can breakdown the today's immune system and lead to total infection and some forms of cancer. Human immune deficiency virus kills by weakening the boys immune system until it can no longer fight infection. Opportunistic infection are illness such as pneumonia, cancer, tuberculosis (TB) or other parasitic, viral and fungal infection that occur when the immune system is weakened. (PRB 2006)

Acquired immune deficiency (AIDS) was first recognized internally in 1981 in New York. It caused due to Retro virus. It is estimated that more than 10 million people are living with HIV world wide (UNAIDS/ WHO 2007). It is estimated that almost 50 percent are women. New infection with HIV is 2.5 million i.e. 6800 new infection per day. More than 96 percent of them are in low and middle income centuries, and death due to AIDS is 2.1 million i.e. 5700 per day in 2007. Every year, an estimated more than 3 million died of AIDS of whom 5,00,000 are children under the age of 15. Although the HIV prevalence rate is still low in south Asia. It is one of the most rapidly growing HIV and AIDS epidemics globally. Because of the largest population base and presence of several factors that enhance the spread of HIV, including poverty, gender inequality and social stigma, the south east Asia is likely to increasingly suffer the brunt of the epidemic in south east Asia in 2008. It is the second highest number of causes in the world after sub-Saharan Africa. While HIV and AIDS cases are now being reported by all countries in the region, 4 countries, namely India, Thailand, Myanmar and Indonesia, account for 99 percent of the total

burden in the region. India, with 2.5 million of cases of HIV and AIDS, is second only to South Africa in terms of the number. (World Bank 2005, NACO, 2005)

According to the estimation of UNAIDS/ WHO, 2007, 69790 people are living with HIV and AIDS in Nepal. The infection is occurring by 92% of in the age group of 15-49 which is equivalent to 0.49% prevalence. The sex ratio for male and female is 3:1. It was estimated that 19366 people living with HIV who are in need of Antiretroviral therapy and 1811 pregnant women also need ARV to prevent mother to child transmission (PMTCT). Altogether 1731 people are receiving ART through 17 ART and 145 PMTCT sites in different district and regional hospitals in Nepal. CNCASC ART report, Baishakh 2065).

But according to National centre for AIDS and STD control (NCASC), 11234 people are reported as PLWHA to the end of Chaitra 2064 (13 April 2008) out of 11234 infected people, male are 7646 and female are 3588. Among the different subgroup of the population, female sex worker, clients of sex worker and intravenous drug users (IUDS) covers the higher number among the reported cases. Out of 11234 adolescents (10-19 age group) are 561. Majority of the infected population (4313) falls under the age group of 30-39 years. It has been reported that 606 children are infected from mother to child transmission NCASC- Chaitra 2064.

Stages of HIV/AIDS

Most of the people have misunderstanding that HIV and AIDS are same but it has some differences. HIV is virus, but AIDS is the syndramatic stage of different diseases, so we can define it is stages.

Window Period (0.4 or 6 months)

In these stages, people may be infected but we can't diagnose by blood test. It is very dangerous period for transmission. In this period, the immune power starts to fight against HIV.

Carrier Stages (3-6 months or 0-10 years)

In this stage, we can see HIV virus in affected blood test. But the infected person is as like as general or, healthy people. At that time, the virus does not show syndrome.

AIDS

AIDS is the last stage of HIV. In this stage, the patients show different syndromes of different diseases for example: diarrhea, fever, headache, etc. at last the patient is to be died.

Symptoms of AIDS

- Weight loss more than 10 percent of patient's body.
- The patient suffers from continuous coughing, diarrhea and mid fever.
- Sows are found in his/her tongue and sexual organs.
- The patient gradually losses all natural defense mechanism.
- Red spots are found in his/her body.
- The HIV virus passes to the brain through the blood which it's cells as a result patient becomes mentally abnormal.

The way to prevent AIDS are:

- Avoid sex with prostitutes and multiple partners.
- Use of condom
- Avoid injections and blood transfusion from infected persons.
- Avoid needles used by infected persons.
- Check the blood before transfusion.
- Infected person should not give birth to babies.
- Don't use drugs.
- Get more information on sexually transmitted disease STIs and AIDS.

1.2 Statement of the Problem

With 60 percent of the world population, Asia is home to some of fastest growing epidemics in the world with 34000 new infection in 2007 along the most in the single year to data in Asia. Though the Africa is the home to 10 percent of the world population, it has 67.77 percent of people living with HIV worldwide. If current rate continues, without access to treatment, 60 percent of today's 15 years old will not reach to 60 birthday.

The first HIV infection in Nepal was identified in 1988. Only 4 causes (3 male and 1 female) was reported among 9016 sample tested in that year (Bista 2002). Since then HIV/AIDS has been increasing each year. The potential for the spread of HIV in Nepal is large because of extensive use of commercial sex workers, high rates of sexually transmitted diseases, low level of condom use and pockets of intravenous drug users. As of April 30, 2005, a total of 876 AIDS and 4904 cumulative cases of HIV infection were reported to the ministry of health, National Centre of AIDs and STD control. HIV infection in Nepal mainly occurs in the younger age groups. There is 81 percent of recorded infections are in people between 20 and 39 years. Very few infection have been recorded in the very young or very old (DOH, 2007).

National Centre for AIDS and STI control has detected 11501 HIV positive people out of which 1786 are living with AIDS and 480 died due to AIDS (NCASC, Baishakh 2065). But the latest estimation shows that 69790 people are living with HIV in Nepal (HIV Estimation NCASC, 2007).

Nepal has now moved generally from low HIV prevalence to having a concentrated epidemic among female sex worker, their clients, migrants and intravenous drug users mostly through unsafe behaviour. It is only a matter of time before we face a generalized epidemic of an expanded response is not initiated immediately.

Safe behaviour is needed to halt the epidemic of HIV and AIDs at current rate of infection so in the context of STDs and HIV/AIDS adolescents should be targeted group because when they are to get the information about reproduction, STDs, HIV/ AIDS.

However, several effort have been launched from continuum to care, the situation still showed that HIV and AIDS is critical.

Various research were conducted on knowledge and attitude towards STIS and HIV/AIDS by many researchers. Most of them are found to be urban basis. Only limited research work are done using the data from remote urban area of Nepal from a policy making point of view, the information each and every part of the country is given an equal importance.

In this case study the study are lies in remote rural areas of Syangja district. There were not conducted any research activity and had not launched any awareness programme due to poor socio-economic condition, political unrest and intense unemployment, thousand of physically and economically productive age-group manpower including adolescents and youth drains to India or other abroad countries to maintain their problem. Likewise Nepalese girls are being trafficked and compelled for prostitution in major cities and India also, while they return, they bring not only money and good but also carry HIV/AIDS. In that study area many people are illiterate so they don't know about the mode of transmission of HIV/AIDS and method of prevention.

STIs particularly HIV/AIDS is a burning and growing problem all over the world as well as Nepal. Most of the Nepalese societies, adolescents particularly in the school age have to face pressure to engage in sexual activities. Adolescents are more vulnerable, they have high risk increasing the transmitting STIs including HIV/AIDS. There have not conducted any studies regarding knowledge and attitude towards STIS and HIV/AIDS among adolescents in Chinnebas VDC of Syangja district. However, the adolescents have little access to information of physical, mental, social, emotional and behavioural change, reproductive health, contraceptive, STDs and HIV/AIDS. So they are facing various problem like unsafe abortion, early marriage and early pregnancy and other sexually transmitted diseases.

1.3 Objectives of the Study

The main objective of this study is to find out the knowledge and attitude on STDs and HIV/AIDS among secondary and higher secondary school adolescents.

The specific objectives are as follows:

- To analyze the knowledge on STDs and HIV/AIDs among adolescents.
- To examine the cause and consequences of STDs.
- To identify the knowledge on mode of transmission and methods of prevention STDs and HIV/AIDs among the respondents.
- To assess their attitude and understanding about STIs and HIV/AIDs.

1.4. Significance of the Study

In Nepal, the constitute of the adolescents is more than one fifth of the total population (CBS, 2001) which will be continue to grow due to result of high population momentum. The students of secondary and higher secondary level are very curious to be exposed with different activities including sexual relation. They are highly vulnerable segment of the population of contracting different STIs including HIV and AIDs. They are considered as the pillar and future of the nation too. From the point of view of the economic contribution to individual and nation, the key respondents are the dawn of the economically productive age group. If this segment of the population be infected with HIV and AIDS, the socio-economic status of the country will be directly affected and go down. As the result the prosperity will be only in dream.

Considering the alarming threat of day by day increasing trend of HIV infection among the marginal students (Janapriya Higher Secondary School), the study has been designed keeping intention to bring forward the existing level of knowledge on STIs, HIV and AIDS and attitude of condom use for prevention of STIs and HIV/AIDs because this type of studies has never been conducted.

Eventually, because of the burning issue, this has become more important. This study represents all hilly region school adolescents so finding of this study helps the policy makers in formulating the preventive measure and minimize risky behaviour measuring regarding to STIs and HIV/AIDS in similar areas of the nation. This study helps to understand the importance of knowledge, attitudes on STIs and HIV/AIDs among school adolescent's parents and community.

1.5 Limitation of the Study

The study attempts to demonstrate the knowledge of STIs and HIV/AIDs among secondary and higher secondary level students of age between 14-19 years. This study has been limited within only one selected school of Syangja district (Shree Jana Priya Higher Secondary School). The study has been undertaken to meet the partial fulfillment of the requirement for Master's degree in population studies. However, the study has the following limitations:

This study is limited within only one school of Syangja district, therefore the finding may not be generalized for all over the nation.

This study only takes account of the school adolescents, so the study does not represent the view of non-school adolescents.

This study is taken among limited number of respondents (150 students from one school).

Due to the cause of time resources, the sample populations are taken from only one higher secondary level students in western part of Syangja.

It does not cover more than one subjective of the study.

1.6 Organization of the Study

This study is organized into six chapters. The first chapter is introductory, that includes background of the study, statement of the problem, objective of the study, significance, limitation and organization of the study. The second chapter represents literature review and proposed research framework. The third chapter includes the methodology, where the sample size, sample selection, questionnaire design, and data collection and data processing, data analysis and interpretation. The socio-economic and demographic characteristics of respondents are described in the four chapter. The fifth chapter the knowledge and attitude on STIs and HIV/AIDs of the respondent has been described. At last, sixth chapter presents the summary, conclusion and recommendations.

CHAPTER-II

LITERATURE REVIEW

2.1 Theoretical Literature

AIDS was first described in medical literature in 1981 in USA in other words AIDS was first diagnosed in 1981 in USA in a homosexual male who was suffering from disease like Kaposi, sarcomapheumocyrtic, chronic and other serious disease which were usual among young Americans .In the year 1985, it has postulated that AIDS may have originated in Africa as AIDS virus was endemic among green monkey. In may 1986 the name HIV was recommended by international comity on taxonomy of virus (Pandey, 2004).

The pandemic nature and the magnitude of the public health problem associated with HIV infection were recognized much later when the proportion of persons infected with HIV rose very rapidly. Scientists have identified two types of HIV virus; HIV-1 is the primary cause of AIDS world wide, HIV-2 is found mostly in West Africa. HIV belongs to the retrovirus family of virus white blood cell of the immune system. The virus commanders destroy the genetic materials of the host cell instructing the cell to replicate more viruses. The newly formed viruses break. Free from the host, destroying the cell in the process. The new viruses get on to infected and destroy other lymphocytes (WHO, 2005).

HIV transmission occurs when a person is exposed to body fluids infected with the viruses such as blood, semen, virginal secretions and breast milk. The primary made of HIV Transmission are (I) sexual relations with an infected person; (II) sharing hypodermic needles or accidental pricking by a needle contaminated with infected bloods; and (III) transfer of the virus form an infected mother to her baby during pregnancy, childbirth or through breast feeding (NCASC, 2007).

The diseases that can transmit from one person to another mainly through sexual contact during unprotected intercourse are known as sexually transmitted diseased STDs. Some STDs can be transmitted by other routes also. In fact, multiple sexual contacts may lead serious health problems and causes various venereal diseases. Some time these diseases are as transmissible through transfusion of unsafe blood, contaminated needles and from infected mother to her children during pregnancy, childbirths or breast feeding. Sexually transited diseases (STDs) have greater impact on human sexuality or morbidity. They largely affect external and internal sexual organs and cause various complications such as PID, entopic

pregnancy, infertility, cervical cancer, miscarriage, stillbirth etc, Chlamydia, causcroids, Herpes, Genital is, Trichiomoniasis, Venereal Wart, hymphogranuloma Venereum Granuloma Inguinal and HIV/AIDS (UNAIDS, 2005).

2.2 Empirical Literature

Almost a quarter of people living with HIV are under the age of 25. Young people now represent half of all new cases. An estimated 6000 young people are infected every day one every 14 minutes. In the 1980s, HIV/AIDS disproportionately affected men. Now the fact of the epidemic is increasingly than of young women. Women between 15-24 are 1.6 time likely than young men to be HIV-positive (UNEFPA, 2005: 45-55). Worldwide, 40million adults and children are living with HIV/AIDS and almost 5million new infections occurred in 2005. The adult prevalence rate has established in sub-Saharan Africa and other developing regions, not because the epidemic has been halted but because the death rate now equals the rate of new infections. Although prevalence rates are level outside of sub-Saharan Africa, the number of people infected is increasing and so is the death rate. There were almost a million new cases in youth and East Asia, where more than 7 million people are new living with HIV/AIDS. In 1994, the international conference on population and developing (ICPD) promised basic sexual and reproductive health services to all by the year 2015. It is important for young people to be represented in countdown 2015 because they are a large part of the global community of the 6.3 billion people on earth, to nearly half are under the age of twenty five. The choices made by this half of the population will impact the future of individual world-wide (UNFPA, 1999).

Young people around the globe seen comprehensive and youth friendly programs that not only after broad reproductive health choices, but also teach effective decision-making skills. They want services that promote education concerning sexually transmitted disease contraceptives, unwanted childbirth, abandonment among other things, they want programs that help shape their future and identify. The most successful sexual and reproductive health programs involve adolescents and take what they to say into consideration (FHI and NCASC, 2003).

2.3 Global Scenario of HIV/AIDS

The AIDS epidemic may become the most divesting health disaster in human history.

The disease continues to ravage families and community through out the world. In addition 25 million people who died of AIDS by the end of 2005 at least 40 million people are new living with HIV at the end of 2005. An estimated 4.9 million people were newly infected with HIV in 2005. Out of the total HIV infected people, 95% are from sub-Saharan Africa, Eastern Europe on Asia. In southern Asia 7,400,000 are living with HIV and 480,000 have died from the AIDS (PRB, 2006).

Table 1: Estimated number of people living with HIV and Newly affected with HIV during 2006.

Region	People living with HIV	People newly affected in 2005	Prevalence % of adult infected	Death due to Aids in 2005
World	40,300,000	4,900,000	1.1	3,100,000
Sub Sahara Africa	25,800,000	3,200,000	7.2	2,400,000
North Africa	510,000	67,000	0.2	58,000
South East Asia	7,400,000	930,000	0.7	48,000
East Asia	870,000	140,000	0.1	41,000
Oceania	74,000	820,000	0.5	3,600
Latina America	1,800,000	200,000	0.6	66,000
Caribbean	300,000	30,000	1.6	24,000
Eastern Europe	1,600,000	270,000	0.9	62,000
Western Europe	720,000	22,000	0.3	12,000
North America	1,200,000	43,000	0.7	18,000

Source: PRB 2006.

The HIV/AIDS pandemic is one of the most serious health concerns in the world today because of high case of fatality rate and the lack of a curative treatment and vaccines. Epidemiological studies have identified sexual intercourse, intravenous injections, blood transfusions and fatal transmissions, from infected mothers as the main routes of transmission of the HIV/AIDS. UNAIDS and the WHO have estimated that approximate 40 million people living with HIV/AIDS infection is far more common in the world than previously. Among 40 million HIV/AIDS infected persons 2.5 million are children under 15 and 37 million are adults. About 5 million were

infected with HIV in 2003 alone of this 700,000 were children. Among infected 40 Million people, 3 millions were died of HIV/AIDS. Among than 2.5 million were adults and 50000. Among infected 40 million peoples, 3 millions were died by 2004 due to HIV/AIDS in which 2.5 million were adults and 50000 were children under 15 years. This overall situation indicates that children and youths are vulnerable to AIDS. (UNAIDS/WHO, 2004).

At present the four most common curable STIS in the world, which cane be cured easily by adequate antimicrobials are syphilis (12 millions), Gonorrhea (62 million) Chlamydia infections (92 millions) and Trichomaniasis (173 million) in the world (WHO, 1999). The increasing mobility of population across the world, urbanization, poverty, and socio demographic changed especially in developing countries, sexual exploitation of woman and changes in sexual behaviour are some of the factors, which have placed on ever-increasing proportion of population of risk for STIS (WHO, 2004).

2.4 Situation of HIV/AIDS in Asia

According UNAIDS (2006). An estimated 8.3 million people are living with HIV/AIDS across South/South East Asia. There are increasing concerns about the spread of the epidemic into this region, particularly in China and India, the two most populous nations in the world. Like Russia, they are considered part of the epidemics "Next Wave" and despite having relatively low prevalence rates today the epidemic could explain significantly over the next decease without increased intervention. India already has the highest number of people estimated to be living with HIV/AIDS in the world (5.7 million) although its prevalence rate is still relatively low 0.9 percent.

Asia is most populated region of the world. Most of the countries are developing in there. The region includes the world's most populous countries India and China.

Asia is not just vast but diverse, and HIV epidemics in the region share that diversity, with the nature, peace and severity of epidemics differing across the region. Overall, Asia 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), other are only now starting to experience rapidly expanding epidemic and need to mount swift, effective responses. They include Indonesia, Nepal, Viet Nam, and several provinces in China. In Myanmar and in parts of India and China, HIV has become well entrenched in some sections of society

despite modest efforts to half the virus spread. Other countries and still seeing extremely low levels of HIV prevalence, even among at high risk of exposure to HIV, and have golden opportunities to pre-empt serious out breaks. These countries include Bangladesh, East Timor, Laos, Pakistan and Philippines (UNAIDS, 2004).

Although in China, moving at a vied pace, HIV has spread to all of china's 31 provinces autonomous regions and municipalities. In some parts such as Henna, Annuli and Shandong. HIV was already speeding a decade ago among rural people, who sold blood plasma to supplement their incomes Else where, the virus has established a more recent but firm presence among injection drug injectors was measured at between 18 percent and 56 percent in cities in the southern provinces of Guangdong and Guangxi in 2002, while in Yunan province some 21 percent of injectors tested positive to HIV in 2003. Sexual transmission of HIV from injecting drug users to their sex partners looks certain to feature more prominently in China fast evading epidemic. Some 147 percent of surveyed female drug infectors in Sichuan province and 21 percent in neighboring Yunan 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 common sex circuits, onward spread of the virus could be quite rapid if current behaviour trends persist. In 2003, almost one quarter of surveyed sex women's 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 using condoms with all their clients in the previous month according to a 2002 study. Little is known about the possible role of sex between men in china's epidemic. A rare survey of men who have sex with men in Beijing, conducted in 2001-2002, found that approximately 3 percent of the men were HIV infected (almost all of whom had been unaware their serostatus) (WHO, 2002).

In south east Asia three countries in particular Cambodia, Myanmar and Thailand are experiencing particularly serious epidemics Cambodia's national HIV prevalence is around 3 percent the highest recorded in Asia. Data suggest that there have been some dramatic changes in the shape of Cambodia's epidemic. For instance infection among brother based sex workers fell form 43 percent in 1998 to 29 percent in 2002 (UNAIDS, 2004).

Most new HIV infections in Asia occur when men by sex and large number of men do so. Household based surveys in a number of Asian countries suggest that between 5 percent and 10 percent of men by sex, which makes commercial sex large and hieratic industries in Asia. Many sex workers epically very young women from ruler areas are either coerced into the industries or joint in under duress, because they lack other employment opportunities. Nepal have reported earning around 2200 rupees or US & 30 a weak six times the average wages income (UNAIDS, 2004).

2.5 Situation of SAARC Countries

The first HIV infection on south region was reported in India in 1986. It is estimated that there are abut 3 to 5 million people infected by HIV/AIDS. The pandemic was introduced in the region some what later in other part of the world. The infection rate in south Asia are lower than Africa but the spread of HIV is Maharastra and Tamilnadu states are main area to rapidly increasing the HIV infection. Multiple sexual contacts have been the main routes of HIV transmission in India. According to Aryal, 2001, 50 percent of the commercial sex workers have been found to be infected in Mumbai.

These are some factors which are very similar in the countries of South Asia and these factors are among other girl trafficking. Commercial sex work seasonal migration and mobility of youth in the such of jobs drug use.

Data on prevalence on STDs, including HIV/AIDS are not available for all SAARC countries and are also limited in scope. However, the limited information that is available reveals a high level of prevalence of RTIs and STDs among both married and unmarried adolescent of unmarried and married adolescent girls and 20 percent of unmarried adolescent boys are reported to have had symptoms of RTIs and STDs respectively. In Sri Lanka, about 7 percent of adolescents are reported to have STDs. The incidence of HIV/AIDS among adolescents is limited but increasing particularly among girls. For example, in Nepal adolescent constitute about 16% of the HIV/AIDS case with adolescent girls representing 72 percent of the cases. Knowledge of HIV/AIDS is found to be limited among adolescents. For example only 19-24 percent of married adolescent girls are reported to have ever heard of HIV/AIDS in Bangladesh and Nepal (UNEFA, 1998).

A recent data on HIV/AIDS estimation of SAARC countries by UNAIDS is present in Table 2.

Table 2: Estimation of Adult Population Living With HIV in SAARC Countries

Countries	Estimated of Number of people living with HIV centre					
	Adults (15-49) end 2003			Adults (15-49), end 2001		
	Estimate	Low Estimate	High Estimate	Estimate	Low Estimate	High Estimate
Bangladesh	-	2,400	15,000	-	2,200	13,000
India	-	2,200,000	7,300,000	-	10,000,000	6,700,000
Nepal	60,000	29,000	98,000	44,000	22,000	72,000
Pakistan	7,300	24,000	140,000	62,000	20,000	120,000
Sri Lanka	3,500	1,100	6,800	22,000	700	4,300

Source: UNAIDS, 2005.

Data indicates that among SAARC countries Nepal will vulnerable to HIV/AIDS, if some measure to control it is not taken immediately. If we compare with previous two years, infected population has estimated nearly double. If this trend remains some in future, this disease would be uncontrollable and our country would face the situation of Africa now.

2.6 The Case of Nepal

HIV/AIDS have become a major public health problem in Nepal. The first case was reported in 1988. The potential for the spread of HIV in Nepal is large because of extensive use of commercial sex workers, high rate of sexually transmitted disease, low level of condom use and pockets on intra venous drug users. As of June 2007, a total 1410 AIDS cases and 9532 of HIV infection are reported by the ministry of Health and Population, Nepal Centre for AIDs and STD control.

AIDS entered in Nepal through the prostitution, either women and girls who were involved in the prostitution in Mumbai or other cities of India (Acharya, 1998). They are generally supposed to come back to home, which helps AIDs to spread in Nepal.

One estimate shows approximately 34,000 cases of HIV/AIDS infection in Nepal (UNAIDS, 2000), and another study of female sex workers with STDs in Kathmandu shows a 17% among intravenous drug user (Gurubacharya, 1994). Therefore, the rise of AIDS spreading into the general population through the sexual partner of intravenous drug users and clients female sex workers in large (NDHS, 2000).

Like much of South Asia, Nepal is experiencing low HIV/AIDS prevalence among the general population but concentrated epidemic among several high risk groups. Given the existing medical and public health infrastructure and the limitations of the national HIV/AIDS surveillance system, it is possible that the actual number of cases in much higher. The experience of other countries has been that once a strong HIV/AIDS; surveillance system is in place, the epidemic is recognized as being more widely spread than earlier believed.

Information from the wider south Asia region is similar worrying. Despite an assumed low prevalence rate in India, its large population means that it is second only to South Africa for the absolute number of people living with HIV/AIDS LP(WHA). Like Nepal, the epidemic is marked by low general prevalence but high prevalence among female SWS, IDUs, MSM, and mobile population. This is particularly worrying for Nepal as an estimated 300,000-600,000 Nepali men and boys might to India migrants to Mumbai have a significantly larger risk of HIV infection. This is believed to be due to the HIV prevalence among female SWS in Mumbai (HIV/AIDS and WCN, 2004).

A study conducted by WHO, shows level of education, place of residence, mass media, source of information exerts a strong effect on level of knowledge of HIV/AIDS. Education is the strongest and the most consistent predictor of HIV/AIDS wariness and the level more likely to be aware of HIV/AIDS. There is positive relationship between education and knowledge about HIV/AIDS. Mass media and national awareness programme have a positive association with the awareness and the level of knowledge of HIV/AIDS. As well as maternal health service is positively and significantly related to the awareness of HIV/AIDS among currently married women (Panta, 2004).

Youth of Nepal is vulnerable to STIs and HIV/AIDS because there is limit ideas about the information education and information to them. It is an age of sexual activities so the prevalence case is predominant in this age (NCASC, 2004).

Adolescent and youth age 10-14 constitute one third of total population in Nepal. The share of adolescent cohort along (aged 10-19) years came be about one-fourth of the total population. The NDHS 2001 shows that the contraceptive prevalence rate (CPR) among rate adolescents (aged 15-19) is reported to be at only 12 percent while it is 23.4 percent among 20-24 age group. Adolescents and youth are

scattered in the community and they are also mobile. The risk taking behaviour of the youth and the situation of being away from homes in search of economic opportunity make then susceptible to contact disease like STD & HIV/AIDS. Moreover, two thirds of adolescents girls in the age group 10-19 years of age illiterate where as the figure is only 24 percent among adolescent boys (Pathak, 2005: 1-2).

Beside the several studies that STD case reports collected and complained from referred centers for STD and five STD clinics reveals increasing number of STD cases coming to health facilities in the year 1997, a total of 2,118 cases were reported with increased to 3,250 cases in 1999 and 5,547 cases in 2000. The percentage of STD cases was high in Mid western and far western in Nepal (Devkota, 2005).

There are 9,344 reported HIV/AIDS cases in Nepal in May 2007 among them, 430 cases are between the age of 15-19 years and 3,816 cases are between the 20 to 29 years. It shows that youth are highly vulnerable and most infected group in Nepal. Youths are passing through the psychological changes occur at the time, it is difficult for them to practice risk free livelihood which being about undesired results (NCASC, 2007).

The HIV situation in Nepal is characterized by the high prevalence among groups involved in high-risk behaviour. Among street sex workers in Kathmandu it rose from about one percent in 1992 to 16 percent in 1998. Among intravenous drug users (IDUS), it rose from about 2 percent in 1991 to 50 percent in1997. The prevalence in general population in Nepal is still low, but is rising rapidly. There are indications that the transmission among house wives is increasing. Though, the infection is found every where, it is concentrated in the capital (UNAIDS, 2005). Young women and men age 15-24 of relatively more knowledge able of various modes of prevention than older respondents, fare instance, about 35 percent of women and 65 percent men aged 40-49 mentioned that using condom and limiting sex to one uninfected partner can reduce the risk of HIV/IDS infection, compared with 65 percent of women and 83 percent of men age 15-24.

Knowledge of HIV/AIDS prevention methods among both women and men is highest among those divorced, separated or widowed. Levels of higher risk sexual intercourse are quite high among young men age 15-24; one in five reports sexual intercourse with some one other than their spouse or cohabiting partner in the last 12 monthly. Higher risk sexual intercourse is especially common among men in the age

group 15-19 years. Among when one in three reports higher in risk sexual intercourse in the previous year.

The proportion of women and men in the 15-24 age comfort who had sex before age 15 and before age 18. Eight percent of young women and four percent of young men had sex by age 15 while 47 percent of young women and 27percent of young men had sex by age 18. The female-male difference in the age of first sexual debut is primarily due to the earlier age at marriage among women (NDHS, 2006, 202: 219).

According to Ministry of Health and Population, National Centre for Aids and STD Control (NCASC) cumulative HIV/AIDS situation of Nepal as Jestha 2066 (in June, 2009) shows the following table:

Table 3: Commutative HIV and AIDS Situation of Nepal June 14, 2009

Condition	Male	Female	Total	New Cases in June 14, 2007
HIV Positive (Including AIDS)	8345	4080	12425	390
AIDS (Out of Total HIV)	1445	599	2044	109

Source: National Center for AIDS and STD Control, Kathmandu, 2009.

Table 4: Commutative HIV infection by Sub-Group and Sex

Sub-Group	Male	Female	Total	New cases in June 14, 2007.
Sex workers (SW)	6	802	808	13
Clients of SWs/STD	5448	143	5591	156
Housewives	-	2780	2780	127
Blood or organ recipients	28	10	38	0
Injecting Drug user	2290	46	2336	41
Men having sex with men (MSM)	69	-	69	19
Children	441	278	719	34
Sub- group not identified	63	21	84	0
Total	8345	4080	12425	390

Source: NCASC, 2009.

2.7 HIV/AIDS and STDS Control Initiatives in Nepal

The current situation of HIV in Nepal is different from the first case which was diagnosed in 1988. There are gaps and challenges to be addressed in the fight against HIV and AIDS. Nepal is low prevalence country for HIV/AIDS (0.5%). However some of the groups show evidence of a concentrated HIV epidemic, e.g. sex workers (19.5%) migrant population (4-10%) and intravenous Drug users (IDUS)

both in rural and urban areas since 1988 when the first case was diagnosed MOHP/DOHS and different stakeholder came forward to address HIV/AIDS issues. The main focus was given to preventive aspects. In 1995 MOHP in consultation with different stakeholder developed a policy for the control of HIV/AIDS. However, the activities were implemented in sporadic and disorganized manner.

MOHP come to the conclusion that every stakeholder working in the field of HIV/AIDs should come forward to the world under one umbrella within the frame work of the single policy. As a result, in 2002 new strategy for HIV/AIDS was developed for 5 years (2002-2006) and consequently for 5 years (2003-2007). However, there are many gaps that were not identified during the development of new strategy guidelines that need to be addressed while revising it in 2007 (MOPE, 2007). The new strategy short lights to the following main areas.

- vulnerable group
- young people
- Treatment, care and support
- Epidemiology's, research and surveillance
- Management and implementation of an expanded response of an expanded response.

Board political commitment is required for an multi-sector approach, civil society involvement, public-private partnership reduction of stigma and discrimination against people infected and affected by HIV/AIDS and human right based approach have been outlined as some of the guiding principles in the development of strategy. To enable high level National AIDS council (NAC) chaired by the prime minister was formed there is National AIDS Coordination Committee (NACC) chaired by the minister of health which is responsible fore reviewing and apperceiving work plans and budgets reviewing report and guiding implementation of the national strategy.

The funding is dues and acts us as the secretarial to the NACC. The NACC secretary that meets on a regular basis to review program activities as well as to guide and direct program implementation (DHS, 2001).

For the prevention of AIDS and STDS some efforts have been implemented in different times and dates. In 1986 organization of STD and HIV/AIDS control committee has been formed. In 1987/88 implementation of short term plan was started to be functioning and its medium term plan implemented in 1990/92. From 1993 a policy is adopted for 100% screening of the donated blood. The second medium term plan for AIDS and STDS control has been implemented. In 1995 a national level policy on AID/STDS prevention is adopted. A new strategic plan for HIV/ AIDS

prevention was adopted from 2002 to 2006. The two national VCT respectively in 2004 standard operating procedures on ART was started in Sukra Raj tropical hospital. The STI case management guideline was developed in 2004 (NCASC, 2005).

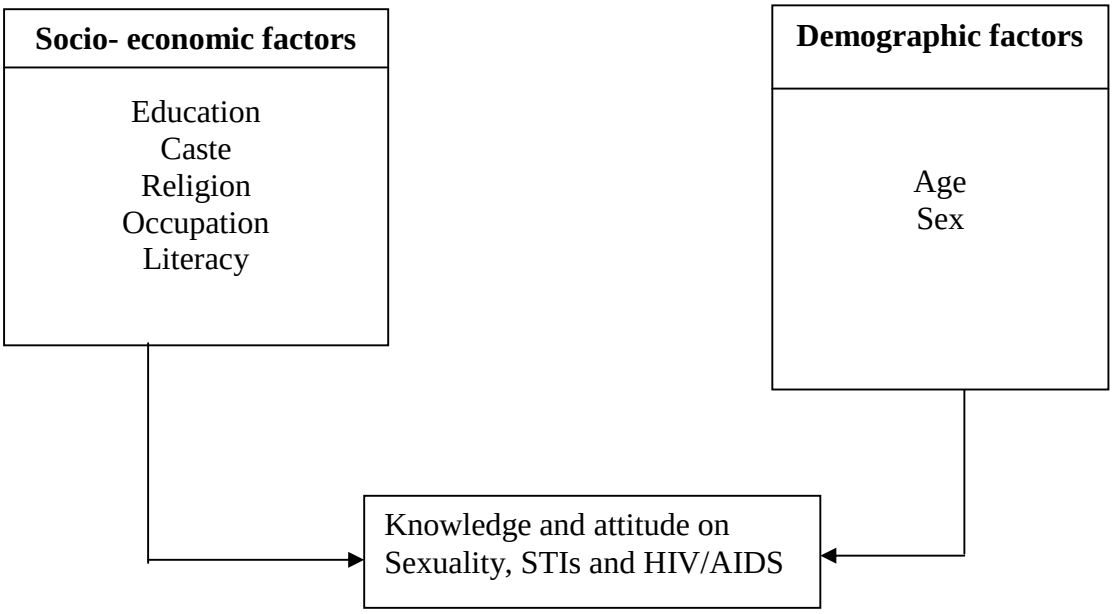
2.8 Conceptual Frame Work of the Study

This conceptual framework is based on the literature review and variable are selected for the analysis of knowledge and attitude secondary and higher secondary students on STIS and HIV/AIDS (A case study of Shree Janapriya H.S.S., Chinnebas) of Syangja district aged 14 to 19. This study concludes that among many variables education in the most important variables for increasing the knowledge on sexuality, STIS and HIV/AIDS.

The conceptual framework helps to show the relationship between dependent and independent variables and also shows that independent variables are socio-economic factors like education, castle, religion, occupation social norms and literacy and demographic factors like age and sex. All these variable effect the knowledge and attitude on sexuality, STIS and HIV/AIDS.

Socio-economic factors like education, caste, religion, occupation, social norms, literacy and demographic factors like age, sex, educational status influence the knowledge and attitude on sexuality STIs/HIV/AIDS.

Conceptual Framework of the Study



CHAPTER –III

METHODOLOGY

The focus of this study is on assessments of Secondary and Higher Secondary level Students knowledge and attitude to STIs and HIV/AIDS. This study reflects his/her real perception about, knowledge and attitude on the subject. Essential methodology and procedure applied accordingly are explained in brief below.

3.1 Selection of Study Area

Syangja is a beautiful hilly district which lies in the Gandaki Zone belonging to the western development region of Nepal. It is extending western part of Nepal. It has the area of 1164 sq. km. According to the population census of 2001, the total population of the district is 340304 of which 154022 (45.26%) are males and 186282 (54.73%) are females. The total no. of household are 56717 with an average household size of 6 person per house. The population density is 85 per sq. km.

According to the VDC survey 2009 (2066), the total population of the Chinnebas VDC is 4000 of which 2200 (55.0%) are females and 1800 (45%) are males. The total households are 700 with an average household of 7 person per house.

Syangja district is surrounded by six districts, Palpa and Nawalparasi in the south, Kaski and Parbat in the north, Tanahun lies in east, Gulmi in west.

There are 60 village development committees (VDCs) and two municipalities (Putalibazar and Waling) in Syangja. This study has been carried out in Chinnebas VDC of Syangja district; within Chinnebas VDCs Shree Jana Priya Higher Secondary School is only one higher secondary school. It lies in the ward no. 3 of Chinnebas VDC. The main occupation of people in the study area is agriculture. The study area has been chosen deliberately because of the pre-informed area for the researcher to draw the real information of respondents.

3.2 Sources of Data

The main source of data are the students of secondary and higher secondary level. Basically the primary data have been collected to find out facts and figure about knowledge and attitude of students on sexuality, STIs and HIV/AIDS of students aged 14 to 19. Primary data have been collected through questionnaire distributed to 150 students aged 14-19 from sampled school (Shree Jana Priya Higher Secondary School). The secondary data was taken from published annual reports of the different organizations like UNAIDS, CBS, UNESCO and UNAIDS. Books journals, previous

reports, VDC report, school report, sub-health post report, articles, census data were also taken as the basic sources of secondary data.

3.3 Sampling Techniques and Selection of Respondents

The primary base information was collected through direct interview using the purposive sampling methods. Of 700 students of Shree Jana Priya Higher Secondary School, 150 students were taken as the sample of the study using purposive random sampling procedure. The total number of respondents is 150. Among them, 80 girls and 70 boys have been selected. Basically the information was collected with the target age group 14-19 years.

3.4 Questionnaire Design

Questionnaires constituted the major tool of this study. Questionnaire has been designed to obtain students individual information. The questionnaire has been distributed to all both girls and boys separately. Household questionnaire has been designed to take the information about father's and mother's education, occupation, household facilities etc. The objectives of individual questionnaire are to know the knowledge and attitude of students on STIs and HIV/AIDS. Whereas the purpose of household questionnaire is to identify the status of respondents' parents.

The questionnaire has been designed into four sections (for detail see appendix 3.1)

I) Individual information

II) Household information

III) Knowledge and attitudes on STIs and HIV/AIDS

IV) Practice of sexuality and use of condom.

3.5 Data Collection Method

Topic of STIs and HIV/AIDS is related to sexuality so its issue is sensitive for unmarried as well as married youth population. Generally, the students were distributed questionnaire separately for both boys and girls in order to avoid the hesitation in them. At first the students were given the questionnaire and asked for filling up the questionnaire. The researcher to help understanding the questionnaire to students also supervised himself for boys and ladies teacher for girls. The selected respondents were asked the questions according to the designed questionnaire.

3.6 Data Processing/Management

The questionnaire filled by students were carefully checked and after getting the data, the researcher, with the help of Ms-Excel prepared tables by using simple statistical methods i.e. number and percentile.

3.7 Method of Data Analysis and Interpretation

The data were processed with the help of computer using database Ms-Excel program. Frequency tables and percentages were developed accordingly. The data analysis is simply based on descriptive type of analysis. The findings of the analysis have been presented in tabular forms and interpreted accordingly.

3.8 Selection of Variables

Two types of variables are included in this study. They are dependent and independent variables which are given as follows:

Independent Variables

I) Socio–economic variables: education, caste, religion, occupation, social norms, literacy.

II) Demographic variables: age, sex and educational status.

Dependent Variables

I) Knowledge, attitude towards STIs and HIV/AIDS

II) Practice of sexuality and using condoms.

CHAPTER-IV

DEMOGRAPHIC AND SOCIO-ECONOMIC CHARACTERISTICS

This chapter presents the demographic and socio-economic characteristic of the respondents. Socio-economic background provides information about respondents' parents occupation, parent's education and religion. Whereas demographic characteristics provides information about age-sex structure and educational status of the respondents.

4.1 Individual Characteristics of the Respondents

The variables used to collected individual characteristic have been described within this subsection.

4.1.1 Age-sex Composition

The respondents were selected at age group of 14-19. Table 5 shows the distribution of respondents by age and sex. The table 5 shows that 52 percent respondents fall under the age group 17-19. Among female 55 percent and among males, 48.58 percent respondents fall in this age group. Similarly, nearly half of the respondents (48%) fall under the age group 14-16. Among females 45 percent and among males, 51.42 percent respondents fall in this age category.

Table 5: Distribution of Respondents by Age-Sex Composition

Age group	Male		Female		Total	
	Number	Percent	Number	Percent	Number	Percent
14-16	36	51.42	36	45	72	48
17-19	34	48.58	44	55	78	52
Total	70	100.0	80	100.0	150	100.0

Source: Field Survey, 2010.

4.1.2 Caste and Ethnicity

The prevalence of HIV/ AIDS is also varies by Caste/ Ethnicity. According to 2001 census has recorded an overwhelming majority of Chhettri i.e. 16 percent at national level. Likewise, similar position has been reported in study area. Literature review shows that some major caste (Brahmin, Chhettri) is less affected by these diseases than other Caste/ Ethnicity because these caste people are more forward in every sector.

Table 6: Percentage distribution of respondents by caste/ethnicity

Caste/ Ethnicity	Number	Percentage
Brahmin	55	36.67
Chhettri	35	23.33
Newar	4	2.67
Magar	35	23.33
Gurung	20	13.33
Dalit	5	3.33
Total	150	100.00

Source: Field Survey, 2010.

The caste/ ethnic group Brahmin contributed largely to the total number as 36.67 percent (55) followed by Chhettri 23.33 percent (35), Magar 23.33%, Gurung 13.33%, Dalit 3.33 and the lowest Newar has only 2.67% population.

4.1.3 Religion

It is universal (100%) in the study area that all of the respondents of the study area are Hindu.

4.1.4 Living Status

Current living status of respondents is presented in Table 7. It is seen that majority of the respondents (94%) are living at their own house followed by at relatives (4%) and at rented house (2%).

Table 7: Distribution of Respondents by Living Status

Living Status	Respondents	Percent
At home	141	94
At rented house	3	2
At relatives	6	4
Total	150	100.00

Source: Field Survey 2010.

4.2 Household Characteristics of Respondents

4.2.1 Educational Status of Parents

The educational attainment of the parents is an important socio-economic factor. This factor can play the vital role for determine of the level of knowledge of their children on STIs and HIV/AIDS. In questionnaire, the educational levels of father and mothers are asked to the respondents separately. The results combining of both of parents is shown in shown in Table 8.

Table 8: Distribution of respondents by Parents' Educational Attainment

Can your parents read and write?				
	Respondents			
Response	Father		Mother	
	N	%	N	%
Yes	101	67.33	61	40.67
No	49	32.67	89	59.33
Total	150	100.0	150	100.0
Completed level of education				
Non formal education	16	10.67	34	22.67
Primary 1-5	22	14.67	13	8.67
Secondary 6-10	49	32.66	11	7.33
SLC and above	14	9.33	3	2
Total	101	67.33	61	40.67

Source: Field Survey 2010.

From Table 8 it is seen that most of the parents are literate. About 67.33 percent of the respondents reported that their father is literate which is 40.67 percent for their mother. The higher proportion of respondents' fathers (32.66%) to have secondary level of education compared to their mothers (7.33%). Only 14.67 percent of respondents' father and 8.67 percent of their mothers have primary level of education. This figures shows that male's educational level is higher than female.

4.2.2 Family Size

The family size may have impact on the quality of life. There was tendency of joint and extended family in this society. The questions were put on to assess this information in this study and the result is shown in Table 9.

Table 9: Distribution of Respondents by their Family Size

Size of family	Respondents	Percent
Less than 5 persons	88	58.67
5 to 10 persons	52	34.67
Above 10 persons	10	6.66
Total	150	100

Source: Field Survey, 2010.

Table 9 shows that 88 respondents (58.67%) have less than 5 members in their family followed by 34.67 and 6.66 percentage having of 5-10 persons and above 10 persons respectively. From this figure it is clear that there is small and nuclear family system in community.

4.2.3 Possession of Household Facility

In the questionnaire, the possession of household facilities like radio electricity, telephone, television were asked to the respondents. Table 14 shows the possession of these facilities in their households.

Table 10: Distribution of the Respondents According to the Possession of the Household Facilities

Facilities	Respondents			
	Have		Don't have	
	No.	%	No.	%
Radio	112	74.67	38	25.33
Telephone	66	44	84	56
Electricity	150	100	0	0
Television	77	51.33	73	48.67

Note: Total percentage is more than 100 due to multiple responses.

Source: Field Survey, 2010.

In this study area, Chinnebas VDC is facilitated by electricity so that electronic facilities are available there. But some of the households are not facilitate due to the economic condition of their family. It is seen that 100% respondents have electricity facility followed by radio in their households (74.67%), television (51.33%) and telephone (44%).

CHAPTER – V

KNOWLEDGE AND ATTITUDE OF STIs AND HIV/AIDS

Analysis of the knowledge and attitude of STIs and HIV/AIDS among the secondary and higher secondary level of students are presented in this chapter.

5.1 Knowledge on STIs

The knowledge on STIs is measured in term of several variables. First of all, it is examined whether the respondents have heard about STIs or not. Then knowledge on symptoms, knowledge on mode of transmission and knowledge on preventive measures have been examined.

5.1.1 Heard of STIs

To know the knowledge of STIs, the question "Have you heard about STIs?" is given to the respondents. Table 11 gives the information either they have heard of STIs or not by their background characteristic.

Table No. 11: Distribution of respondents according to heard of STIs by background characteristics.

Background Characteristics*	Heard of STIs			
	Yes		No	
Sex	No	%	No	%
Male	58	38.67	12	8
Female	61	40.67	19	12.67
Total	119	79.34	31	20.66
Age Group				
14-16	58	38.67	14	9.33
17-19	61	40.67	17	11.33
Total	119	79.34	31	20.66
Education				
Secondary	42	28	17	11.33
Higher secondary	77	51.33	14	9.33
Total	119		31	20.66

***** *Background Characteristics refers to sex, age and education of respondents.*
Source: Field Survey, 2010.

It shows the distribution of respondents according to heard of STIs by their background characteristics. It illustrate that more number of female have heard about STIs than male, (40.67% Vs 38.67%). Observing the age group, it is 40.67 percent for the respondents aged 17-19 and 38.67 percent for the respondents aged 14-16 years. The proportion of heard of STIs is different between males and females. Similarly, it is seen to be affected by the educational attainment level. It is found that higher secondary level students' have heard more about STIs i.e. 51.33 percent followed by

secondary level (28%). In the same way most of the students of secondary level have not heard about STIs i.e. 11.33 followed by higher secondary level students i.e. 9.33 percent.

5.1.2 Knowledge About Types of STIs

It is essential to check whether the respondents have knowledge about types of STIs and the respondents who have knowledge about types of STIs were further asked the knowledge on specific types and the results is shown in table 12.

Table 12: Distribution of Respondents by Knowledge on types of STIs and knowledge on specific types

Knowledge on types of STIs	Respondents	Percent
Yes	113	94.95
No	6	5.05
Total*	119	100.0
Knowledge on Specific types of STIs		
Syphilis	78	69.02
Gonorrhea	104	92.03
HIV/AIDS	113	100.00
Other **	39	34.51

* *only those who have heard of STIs.*

** *other includes leprosy, cholera, chicken pox*

Note: Total percent on knowledge on specific types is more that 100 due to multiple responses (N=119)

Source: Field Survey, 2010.

It seems that 94.95 percent respondents have knowledge on types of STIs and 5.05 percent respondents don't have knowledge on it. Observing the specific types, HIV is very common types of STIs which is universal (100.00%). The other types of STIs are gonorrhea, which is heard by 92.03 percent and syphilis, which is heard by only 69.02 percent of respondents.

5.1.3 Source of Information about STIs

There are various sources, which gives information about STIs. Table 13 shows the sources of information about STIs in study area. It illustrates that majority of the respondents (76.47%) reported television as the source of information and second major source is radio (46.21%) followed by teacher (27.73%), newspaper (10.08%), others (13.45%), and parents (3.36%).

Table 13: Distribution of respondents according to source of information about STIs

Source of Information	Respondents	Percent
Radio	55	46.21
Television	91	76.47
Newspaper	12	10.08
Teacher	33	27.73
Parents	4	3.36
Others	16	13.45

Note: Total Percentage is more than 100 due to multiple responses (N=119)
Source: Field Survey, 2010.

5.1.4 Knowledge on Transmission of STIs

In questionnaire, the questions to asses the knowledge of Transmission of STIS was included. Respondents who have heard of STIs were asked whether they know the mode of transmission of STIs or not. Table 14 gives the information about knowledge on transmission of STIs in respondents.

Table 14: Distribution of Respondents according to knowledge of mode of transmission of STIs by background characteristics

Respondents						
Background Characteristics*	Knowledge on transmission of STIs					
	Yes		No		Total	
Sex	No	%	No	%	No	%
Male	53	91.37	5	8.62	58	100.0
Female	57	93.44	4	6.56	61	100.0
Age group						
14-16	57	90.47	6	9.52	63	100.0
17-19	53	94.64	3	5.35	56	100.0
Education						
Secondary	52	89.28	6	10.71	56	100.0
Higher Secondary	58	95.23	3	4.76	63	100.0

** Background Characteristics refers to sex, age and education of respondents.*

Source: Field Survey, 2010.

Table 14 illustrates that higher no. of female respondent (93.44%) have knowledge on transmission of STIs than male (91.37%). By observing the knowledge on transmission of STIs by age group, it is found that the no. of respondents of knowledge of STIs is higher in age group 17-19 (94.64%) than the age group 14-16 (90.47%). Education is one of the tool, which determine the knowledge on transmission of STIs. It is found that higher the level of educational attainment seems higher knowledge on transmission of STIs. Higher secondary level students are found having more knowledge of STIs i.e. 95.23% than secondary level students' i.e. 89.28%. The respondents who have knowledge on mode of transmission of STIs were further asked to the different types of mode (way) of transmission. Table 15 gives the result.

Table 15: Distribution of Respondents by Types Mode of Transmission of STIs

Types Ways of Transmission	Respondents	Percent
Sexual contact with infected person	107	89.91
Infected mother to fetus	89	74.78
Living together with infected person	11	9.24
Don't know	4	3.36
Other	1	0.84

Note: Total Percentage is more than 100 due to multiple responses (N=119)

Note: Others include kissing, shaking, walking together.

Source: Field Survey, 2010.

Table 15 shows that about 107 respondents (89.91%) said sexual contact with infected person is the most important mode of transmission. Likewise, 89 respondents (9.24%) reported living together with infected persons as the mode of transmission. About 74.78 percent of respondents said infected mother to fetus as the mode of transmission followed by don't know (3.36%) and others (0.84%).

5.1.5 Preventive Measure of STIs

It is essential to check whether the respondents have knowledge on preventive measure of STIs or not. The question on knowledge on preventive measures was included in the questionnaire. Table 16 gives the information about preventive measures of STIs by their background characteristics.

Table 16: Distribution of Respondents according to knowledge on preventing measure of STIs by background characteristics

Respondents						
Background Characteristics*	Knowledge on preventing measure of STIs					
	Yes		No		Total	
Sex	No	%	No	%	No	%
Male	53	91.37	5	8.62	58	100.0
Female	57	93.44	4	6.55	61	100.0
Age group						
14-16	54	93.44	4	6.55	58	100.0
17-19	56	91.37	5	8.62	61	100.0
Education						
Secondary	52	89.28	6	10.71	56	100.0
Higher Secondary	58	95.23	3	4.76	63	100.0

** Background Characteristics refers to sex, age and education of respondents.*
Source: Field Survey, 2010.

By observing the table 16 it is found that 91.37 percent of male and 93.44 percent of female have knowledge on preventive measure of STIs. Similarly 93.44 percent who is in 14-16 age groups have knowledge on preventive measure which is higher than the respondents who are in age group 17-19 (91.37%). Educational attainment level is another tool for knowledge on preventive measures of STIs. During study, it is found that higher the educational attainment level higher the proportion of knowledge on preventive measures of STIs. For the respondents who have the educational attainment of secondary level is 89.28 percent knowledge on preventive measures of STIs whereas 95.23 percent of higher secondary level students have knowledge on preventive measures of STIs. The respondents who have knowledge on preventing measures of STIs were further asked to the knowledge on types of preventive measures. Table 17 gives the result.

Table 17: Distribution of Respondents by knowledge on types of Preventive Measures of STIs

Knowledge on types of preventive measures	Respondents	Percent
Use condom	107	97.27
Avoid walking together with infected person	3	2.72
Strict to only one uninfected sex partner	46	41.81

Note: Total Percentage is more than 100 due to multiple responses (N=110)
Source: Field Survey, 2010

It is shown in the Table 17 that use of condom was the most preferred way of preventive measure of respondents from sexually, transmitted infection, which had been reported by 97.27 percent of respondents. Likewise, strict to only one uninfected sex partners (41.81%), avoid walking together with infected person (2.72%).

5.2 Knowledge on HIV/AIDS

Question had been asked to the respondents whether they have knowledge about HIV/AIDS. First of all, very common question "Have you heard about HIV/AIDS" is given in the questionnaire. Similarly other supporting questions such as mode of transmission, major symptoms, preventive measures are used to further analyses.

5.2.1 Heard of HIV/AIDS

To know the knowledge of HIV/AIDS the question "Have you heard about HIV/AIDS?" is asked to the respondents. Table 18 gives the information either they have heard of HIV/AIDS or not by their background characteristics.

Table 18: Distribution of Respondents Hearing of HIV/AIDS by Background Characteristics

Respondents						
Background Characteristics*	Heard of HIV/AIDS					
	Yes		No		Total	
Sex	No	%	No	%	No	%
Male	57	98.27	1	1.72	58	100.0
Female	58	95.09	3	4.91	61	100.0
Age group						
15-19	56	96.55	2	3.44	58	100.0
20-24	59	96.72	2	3.27	61	100.0
Education						
Secondary	55	94.82	3	5.17	58	100.0
Higher Secondary	60	98.36	1	1.63	61	100.0

* *Background Characteristics refers to sex, age and education of respondents.*

Source: Field Survey, 2010.

It illustrates that more no. of male have heard about HIV/AIDS than female (98.27% vs. 95.09%). It is 96.72 percent for the respondents aged 14-16 and 96.55

percent for the respondents aged 17-19 years. Similarly, it is seen to be affected by the educational attainment level. It is found that the higher secondary level students have heard more about HIV/AIDS than the secondary level students (i.e. 98.38% vs. 94.82%).

5.2.2 Knowledge on Transmission of HIV/AIDS

Knowledge of transmission of HIV/AIDS was assessed during study. The knowledge of transmission was get different according to respondents background characteristics. Table 19 gives information about the knowledge of transmission of HIV/AIDS in the study area.

Table 19: Distribution of Respondents according to knowledge on transmission of HIV/AIDS by background characteristics

Respondents						
Background Characteristics*	Knowledge on transmission on HIV/AIDS					
	Yes		No		Total	
Sex	No	%	No	%	No	%
Male	57	98.27	1	1.72	58	100.0
Female	58	95.09	3	4.91	61	100.0
Age group						
14-16	57	96.61	2	3.38	59	100.0
17-19	58	96.67	2	3.33	60	100.0
Education						
Secondary	55	94.82	3	5.17	58	100.0
SLC and above	60	98.36	1	1.63	61	100.0

* *Background Characteristics refers to sex, age and education of respondents.*

Source: Field Survey, 2010.

Table 19 illustrates that higher number of male respondents have knowledge on transmission of HIV/AIDS than female. 98.27 percent male and 95.09 percent female reported that they have knowledge on transmission of HIV/AIDS. Observing the age group, there is slightly different knowledge on transmission of HIV/AIDS, 96.67 percent respondents aged 17-19 and 96.61 percent respondents aged 14-16 reported that they have knowledge on transmission on HIV/AIDS. Similarly, educational attainment level is another determinant of knowledge of transmission of

HIV/AIDS. It is seen that higher secondary level students have higher attainment level i.e. 98.36% than the students of secondary level i.e. 94.82% knowledge on transmission of HIV/AIDS. The respondents who know about mode of transmission of HIV/AIDS were further asked the way of specific transmission of HIV/AIDS and the results are given in Table 20.

Table 20: Distribution of Respondents by knowledge on types of Mode of Transmission of HIV/AIDS

Ways of transmission	Respondents	Percent
Sexual contact with infected person	112	97.39
From mother to fetus	81	70.43
Infected blood transfusion	88	76.52
Sharing unsterilized needle	33	28.69

Note: others include kissing, shaking, eating same disk.

Note: Total Percentage is more than 100 due to multiple responses (N=115)

Source: Field Survey, 2010.

Almost all respondents (97.39%) considered that sexual contact with infected person is a mode of HIV/AIDS transmission. About 76.52% of the respondents gave positive response by infected blood transfusion followed by 70.34% respondents about transmission of HIV/AIDS from mother to fetus, followed sharing unsterilized needle (28.69%).

5.2.3 Knowledge on Symptoms of HIV/AIDS

It is essential to know the symptoms of HIV AIDS. It is because if any body have knowledge of symptom of HIV AIDS then he/she can adopt other kinds of treatments which are necessary. Table 21 gives information about the knowledge on symptoms of HIV/AIDS and types of symptoms in study area/population.

Table 21: Distribution of Respondents by the knowledge on Symptoms of HIV/AIDS and types of Symptoms

Knowledge on Symptoms of HIV/AIDS	Respondent number	Percent
Yes	113	94.95
No	6	5.05
Total*	119	100.00
Types of Symptoms of HIV/AIDS		
Loss body weight by 10 percent	31	27.43
Diarrhea for more than one month	33	29.20
Fever for more than one month	79	69.91
No response	6	5.30

*only those who have knowledge about HIV/AIDS.

Note: Total Percentage is more than 100 due to multiple responses. (N=113)

Source: Field survey, 2010.

It seems that out of total 119 respondents who have heard of HIV/AIDS. Only 94 percent knows the symptoms of it. At the conditions of types of symptoms, 27.43 percent reported loss body weight by 10 percent as symptoms of HIV/AIDS. Similarly, 29.20 percent reported diarrhea for more than one month and 69.91 percent said fever for more than one month as a symptoms of HIV/AIDS and only 5.30% gave no response.

5.2.4 Knowledge on Preventive Measure of HIV/AIDS

There are different methods of preventing the HIV/AIDS. The questionnaires were examined whether the respondents have knowledge of preventing it or not. Majority of respondents have knowledge of preventing it. Table 22 gives in formation about the knowledge of preventing HIV/AIDS of respondents of their background characteristics.

Table 22: Distribution of Respondents according to knowledge on preventing measure of HIV/AIDS by background characteristics

Respondents						
Background Characteristics*	Knowledge on preventing measure of HIV/AIDS					
	Yes		No		Total	
Sex	No	%	No	%	No	%
Male	55	94.82	3	5.17	58	100.0
Female	57	93.44	4	6.55	61	100.0
Age group						
14-16	56	96.55	2	3.44	58	100.0
17-19	56	91.80	5	8.19	61	100.0
Education						
Secondary	33	93.10	4	6.89	58	100.0
Higher Secondary	58	95.08	3	4.91	61	100.0

** Background Characteristics refers to sex, age, and education of respondents.*

Source: Field Survey, 2010.

Table 22 shows that majority of male (94.82%) and female (93.44%) have knowledge on preventive measure of HIV/AIDS. It is higher for the respondents aged 14-16 than 17-19 years. It is 96.55 percent for aged 14-16 years respondents and 91.80 percent for aged 17-19 years. Similarly, it's scenario is different according to their educational attainment level. While comparing the education level higher secondary level of student have more knowledge of preventing measure HIV/AIDS i.e. 95.08% and secondary level only 93.10%. It is essential to check whether the respondent have knowledge on different types of preventive measures of HIV/AIDS or not. The result is shown in Table 23.

Table 23: Distribution of Respondents by knowledge on types of Preventive Measure of HIV/AIDS

Types of preventive measure of HIV/AIDS	Respondents	Percent
Avoid sex with multiple partner	85	75.89
Sexual abstinence	38	33.92
Use condom	75	66.96
Scan blood before transfusion	24	21.42
Others	15	13.39

Note: Total percentage may exceed 100 due to multiple responses (N=112).
Note: Others includes sterilized needles, avoid birth from infected mother.
Source: Field Survey, 2010.

About 75.89 percent respondents reported that avoid with multiple partner is preventive measures of HIV/AIDS. Similarly, 66.96 percent respondents said that proper use of condom during sexual intercourse is the measure for prevention from HIV/AIDS. Likewise, 33.92 percent respondent reported the knowledge of preventive measure as sexual abstinence. About 21.42 percent of the respondents reported that testing blood before transfusion can be one of the preventive measures of HIV/AIDS. About 13.39 percent reported others categories of preventive measure of HIV/AIDS. Respondents of the study area are more knowledgeable about knowledge on types of preventive measures of HIV/AIDS.

5.3 Attitude towards HIV/AIDS

The attitudes towards HIV/AIDS perception about this disease and infected persons have been assessed from various aspects in this study.

5.3.1 Attitude on Curative Measures of HIV/AIDS

It was aimed to collect the information from respondents whether HIV/AIDS can be cured or not. Table 24 gives attitude of respondents on curative measures of HIV/AIDS in the study area.

Table 24: Distribution of Respondents by Attitude on Curative Measures of HIV/AIDS

Attitude	Respondents	Percent
Curable	11	9.73
Not Curable	97	85.84
Don't Know	5	4.42
Total*	113	100.0

**Note: Only these who have knowledge about HIV/AIDS*

Source: Field Survey, 2010.

From Table 24, it is seen that 85.84 percent of the respondents said that HIV/AIDS can't be cured whereas about 9.73 percent said that it can be cured. About 4.42 percent respondents have no knowledge about it.

5.3.2 Attitude Towards the Infected People

The youth population is very elite group of society. If they are infected from the HIV/AIDS their future life will be in trouble. Thus, the question related to their attitude towards infected person was asked to collect this information and the result is shown in Table 25.

Table 25: Distribution of Respondents by Their Attitudes towards Infected Person

Attitude	Respondents	Percent
Love and respect them	57	50.44
Hate them	38	33.62
Don't Know	18	15.92
Total	113	100.0

Source: Field Survey, 2010.

According to Table 25, more than half of the respondents (50.44%) reported that they should love and respect to the HIV/AIDS infected person. Similarly, one third said they should be hated and 33.62 percent of respondents reported that they don't know how they should be behaved.

5.4 Practice of Sexuality and Use of Condom

In this section, the information about sexual partner, use of condom, the purpose of condom use and reason of not to use condom are discussed. The information helps to the risky or safe behaviours of respondents and vulnerability to the HIV/AIDS infections to them.

5.4.1 Perception about sex

According to table 26, it is clear that out of 117 respondents, 67.5 percent reported the need for propagating the next generation and 63.2 percent reported sex as basic needs. Similarly, absurd (45.3%) and others (9.4%) are some responses reported by the respondents. Table 30 shows the perception about sex in the study area.

Table 26: Distribution of Respondents by perception about Sex

Perception about sex	Respondents	Percent
Basic needs	74	65.84
Absurd	53	46.90
Need for propagating the next generation	79	69.91
Others	11	9.73

Note: Others include means of satisfaction, part of life.

Note: The total percentage is more than 100 due to multiple responses (N=113)

Source: Field Survey, 2010.

5.4.2 Information about Sexual Partner

At first to know the information about sexual partner of respondents, "Have you ever had sexual intercourse?" was asked to both girls and boy students. The results have been presented in Table 27.

Table 27: Distribution of Respondents Having Sexual Partner

Sexual Partner	Boys		Girls		Total	
	N	%	N	%	N	%
Yes	23	32.85	17	21.25	40	26.67
No	47	67.15	63	78.75	110	73.33
Total	70	100.0	47	100.0	117	100.0

Source: Field Survey, 2010

According to Table 27, 40 respondents (26.67%) have sexual partner and 110 respondents (73.33%) have not sexual partner. Among the boy respondents, 32.85

percent have sexual partner and 67.15 percent respondents have not sexual partner. Likewise in case of girls only 21.25% have sexual partner and 78.75% do not have sexual partner. This figure shows that there is also prevalence of the premarital sex. This may cause high risk of STIs and HIV/AIDS. The respondents who have sexual partner were also asked the question about type of sexual partner and the result is shown in Table 28.

Table 28: Distribution of Respondents by Type of Sexual Partners

Sexual Partner	Boys		Girls		Total*	
	N	%	N	%	N	%
Boy/Girl friend	23	100.0	17	100.0	40	100.0
Total*	23	100.0	17	100.0	40	100.0

**Note: Only those who have had sexual partners.*

Source: Field Survey, 2010

Table 28 shows that 23 boy respondents and 17 girl respondents have sexual partner. For both boys and girls it is universal (100%) that they have boy/ girl friend as a sexual partner.

5.4.3 Information about Condom Use

It is also important to know whether respondents have used condom or not while intercourse with their sexual partner. Thus the question was asked "in your first time intercourse did you use condom?" The results are shown in Table 29.

Table 29: Distribution of Respondents by Condom use in first sexual intercourse

Condom use	Respondents	Percent
Yes	29	72.5
No	11	27.5
Total*	40	100.0

**Note: Only those who have had sexual partners.*

Source: Field Survey, 2010

Out of total 40 respondents who have ever experience of sexual intercourse, only 29 respondents used condom at their first sexual intercourse, on contrary to 11 respondents (27.5%) who did not use condom in the first time sexual intercourse.

5.4.4 Purpose of Condom Use at first intercourse

The use of condom at first sexual intercourse is mainly for the prevention of pregnancy among respondents. Table 30 shows the purpose of condom use among the respondents.

Table 30: Distribution of Respondents by the Purpose of Condom Use

Purpose of condom use	Respondents	Percent
To prevent pregnancy	21	72.41
To prevent STDs and HIV/AIDS	8	27.58
Total*	29	100.0

**Note: Only those who have used condom at their first sexual intercourse*

Source: Field Survey, 2010.

According to Table 30, out of total 29 condom user respondents, 21 respondent (72.41%) used condom for preventing pregnancy and 27.58% used for preventing STDs and HIV/AIDS.

5.4.5 Reason for Not Using Condom at First Intercourse

Some of respondents who have had sexual partner but they did not use condom while first intercourse. They were asked for the reasons for not using condom and the result is shown in Table 31.

Table 31: Distribution of Respondents According To Reasons for Not Using Condom at First Intercourse

Reasons	Number	Percent
Tedious	5	45.45
Not available	6	54.55
Total*	11	100.0

** Note: Only those who did not use condom at first intercourse.*

Source: Field Survey, 2010.

According to Table 31, 11 respondents did not use condom at first intercourse and out of them, 6 respondents (54.55%) did not use condom because of not availability and only 45.45% replied that it is tedious to use.

CHAPTER –VI

SUMMARY, CONCLUSION AND RECOMMENDATION

This study analyzed the knowledge and attitude of secondary and higher secondary level in HIV/AIDS in Chinnebas VDC, Syangja district. Data for the study was collected from the questionnaire filled by the students at the school. The study was conducted in June/July 2010. Altogether 150 students were sampled from secondary and higher secondary level students of Shree Jana Priya Higher Secondary School, Chinnebas VDC.

6. 1 Summary

6.1.1 Individual Characteristics

- Majority of the respondents at 17-19 years age group are about 52 percent followed by 48 percent at 14-16 years age group.
- Majority of the respondents belong to Brahmin caste/ ethnicity i.e. 36.67% followed by Chhetri 23.33%, Magar 23.33%, Gurung 13.33%, Dalit 3.33% and Newar 2.67% respectively.
- All of the respondents (100%) are Hindu religion.
- Among the respondents 72 are from secondary level and 78 from higher secondary level.

6.1.2 Household Characteristic

- Most of the respondents parents are literate, about 67.33 percent fathers and 32.67% mothers are literate.
- Large proportions of respondents have radio (74.67%) and about television 44%, electricity 100% and radio 77%.
- The family size of respondents is small. There is 58.67 percent respondents' family having less than 5 persons. 34.67 percent have 5 to 10 members and having more than 10 person is 6.66 percent.

6.1.3 Knowledge and Attitude of STIs and HIV/AIDS

- Most of the respondents about 79.34 percent in total (boys and girls) have heard about STIs.
- According to age group 14-16 years age groups have simply less knowledgeable about STIs (38.67&) with compared to the 17-19 years age group (40.67%).
- Most of the respondents get information about STIs from television (76.47%), followed by radio (46.21%), teachers (27.73%), newspaper (10.08%) and parents 3.36%.
- Most of the respondents (89.91%) have knowledge about ways of transmission of STIs and majority of the respondents (94%) have knowledge about preventing measures of STIs.
- The use of the condom during sexual intercourse is the main preventing measure of STIs is reported by 97.27 percent respondents. Similarly strict to only one uninfected sex partner (41.81%), avoid walking together (2.72%).
- Most of the (97.33%) heard about HIV/AIDS out of total 150 respondents.
- Almost of the respondents have knowledge on HIV/AIDS who had educational status of secondary and higher secondary i.e. 97.33.
- Male respondents (98.27%) are more knowledgeable than female respondents (95.09%) about HIV/AIDS.
- Out of 119 respondents, who know about knowledge on mode of transmission of HIV/ AIDS, 97.39 percent respondents considered sexual contact with infected person is a mode of transmission. Similarly, from mother to fetes (70.43%), Infected blood transfusion (76.52%) sharing unsterilized needle (28.69%).
- Majority of respondents (95.33%) had knowledge of preventive measure of HIV/AIDS. Among them respondents of the age group 14-16 year is 5 percent less than respondents of the age group 17-19 years i.e. (96.55% vs. 91.80%).
- About 75.89 percent respondent reported that avoid sex with multiple partner and 66.96 percent respondent reported that use of condom during sexual intercourse is preventive methods of HIV/AIDS.

6.1.4 Practice of Sexuality and Use of Condom

- Out of total 113 respondents, 69.91 percent respondents said that sex is need for propagating. The next generation similarly sex is basic needs (65.84%), Absurd (46.90%), others (9.73%).
- Only 29 respondents out of 40 used condom at their first sexual intercourse and 11 respondents didn't used condom at their first sexual intercourse.
- The main purpose of using condom was for preventing pregnancy (72.41%), to prevent STD and HIV/AIDS (27.58%).
- Respondents who do not use condom 5 (45.45%) reported that it is tedious and 6 (54.55%) replied that not available.
- Among the respondents who have knowledge about HIV/AIDS, about 50.44 percent said that we should love and respect for HIV/AIDS infected person followed by hate them (33.62%), don't know (15.92%).
- Among respondents who have knowledge about HIV/AIDS they most of them take HIV/AIDS as not curable i.e. 85.84%, 9.73% said that it is curable and only 4.42% replied they don't know about curative measures.

6.2 Conclusion

- This study seems that educational status play the vital role for knowledge attitude and behaviour toward STIs and HIV/AIDS. When the educational status is higher there is also high level of knowledge but if the educational status is low the level of knowledge seems also low.
- Respondents' age group, sex and educational level affect the knowledge attitude and behaviour on STIs, HIV/AIDS.
- The communication facilities plays important role for the knowledge attitude and behaviour on STIS, HIV/AIDS.
- The level of knowledge and attitude toward STIs and HIV/AIDS are higher for male than female.
- Nearly 79.34 percent of the respondents have heard about STIs and HIV/AIDS but they have confusion about symptoms, mode of transmission preventive measure about HIV/AIDS.
- One third of the respondents have a miss perception to the HIV/AIDS infection people.

6.3 Recommendations

From the above conclusion we came to know that education is the most effective way to prevent STIs and HIV/AIDS. The following recommendations are prescribed:

- Education plays the vital role to determine every change in society. Sex education should be provided in school level including all lower caste and ethnicity.
- Appropriate health personal with basic training related to personal health, with the specific knowledge of reproductive health is better to be manage.
- Go, NGO, and INGO co-operatively provide training concerning the public health and reproductive health areas to the concerned population in the community and mechanism of monitoring should be developed and for remedial improvement timely follow up is to be also managed.
- Female education and social status should be raised.
- Conduct special programs like as peer education, sex education, and aiming.

6.4 Further Research

Because of lack of time and resources, this study has not covered every issue related to HIV/AIDS. Even the area of the study is small and no. of respondents are less; so the following areas further research.

- This study on knowledge and attitude on STIS and HIV/AIDS is mainly based on only one secondary and higher secondary level students of Jana Priya Higher Secondary School, Syangja District. Similar type of study among the other school, VDC and whole district to find out the variation can be carried out in the respect.
- This study is only based on secondary and higher secondary level adolescent students. So, all the level of school students as well as non-school adolescents should be include for further study.

REFERENCES

Acharya, L.B., 1999, “Knowledge of HIV/AIDS: Case of Married Female of Age 15-19 in Nepal”, in Bal Kumar K.C. (ed.), *Population and Development in Nepal*, Vol. 6, pp. 127-136.

Bista, N.K., 2002. *Working with the young people HIV AIDS.* EPAN's experiences. In Bal Kumar K.C. (ed) Population and Development in Nepal, Vol. 9 (Kathmandu: CDPS): 15-19.

Central Bureau of Statistics (CBS), 2001, *Population Monograph of Nepal* (Kathmandu: Central Bureau of Statistics).

Devkota, B. 2005, Knowledge of STDs HIV/AIDs and Sexual Behaviours, An Unpublished M.A. Dissertation Submitted to Central Department of Population Studies. Kathmandu: CDPS.

DHS, 2001, "AIDS Newsletter" Kathmandu: National Centre for AIDS and STDS Control.

Gurubajacharya V.L. 1994, HIV/AIDS: Everybody's Concern: Red Light Traffics. Kathmandu: ABC (Nepal): 42-48.

HIV/AIDS and WCN 2004, "HIV/AIDS Situation of Nepal". *Population Magazine*, Kathmandu, PSSN, Vol. III, pp. 25.

Khanal, H., 1997, “Adolescents Reproductive Health in Asia: Current Needs and Status”, *Nepal Population and Development Journal*, pp. 3-4.

MOH, 2003. *Knowledge on HIV/AIDS*, Nepal Demographic health Survey (Kathmandu, MOH) pp. 195-205.

MOH, New ERA and ORC Macro, 2002, *Nepal Demographic and Health Survey, 2001* (Kathmandu: Family Health Division, MOH).

MOPE, 2007, Ministry of Health and Population (MOPE) [Nepal], New Era and Macro International Inc, 2007, Nepal Demographic and Health Survey.

NDHS, 2000, "Family Health Division, Department of Health Service". Ministry of Health, Nepal Government, Kathmandu Nepal, pp. 195-207.

NCASC, 2004, *Cumulative HIV/AIDS Situation of Nepal* (Kathmandu: NCASC).

_____, 2005, *Cumulative HIV/AIDS Situation of Nepal* (Kathmndu: NCASC).

_____, 2006, *Cumulative HIV/AIDS Situation of June 14* (Kathmandu: ACHSC).

_____, 2007, *Cumulative HIV/AIDS Situation of June 14* (Kathmandu: NCASC).

Pandey, L., 2004, *Knowledge of STDs-HIV/AIDS and Sexual Behaviours among Higher Secondary School Students, A School Based Study*, An Unpublished M.A. Dissertation Submitted to the Central Department of Population Studies (Kathmandu: CDPS).

Panta, R., 2004, "Level of knowledge of HIV/AIDS among the Currently Married Women in Nepal", *Tathyanka Gatibidhi*, Vol. 76, pp: 54-65.

Pathak, R.S. and Dhanendra Veer Shakya, 2005, *Baseline Survey Report on Sexual and Reproductive Health Knowledge Attitude, Behaviour and Practice Among Adolescent and Youth People in FPAN Operational Area* (Kathmandu: CDPS/FPAN).

PRB, 2006, *World Population Data Sheet* (Washington D.C: PRB).

UNAIDS and WHO, 2004, *AIDS Epidemic Update: December 2001* (Geneva: UNAIDS/WHO).

UNAIDS, 2000, *Report on the Global AIDS Epidemic*, 2000 (Geneva: UNAIDS).

UNAIDS, 2004, *Report on the Global AIDS Epidemic*, 2004 (Geneva: UNAIDS).

_____, 2005, *Report on the Global HIV/AIDS Epidemic*, July 2005 (Geneva: UNAIDS).

_____, 2006, *Epidemiologic Slides* (Geneva: UNAIDS).

UNFPA 1998, *HIV/AIDS Preventing in UNFPA Programming in South and West Asia* (Kathmandu UNFPA).

UNFPA 2003, *Strengthening HIV/AIDS Preventing in UNFPA Programming in South and West Asia* (Kathmandu UNFPA).

_____, 2005, *The State of the World Population* (New York: UNFPA).

_____, 1999, *The State of the World Population* (New York: UNFPA).

_____, 1998; 1999, *The State of the World Population* (New York: UNFPA).

United Nations, 2004, *World Population Prospects*, The 2002 Revision, Vol. III, Analytical Report (New York: UN).

WHO, 1997, *Adolescence the Articles Phase, How to Prevent STD and HIV/AIDS* (New Delhi: Regional Office for South East Asia).

_____, 2002, *HIV/AIDS Strategies Framework for WHO South East Asia, Region 2002-2006* (New Delhi: WHO Regional Office for South East Asia).

_____, 2005, *HIV/AIDS Strategies Framework for WHO South East Asia, Region 2005-2006* (New Delhi: WHO Regional Office for South East Asia).

QUESTIONNAIRE

Tribhuvan University

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"Knowledge and Attitude on HIV/AIDS Among Secondary and Higher Secondary School Students"

(A case study of Shree Jana Priya Higher Secondary School, Chinnebas VDC, Syangja District Ward No. 3)

A. Individual Questionnaire:

Respondents Number: .....

School: .....

Name of student: .....

Class: .....

1. Age (Completed)……..
2. Sex: 01. Male
   02. Female
3. Religion
   01. Hindu 03. Christian
   02. Buddhist 04. Others (Specify)
4. Where are you living now?
   01. At home 04 At rented house
   02. At hostel 05 At relatives
   03. Others (Specify)

B. Household Questionnaire

5. How many members are there in your family?
   …….members
6. How many brothers and sisters do you have?
   ……Brothers ……..Sisters
7. Can your mother read and write?
   01. Yes 02. No
8. If yes, which class has she completed?
   01. Primary (1-5) 03. Secondary (6-10)
   02. SLC and above
9. Can your father read and write?
   01. Yes 02. No
10. If yes, which class has he completed?
    01. Primary (1-5) 02. Secondary (6-10) 03. SLC and above
11. Do you have the following facility at home? (Multiple responses possible)

01. Television
02. Electricity
03. Telephone
04. Radio

C. Knowledge and attitude of STIs and HIV/AIDS

12. Have you ever heard about STIs?
    01. Yes 02. No
13. Which of the following STIs have you heard? (Multiple response possible)
    01. Syphilis 03. Gonorrhea
    02. HIV/AIDS 04. Others (specify)
14. If yes, form which source have you heard about STIs? (Multiple responses possible)
    01. Radio 05. Television
    02. Newspaper 06. Teacher
    03. Parents
    04. Other (specify)
15. Do you know about the ways of transmission of STIs?
    01. Yes 02. No
15. If yes, how are STIs transmitted? (Multiple responses possible)
    01. Sexual contact with infected persons
    02. Infected mother to fetus
    03. Living together with infected persons 05. Don't know
    04. Other (specify)
17. What are the methods of preventing measure of STIs? (Multiple responses possible)
    01. Use condom
    02. Avoid walking together with infected person
    03. Strict to sex partner
    04. Other (specify)
18. Have you heard about HIV/AIDS?
    01. Yes 02. No
19. Do you know the full form of AIDS?
    01. Yes 02. No
20. If yes, write the full form of AIDS.
    .....
21. Do you know how can be HIV/AIDS Transmitted?
    01. Yes 02. No
22. If yes, how can be HIV/AIDS transmitted? Multiple responses possible)
    01. Sexual contact with infected persons
    02. From mother to child
    03. Infected blood transfusion
    04. Sharing un-sterilized needle
    05. Other (specify)
23. What are the major symptoms of HIV/AIDS? (Multiple responses possible)
    01. Loss body weight by 10 percent
    02. Diarrhea for more than one month

03. Fever for more than one month

24. Do you know the preventive measure of HIV/AIDS?
    01. Yes 02. No
25. If yes, what are the methods for preventing HIV/AIDS (Multiple responses possible)
    01. Avoid sex with multiple partner
    02. Use condom
    03. Sexual abstinence 04. Scan blood before transfusion
    05. Other (specify)
26. Is AIDS curable?
    01. Yes 02. No
    03. Don't know
27. How should we behave to the HIV infected person?
    01. Love and respect them
    02. Hate them
    03. Don't know

D. Practice of Sexuality and Use of Condom

28. In your opinion, what is sex?
    01. Basic needs 02. Absurd
    03. Need for propagating the next generation
    04. Other (specify)
29. Have your ever had sexual intercourse?
    01. Yes 02. No
30. If yes, with whom did you have intercourse first time?
    01. Boy friend/girlfriend 04. Neighbors
    02. Sex worker 03. Other (specify)
31. In your first time intercourse did you use condom?
    01. Yes 02. No
32. If yes, why did you use condom?
    01. To prevent pregnancy
    02. To prevent STD and HIV/AIDS
    03. Other (specify)
33. If no, why did not you use condom?
    01. Not available
    02. Tedious
    03. Other (specify)
34. If you meet HIV/AIDS affected person, what would you behave?
    01. Neglect him/her
    02. Love and affect
    03. Hate him/her
    04. Don't know