

CHAPTER ONE

INTRODUCTION

1.1 Background of the study:

Adolescent is the period of physical, psychological and social maturing from childhood to adulthood. These are the formative years. when the maximum physical, psychological and behavioral change take place, these years are also time of preparation for taking greater responsibilities, a time of exploration widening horizons, and a time of ensure healthy, all round development. Adolescent is a large and growing segment of the population (WHO/UNFPA/UNICEF. 1999).

Adolescent especially those aged 15 to 19 years are believed to engage in high level of unprotected sexual activity both within and outside marriage leaving them exposed to risk of unplanned and unwanted pregnancy and contracting STIs including HIV/AIDS (UNAIDS/WHO. 2006).

Nepal being a landlocked and one of the least developed countries in the world with immense problem of poverty, illiteracy, ignorance and number of young unemployed population, has all the predisposing factors of increasing proportion of population being at the risk of HIV/AIDS (UNAIDS/WHO. 2006).

AIDS (Acquired Immuno-Deficiency Syndrome) is the late stage of infection with Human Immunodeficiency Virus (HIV) when the infected person becomes ill with Symptoms and signs of the disease. Once infected with HIV a large proportion die 5-10 years (WHO, 2004). AIDS reduces the body's ability to fight against disease. HIV is most commonly transmitted through semen and vaginal fluids during unprotected sex. Besides sexual intercourse HIV can also be transmitted during drug injection by sharing

needles contaminated with infected blood, by the transfusion of blood products and from infected women to her fetus during pregnancy or child birth. Sometimes a woman passes HIV to her breast milk. Epidemiological studies have identified sexual intercourse, intravenous injection, blood transfusion and infected mother to fetus are transmission of HIV. Shaking hands, mosquito bites, kissing and sharing food do not spread HIV. There is currently no vaccine for HIV/AIDS though research is under way to produce an effectiveness vaccine. Although initial results are promising scientists do not yet know whether the vaccines would protect people against infections. There is no cure of AIDS the currently licensed drugs for AIDS illness has been shown to prolong survival and improve the quality of people living with HIV/AIDS (WHO, 2007).

HIV is a global health problem affecting all regions and countries around the World. There are about 33.2 million people living with HIV/AIDS at the end of 2007. Out of them over 3.8 million are adult and 15.4 million are women as well 2.5 million are children who are under fifteen. (UNAIDS/WHO, 2007). During 2005 some 4.9 million people became infected with HIV In respect to children, 1,400 children under the age of 15 are infected with HIV everyday. In 2007 alone, an estimated 420,000 children were newly infected with HIV, with approximately 90 per cent of these infections occurring in sub-Saharan Africa. Mortality among HIV infected children is extremely high. Without appropriate care and treatment, more than 50 per cent of the newly infected children will die before their second birthday (WHO, 2007).

There is need for more organizations to adopt a comprehensive and integrated approach to delivering maternal and child health services with a linkage to HIV prevention, care, treatment and support services. Together, we Mortality among HIV infected children are extremely high. Without

appropriate care and treatment, more than 50 per cent of the newly infected children will die before their second birthday (WHO, 2007).

Nepal's first case of AIDS was detected in 1988 (NCASC, 2006). Since then, survey have indicated a gradual increase in HIV prevalence among certain populations, including people seeking treatment for sexually transmitted infections (STIs), sex workers and their clients, and injections drug users (IDUs). AIDS is health condition resulting from infection by Human Immune Deficiency Virus. This disease called syndrome because it consists several signs and symptoms affecting different parts of human body. When HIV enters our body it takes two to ten years to develop AIDS. The window period is the most dangerous period, because in this period a person's HIV test will be negative even though he has had infection. AIDS itself is not a disease, it is a syndrome caused by a virus in the body's immune system. It is the situations of loosing the immunity power and finally gets death. There are three stages in the development of AIDS window period, carrier stage and full-blown AIDS. HIV can be detected in window period even when HIV antibody test is carried out but the person can transmit the infection others, AIDS virus is seen in carrier stage this stage is also called a HIV positive stage.

a) Window period: In this period when HIV virus enters into the human body generally cold cough may appear and disappear after some times. The virus safely settles in cell whereas person is to be looked healthy. This is not much risky period because it is possible to transform of HIV by involving sexual intercourse and other activities. In this period it is difficult to find out the presence of virus when the blood is checked.

b) Carrier stage: although person seems to be healthy in this period HIV increase inside human body. It takes 5 to 10 years for adult and takes 1 to 2

years time for child. If we check the blood, there seems the presence of the HIV.

c) Full-blown AIDS: After 6 months to 10 years period, sign and symptoms of AIDS are seen. Person looks healthy until the sign and symptoms are seen physically and after checking the blood, and if it shows the HIV positive, this situation is called AIDS (Sapkota, 2005).

1.1.1 Mode of Transmission of HIV

HIV is found in body fluids such as blood, semen vaginal fluids and breast milk. It passes from one person to another only in very specific ways. The main ways of transformation are:

Unprotected sex: a person can get infected with HIV through sexual intercourse, which means both vaginal and anal, with an infected person.

Sharing of needles: if a person used needles or syringes used by a HIV infected person, either for injecting drugs or medicines, for drawing blood or for any other purpose involving piercing, s/he can get infection by contaminated instruments used for piercing the skin such as tattooing and acupuncture.

Infected blood: if blood from a person infected by HIV gets into the blood stream of another person, it will also infect the other person. Infection may occur during blood transfusion after an accident, a surgery, after childbirth, or other medical treatment.

Non-sterilized equipment: surgical instruments like syringes and blade of an HIV infected person can transmit the infection if used again without proper sterilization.

Mother to child: if HIV positive women become pregnant, the HIV virus can pass from her blood (through the placenta) into the growing baby during pregnancy or during birth. Breast milk can also act as transmission medium (UNAIDS/WHO. 2002).

1.2 Statement of the Problem

With the large number of adolescents falling prey to the HIV/AIDS, the country is going to face an alarming situation where its youth and energetic population will be vulnerable to killer disease. Although the country still has low prevalence rate of HIV, it is heading towards the situation of concentrated epidemic. If proper steps are not taken to intervene the spread of the disease, gravest of consequences are likely to hit the nation in the years ahead. As the time is running out, the country needs to start dealing with crisis before blows out of control.

Male and female population of age 10-19 years is defined as adolescent. Adolescent can be divided into two categories: early adolescent (10-14 years) and late adolescent (15-19). Adolescent is a transitional period from childhood to adulthood, many children experience biological as well as social change during this period. Similarly, Encarta Encyclopedia (2004) defines adolescence in slight different ways. “Adolescence, stage of maturation between childhood and adulthood. The terms denote the period from the beginning of puberty to maturity; it usually starts at about age 14 in male and age 12 in female. The transition to adulthood varies among cultures, but it is generally defined as the time when individuals begin to function independently of their parents.”

With considering this age bar, from the first case registered in 1988 to till now, 69,790 people are infected by HIV. Out of this, 1,857 person upto the

age of 14 years, 64,585 people at the age of 15-49 years, 3,348 people above 50 years and 16,387 female are infected by HIV (NCASC, 2008). It shows that these age groups are not far from the reach of HIV. HIV/AIDS evidences are increasing among the adolescents in Nepal. It is widely accepted that adolescent's sexual activities are increasing over time but, at present, it is must to know about their level of knowledge regarding HIV/AIDS. Though many organizations like GOs/ NGOs/ INGOs, /CBOs are involving this sector much more left to do.

Any delay in initiating policy action on HIV/AIDS will have a divesting impact on national economy, with adverse consequences in the region; national productivity will be the first casualty since HIV/AIDS largely affects people in the 15-49 ages. It shows the importance of the adolescents in the nation's prosperity because experts also include the adolescents in this age group. So I believe this research study will help to know the adolescent's knowledge and attitude towards HIV/AIDS.

1.3 Objectives of the Study

The main objective of this study is to examine the knowledge and attitude of HIV/AIDS among the school adolescent.

The Specific Objectives:

-) To find out the socio-economic and household characteristics of the school adolescents.
-) To identify the knowledge and preventive measures of HIV/AIDS among the school adolescents.
-) To identify their attitudes towards HIV/AIDS.

1.4 Significance of the Study

People will have to face the worse effects of HIV/AIDS in all aspects of life in our context. Though, some researchers on HIV/AIDS have been carried out especially focusing to secondary level students, they are not enough. Majority of the researchers are concerned to community people or adults. In the context, this research would be a vital source for identifying level of knowledge, attitude and practice of youth/young on HIV/AIDS to cope with the prevalence of HIV/AIDS in developing countries like Nepal. I have also chosen in my study, the most risky group adolescents. From my study it will be able to assess the knowledge of HIV/AIDS among the student of Secondary level. This study will also be fruitful for policy makers, planners, program implementers and demographers. Individual with HIV or AIDS may be isolated from the society and even from the family members. This situation is psychologically and emotionally traumatic to the HIV infected person. They may lose their job or be forced to discontinue education and training opportunities. This situation may lead to frustration, stress fear, and guilt and might result in extreme conditions like suicide. Some people may be aggressive to the extent of taking revenge with other people by spreading the infection.

HIV/AIDS may create disharmony in community relationship. People may lose faith and trust in each other. Increased number of orphans, drop-outs from school and campus, mass of job less people in the community might not only be a burden to the society but it may also give raise to crimes, social values and the moral of the community as a whole.

1.5 Conceptual Frame work

The following conceptual framework, which is made on the basis of review of literature, helps to analyze the knowledge and attitude on HIV/AIDS of secondary school adolescents.

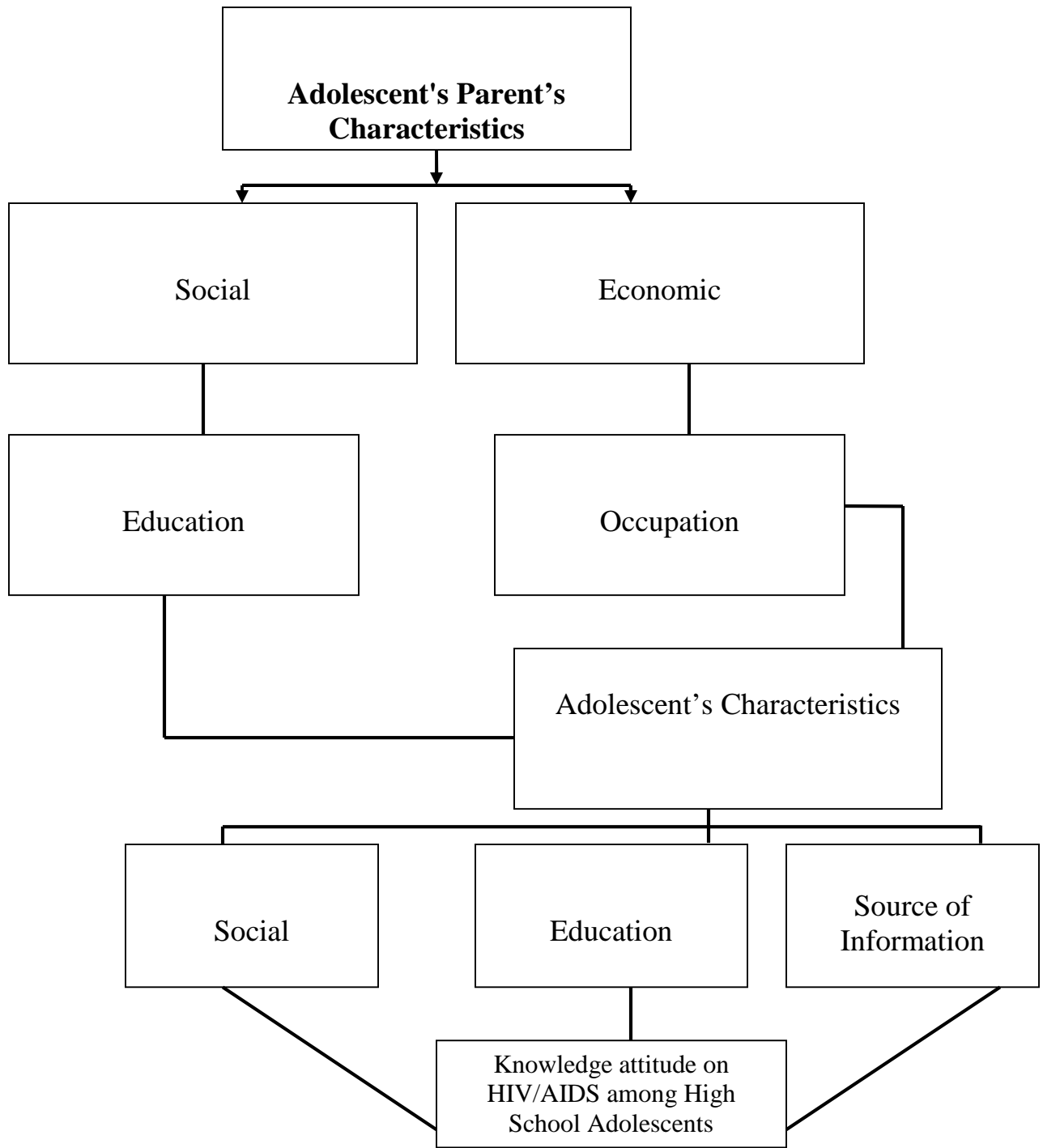


Figure 1: Conceptual Frame Work of the Study

1.6 Operational definition

AIDS: The initial AIDS stands for Acquired (A) Immuno (I) Deficiency (D) Syndrome (S), a group of symptoms and signs caused by Human Immuno Deficiency Virus.

HIV: The abbreviation for human immunodeficiency virus, the virus that can cause to the development of AIDS. The virus was previously known by a variety of names such as IAV and HTLV III. Two types of HIV have been isolated so for HIV 1 and 2.

HIV Negative: A Person who on testing does not have antibodies to HIV and hence either

-) Is not infected
-) Has recently been infected but has not yet produced antibodies (window period)or
-) Was infected some time ago, but is no longer producing antibody.

HIV positive: A person who, on testing has been found to have antibodies to HIV.

Immune System: The body's defense mechanism against attack by bacteria, viruses, harmful food substances and some proteins.

Syndrome: A set of symptoms and signs resulting from a single cause, or so commonly occurring together that a definite clinical picture is manifest.

Safer Sex: Sexual practices which reduce the risk of transmitting HIV during sexual activity e.g. condom use. Unsafe sex,

on the other hand, allows exposure to fluids that can transmit HIV.

Condom:

A soft rubber device made of latex, which is worn by the male before sexual intercourse begins and during intercourse. The condom prevents sperm from entering the female genital tract seminal and vaginal fluids these by preventing the transmission of STD and HIV from either partner.

CHAPTER TWO

LITERATURE REVIEW

2.1 Sexually Transmitted Infections (STIs)

Sexually transmitted infections (STIs) are the leading cause of the transmission of the HIV/AIDS virus. In the case of adolescents, it has been estimated that each year, one out of 20 adolescents contracts STIs. Many of the cases, especially young adolescent males, do not seek medical assistance even when they knew that they have contracted the disease. More than half of the adolescent female STI patients were involved in commercial sex trade (NRC-NFE, 2000).

The prevalence among STI patients varies in the different regions of the country. In Kathmandu, it ranged from one to five percent in 1998. In Mahendrangar, there was a clear upward trend in the 1990s. In Nepalgunj, the situation was static between 1996 and 1999. In essence, the prevalence was up to 3 percent. Sentinel surveys in pregnant women in 1991 and 1992 in eight districts showed no evidence of STIs (UNAIDS/WHO. 2006).

In a study conducted by Family Health International (FHI) and United States Agency for International Development (USAID) in 2000 among female sex workers (FSWs) and Truckers, 10 percent of the truck drivers had at least one STI. The most common STIs that affected them were syphilis, Chlamydia, gonorrhea and *Trichomonas*. Those, who had the highest prevalence of STI, belonged to the age group 30 to 39 years. Majority had active syphilis wherein they were either untreated or currently being treated. The prevalence rate of STIs was highest among the illiterates and informally literate truckers. Married truck drivers were more likely to have STIs than the unmarried truckers. Therefore, there would be a high rate of transmission

to their spouses (FHI and USAID. 2000).

On the other hand, nearly half or 47.3 percent of the female sex workers (FSWs) had at least one STI and 12.4 percent had more than one. Seventy-seven percent had untreated syphilis and nine percent were HIV positive. Other STIs found in the FSWs were gonorrhea, *Chlamydia*, *Trichomonas* and *Bacterial Vaginosis*. A higher incidence of gonorrhea and chlamydia was present among younger women. Furthermore, it was more prevalent among the sex workers who had worked in Mumbai (68.8%). More than half of the sex workers coerced into working in India was infected with at least one type of STI (FHI and USAID. 2000).

2.2 HIV/AIDS

2.2.1 Global Scenario of HIV/AIDS

HIV is a global health problem affecting all regions and countries around the World. There are about 33.2 million people living with HIV/AIDS at the end of 2007. Out of them over 38 million are adult and 15.4 million are women as well 2.5 million are children who are under fifteen. (UNAIDS/WHO, 2007). During 2005 some 4.9 million people became infected with HIV In respect to children, 1,400 children under the age of 15 are infected with HIV everyday. In 2007 alone, an estimated 420,000 children were newly infected with HIV, with approximately 90 per cent of these infections occurring in sub-Saharan Africa. Mortality among HIV infected children is extremely high. Without appropriate care and treatment, more than 50 per cent of the newly infected children will die before their second birthday (WHO, 2007). UNAIDS and WHO stated that the absence of effective interventions can lead to the rapid increase of HIV prevalence. Even a “low to moderate growth scenario” would make AIDS the leading cause of death in the 15-49

age group over the coming years (UNAIDS/WHO. 2006).

2.2.2 HIV/AIDS in South Asia

South Asia is facing a severe HIV epidemic in magnitude and scope, with an estimated 5.5 million to 6 million people infected. At least 60 percent of HIV-positive people in Asia live in India alone. The epidemic is not homogenous and requires well informed, prioritized, and effective responses. This report attempts to provide the basis for rigorous, evidence-informed HIV policy and programming and to increase understanding of the diversity of the epidemic between and within the countries of the South Asia Region (World Bank, 2006).

A diverse range of structural factors amplify HIV vulnerability and risk in the region, including widespread poverty and socioeconomic inequality, illiteracy, low social status of women, trafficking of women into commercial sex, and a large sex work industry. The region's borders are porous, permitting widespread rural-urban, interstate, and international migration. High rates of sexually transmitted infections and limited condom use prevail, and social stigma is an important impediment to delivering effective programs (World Bank, 2006).

This report describes how sex work and injecting drug use fuel concentrated epidemics. Men who have sex with men represent an important vulnerable population, but more information is required to better understand their role in HIV transmission dynamics. The report also draws attention to significant rural epidemics in parts of India and Nepal and the need to increase understanding of HIV prevention needs and service delivery patterns in South Asia's rural settings. Understanding rural epidemics and configuring an effective response to them constitute a major challenge (World Bank,

2006).

Thus, South Asia's HIV epidemic is severe in magnitude and scope, with at least 60 percent of all people with HIV in Asia living in India. Because the HIV epidemic is highly heterogeneous, designing informed, prioritized, and effective responses necessitates an understanding of the epidemic's diversity between and within countries. This review was undertaken to provide a basis for rigorous, evidence-based HIV policy and programming in South Asia (World Bank, 2006).

2.2.3 HIV/AIDS Situation in Nepal

The first reported case of AIDS in Nepal was in 1988. By early 2005, more than 800 cases of AIDS and over 4,700 cases of HIV infection were officially reported, with three times as many men infected as women. However, due to the limited capability of the government to obtain the actual number, it is assumed that the rate of infection is much higher (World Bank, 2006).

In 2002, UNAIDS and WHO estimated around 60,018 people living with HIV/AIDS and 2,958 AIDS related deaths where as about 69,790 people are infected by HIV at the mid of 2008 (NCASC. 2008). The statistics of HIV/AIDS is reported in different year is presented in the Table 1 Below.

Table 1: Statistics on HIV/AIDS on the Selected Years

S. No.	Categories	Number	Date
1	Estimated adult and child mortality due to HIV/AIDS	2,958	End of 2002
2	Estimated number of adults and children living with HIV/AIDS	62,000	End of 2003
3	Estimated number of children orphaned by HIV/AIDS	13,000	End of 2003
4	Reported HIV Cases	4,700	Early 2005
5	Reported AIDS Cases	800	Early 2005
6	Reported HIV infected	69,790	Mid of 2008

(Source: NCASC. 2008)

From the total number of those affected, nearly three fourths were males while females comprised a quarter. According to the Family Planning Association of Nepal (FPAN), those who usually contract HIV/AIDS are those in the age group 14-29 years. This clearly shows that adolescents are part of the “most-at-risk” populations or groups (FPAN, 2006). They are increasingly vulnerable to HIV due to changing values, group norms and freedom. Girls, even if they have knowledge about HIV/AIDS and other STIs, do not have the means of protecting themselves due to lack of knowledge and their traditionally inferior social status. Teenagers, although apparently highly aware of the HIV risk, do not necessarily translate awareness into safe sex practices. A high prevalence of premarital sex exists, with 20 percent of teenagers considering it acceptable among young people (World Bank, 2006).

The predominant mode of transmission is sexual contact, mainly heterosexual. There is limited information regarding homosexual or bisexual transmission (UNAIDS/WHO, 2006). The highest rates of HIV prevalence have been identified in the injecting drug users (IDUs) and commercial sex workers (CSWs). The former are at risk not only by their injecting practices but also by a societal response, which ostracizes drug use and uses a predominantly punitive model coupled with limited drug treatment facilities. In order to treat this group, Nepal was the first country to initiate a Harm Reduction Programme with needle exchange for IDUs. However, the program's coverage was limited. Thus, the impact on the HIV spread was also limited. The rapid assessment conducted in 1999 showed a HIV prevalence of 40 percent in a nationwide scale and 68 percent in Kathmandu alone (UNAIDS/WHO, 2006). The reason for this rapid spread of the virus was needle sharing. Another study in 2004 reported that HIV prevalence among IDUs nationwide was 38.4 percent and among IDUs in Kathmandu, 68 percent (World Bank, 2006). Although there was a decrease on the aggregate level, the numbers may not be accurate because a lot of cases were not reported or recorded by the authorities.

Commercial sex workers (CSWs) or female sex workers (FSWs) and their clients have the second highest HIV prevalence level. Since women are marginalized in Nepalese society, they lack access to information and services. Cultural, economic and social constraints further narrow their access to legal protection and medical services (UNGASS, 2005). Approximately, 60 percent of their clients – transport workers, members of the police or military, wage earners and migrant workers – do not use condoms. At the national level, HIV prevalence among female sex workers was 4 percent, infection rates among street-based sex workers in the

Kathmandu valley were between 15 to 17 percent. Clients of FSWs have been estimated to have a HIV prevalence rate of 2 percent (World Bank, 2006).

Another survey conducted in Kathmandu in 2000 revealed that 17 percent of CSWs were HIV-positive – an increase from 2.7 percent in 1997. It is estimated that 70 percent of CSWs returning from India were HIV-positive. The study acknowledged the lack of data on prevalence among CSWs but it presumed that it is high and increasing (SACTS. 2001).

For Nepal, this would mean that around 100,000-200,000 young adults will become infected and that overall, 10,000-15,000 annual AIDS cases and deaths due to related illnesses may be expected (UNAIDS/WHO. 2006).

A generalized epidemic with high mortality in the productive age group would start a “vicious cycle”. The impact of HIV/AIDS would increase poverty and vulnerability. This increased vulnerability would lead to more HIV infections and a higher impact. Besides, the negative impact on socio-economic development and the loss of productive life, the burden of disease would change dramatically over the next 10 years and would further stress the health sector and local communities (UNAIDS/WHO. 2006).

2.3 High-risk/Target Groups of HIV/AIDS

2.3.1 Mobile Population/Migrant Population

About 800,000 people cross the Southern border as seasonal migrant labor to India every year and approximately 350,000 migrate from one part of the country to another for wage earning. Majority of those who migrate are males and they live alone for a long time. As a consequence of their loneliness and distance from their wives, they come to establish sexual

relationships with CSWs. Most of these migrants do not have access to information, condoms and supportive services that will enable them to have safer sex. They are likely to take the virus back to their wives who could transmit it to their babies and at the same time work as HIV/AIDS breeding populations (FPAN. 2006).

In a UN/New Era study conducted in six districts outside Kathmandu among migrant laborers in 2005, a high level of knowledge (mid to high 90s) on HIV, STIs and AIDS was reported, especially among the age group 20-29 years. However, less than half of the respondents would use condoms whether with their wives or sex workers. Only six percent reported sexual intercourse with a sex worker, and 8 percent reported having sex partners other than their wives and sex workers. A more revealing finding is the perception that HIV and AIDS are consequences of immoral sexual behavior, indicating the need for the integration of stigma and discrimination messages in HIV prevention efforts (UNGASS, 2005). A survey of women in migrant communities located in the Kailali district of Nepal showed that they were prone to contracting STIs and HIV/AIDS. (FHI, 2001).

2.3.2 Men Having Sex with Men (MSM)

Some males in Nepal are involved in same sex relationships. Some of them are voluntarily engaged in homosexual relationships while other especially young boys and street children, are forced on it. Eventually, they also establish sexual relations with females, which further increase the chance of HIV infection. Some of the homosexuals are already infected with HIV/AIDS and others with STIs. Their sex with multiple partners whether voluntary or forced, puts them at risk of HIV infection (FPAN, 2006).

Although accurate data on sex between men are not available, a recent report suggests that MSM activity is not different from that of the South Asia region. The knowledge of safe sex and condom use is low among this community. Furthermore, many men who have sex with men are also married, which puts their spouses at risk of becoming infected with HIV (FPAN, 2006).

Most MSM are married due to social pressure. Therefore they are exposed to sex with the spouse and multiple partners. A focused group discussion (FGD) conducted among the MSMs indicated that wives of MSM do not know the sexual orientation of their husbands. Therefore they have sex without the use of condom for fear that their status will be discovered in this way. The same FGD reported that MSM face harassment from police and security personnel for carrying condoms (World Bank, 2006).

2.3.3 Adolescents

Adolescents in Nepal are regularly exposed to conflict, socio-economic deprivations, peer pressure, ambitions and poor access to information and services (UNGASS. 2005).

In the 2005 UNAIDS/NEW Era Behaviour, Information and Services (BIS) Survey, broadcast media (TV and radio) was recorded as the primary source of information on HIV/AIDS. A surprising but positive finding was that, among young people who would have sexual intercourse with sex workers, 86 percent would use condoms. It closely correlates with consistent condom use of those who had sexual intercourse with sex workers in the last 12 months (71%) (UNGASS. 2005).

Another study done by RHIYA/UNFPA in 2005 among 2,748 youths indicated that only 57 percent of youth found it easy to obtain information about HIV/AIDS. Nonetheless, 91 percent of respondents were aware of the ways of avoiding HIV/AIDS. Premarital sex among the boys (13%) was quite high compared to girls (2%) and condom use in their first sexual contact was found to be only 14 percent (UNGASS. 2005).

2.4 Knowledge on HIV/AIDS

It is reported that in 2001, knowledge of AIDS was much higher among men (72%) than women (50%). Though women's knowledge of AIDS may be lower compared to the men, the percentage of women who heard of AIDS nearly doubled in the last five years from 27 percent in 1996. Two-fifths of women and two-thirds of men believed there is a way to avoid HIV/AIDS. Respondents who were younger, those living in urban areas, those living in the hill region and those from the Western development region were more likely to have heard about AIDS. It is also reported that, education has a positive effect on the knowledge about AIDS. The higher the educational attainment, the more aware the respondent is about the virus (MOH, 2002). In relation to knowledge on prevention of transmission of the virus, 58 percent of women and nearly one-third (32%) of men had either not heard about AIDS or did not know whether the disease can be avoided. Three percent of women and 2 percent of men thought that there is no way to avoid HIV/AIDS. Fifty one percent of the men and 21 percent of the women spontaneously responded that AIDS can be avoided by using condoms. Thirteen percent of women and 28 percent of men mentioned that it can be prevented by limiting the number of sexual partners. Eighteen percent of women and 21 percent of men believed the virus transfer can be prevented

by avoiding sex with a person who has many partners. The percentage of respondents who mentioned avoiding sex with prostitutes was much higher among males (25%) than among females (3%) (FPAN, 2006).

A study on young factory workers reported that having boy/girl friends, physical contact such as holding hands, kissing, petting and even sexual intercourse were common among them. Awareness of at least one contraceptive method was almost universal (95%). Correct knowledge of the method is generally higher among boys than girls. A large majority of the young factory workers heard about STIs. Knowledge on STIs was higher in boys (80%) than girls (62%). Knowledge of AIDS was higher in boys than girls too (FPAN, 2006).

2.5 Epidemic Overview and Nepal response to HIV/AIDS

2.5.1 Epidemic Overview of HIV/AIDS in Nepal

Nepal appears to have the potential for a substantial epidemic, at least among high-risk groups, especially female SWs and IDUs. Injecting drug use occurs across the country and significantly overlaps with commercial sex. A high number of women migrate or are trafficked to work as female SWs in India, especially Mumbai. Those returning to Nepal from Mumbai have much higher HIV prevalence than those who have remained in the country, so migration and trafficking to and from Mumbai can rapidly increase HIV prevalence in Nepali SW networks. As with other South Asian countries, injecting drug use, as well as female and male sex work, is likely to continue to drive the HIV epidemic in Nepal, particularly in light of the nexus between injecting drug use and sex work.

2.5.2 Nepal Response to HIV/AIDS

The National AIDS Control Program was established in Nepal in 1988, after the first cases of AIDS were reported. Four years later, the National AIDS Coordination Committee (NACC) was formed. Chaired by the minister of health, NACC is a multi-sectoral body providing overall policy guidance with representatives from other line ministries, United Nations (UN) agencies, NGOs, civil society groups, and other stakeholders. To implement the National Policy for HIV Prevention and other related activities, the National Center for AIDS and Sexually Transmitted Disease Control (NCASC) was established in 1995 and reports to NACC, advising it on technical issues. NCASC consists of a director, deputy director, medical and public health officers, and consultants. More recently, the National AIDS Council (NAC) was established, with the prime minister as the chair, to raise the profile of HIV/AIDS issues. NACC now reports to the NAC. At the district level, district development committees implement and monitor HIV/AIDS projects according to national strategies and guidelines. They report to the NCASC. Surveillance of HIV, STIs, and behavior in Nepal has been neither systematic nor continuous, because of political instability and other reasons. Much of available HIV prevalence data derive from clients of voluntary counseling and testing (VCT) centers, which have very limited coverage and capacity and are probably biased toward clients who undergo diagnostic testing. Limited surveillance on STI patients and cross-sectional studies on high-risk groups provide additional bio-behavioral data (USAID, 2008).

In 2000, the NCASC commissioned a situation and response analysis, which recommended developing a clearer national strategy, increasing political commitment, strengthening technical and management capacity, decreasing

frequent staff turnover, increasing program coverage among high-risk groups, and providing care and support for people living with HIV and AIDS (PLWHAs). A new national HIV prevention strategy was developed for 2002–6, with a budget of about US\$50 million, of which the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM) was expected to contribute about 20 percent. Priority areas include expanded HIV and STI prevention among high-risk groups and young people; accessible care and support services for PLWHAs; enhanced surveillance, monitoring, and evaluation; and more effective and efficient management. The Nepal Initiative was launched by the following partners to carry out this national strategy: the government of Nepal, the Joint United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Development Programme (UNDP), the Australian Agency for International Development (AusAID), DFID, and USAID (USAID. 2008).

Although the Nepal Initiative ended in 2003, external agencies continue to coordinate their efforts through the Expanded UN Theme Group. Projects have been launched in this manner on behavior-change communication, condom promotion, condom social marketing, and mass media awareness. Plans are in place to expand prevention programs for migrants and youth, as well as care and support services for PLWHAs through the GFATM. However, little of the overall plan has actually been implemented, largely because of Nepal's political instability. Nepal currently has nine VCT centers, three run by the government and six by NGOs, but further efforts are needed to expand those centers in scope and coverage (USAID. 2008).

Although less than 1 percent of Nepal's adult population is estimated to be HIV-positive, according to UNAIDS, the prevalence rate masks a

concentrated epidemic among at-risk populations such as female sex workers (FSWs), injecting drug users (IDUs), men who have sex with men (MSM), and migrants. Since Nepal's first cases of HIV/AIDS were reported in 1988, the disease has primarily been transmitted by injecting drug use and unprotected sex. Available data indicate that there was a sharp increase in the number of new infections starting in 1996, coinciding with the outbreak of civil unrest. However, the incidence appears to be leveling off with recent evidence of reduced prevalence and lower overall numbers. As of December 2007, the Government of Nepal reported 1,610 cases of AIDS and 10,546 HIV infections. UNAIDS estimates from 2007 indicate that approximately 75,000 people in Nepal are HIV-positive, including all age groups. The Government of Nepal's National Center for AIDS & STD Control (NCASC) estimated that number to be closer to 70,000 in December 2007 (USAID. 2008).

Despite this fact, substantial progress has been made with respect to national commitment and a strengthened response to address the HIV/AIDS epidemic in the country. HIV and AIDS have been recognized as a priority in the new interim three-year development plan. The national program is implemented under one national HIV/AIDS action plan framework. A national monitoring and evaluation system has been developed, and the Government of Nepal has taken initial steps toward establishing a semi-autonomous coordination body for HIV and AIDS. There is strong civil society engagement in the response (USAID. 2008). Given the nature of the epidemic in Nepal, most of the national initiatives have focused on leadership, partnerships and the involvement of civil society for prevention, care, and support for its most-at-risk populations. From 2003, the NCASC implemented the HIV/AIDS

Operational Plan based on the National Strategy 2002–2006. Currently, the HIV/AIDS activities are shaped by the second National HIV/AIDS Strategy 2007–2011, and implementation is coordinated under the 2006–2008 National Action Plan, which has the following priorities:

-) Preventing the spread of sexually transmitted infections (STIs) and HIV infection among at-risk groups;
-) Ensuring universal access to quality treatment, diagnostics, care, and support services for infected, affected, and vulnerable groups;
-) Ensuring a comprehensive and well-implemented legal framework on HIV/AIDS promoting human rights and establishing HIV/AIDS as a development agenda;
-) Enhancing leadership and management at national and local levels for an effective response to HIV/AIDS;
-) Using strategic information to guide planning and implementation for an improved effective response; and
-) Achieving sustainable financing and effective utilization of funds.

The vision of the national strategy is to expand the number of partners involved in the national response and to increase the effectiveness of Nepal's response. It also emphasizes prevention as key for an effective response to the epidemic, particularly in areas with high levels of out-migration. The strategy includes care and support for people infected and affected by HIV/AIDS while recognizing the contribution of care and support to effective prevention. It also recognizes the importance of accurately tracking the epidemic to monitor the effectiveness of interventions (USAID. 2008).

Nepal receives assistance from several international donor organizations, including the Global Fund and Great Britain's Department for International Development. The Global Fund approved a second-round grant in 2003 to support HIV/AIDS prevention among labor migrants and young people and to care for HIV-infected individuals. Nepal was also approved for a seventh-round grant in 2007 that will focus on labor migrants and target gaps in services for MSM and IDUs (USAID. 2008).

2.6 Empirical Study Focusing on Knowledge, Attitude and Practice of HIV/AIDS of School Adolescents

2.6.1 South Asia

India, Nepal, Pakistan and other Asian countries among children (5-18 yrs old) at a micro level to assess its relevance and significance in South Asia in programming. The paper states that children are especially vulnerable to HIV and AIDS either by the life style they choose or by the actions of others. It highlights the fact that children have rights to information and opportunities to develop education and information for which school is suggested as the best place. Various schools have integrated HIV prevention programs with adolescent education. Peer group education and life skill enhancement are the salient features of all interventions. Some of the lessons learned from the region are: child participation and responsibility sharing are critical, and integration of HIV education and prevention in health programs both for in and out of school children is important. The key constraints identified comprise: limited experience in HIV and AIDS education in the region; serious gaps in the knowledge of HIV and AIDS; HIV not receiving adequate attention among the media, academics, politicians and the public at large. The study recommends institutionalizing an AIDS awareness program

within the formal school system, incorporating HIV and AIDS prevention education for children within a broad rights and citizenship curriculum framework; advocating to government for HIV and AIDS prevention education for children to be given highest priority, and better understanding of children's point of view in order to prevent HIV and AIDS among children in the region (UNFPA, 2006).

2.6.2 Nepal

BIS Survey in four urban areas in Nepal states that, about 42 percent of men and women respondents acknowledged to have been engaged in sexual intercourse of which 35 percent were married and 6 percent unmarried. It was found that youth got involved in sexual acts after marriage, as almost 80 percent of married respondent's first sexual partners were their spouses.

Among unmarried respondents, 12 percent had their first sex with their boy and girl friends and more than 2 percent with commercial sex workers. Only 22 percent of respondents only reported to have used a condom during their first sexual intercourse. The majority of respondents who had not used a condom reported that they had done so because they did not find it necessary (54.4%), because their partner objected to its use (27.3%), because it did not give sexual satisfaction (27.3%) etc. More men than women reported to have heard about HIV and AIDS. An overwhelming majority (99%) of respondents who had heard of HIV and AIDS reported to have knowledge on its modes of transmission among which almost all knew at least one way to avoid HIV and AIDS transmission. The survey also covers sexual and reproductive health and voluntary counseling and testing services (UNFPA, 2006).

A total of 1,400 teenagers were randomly selected from across Nepal's five developmental regions for interviews. Questions were asked to ascertain teenagers' abilities to cope with daily issues and changes experienced in adolescence, particularly on life skills and HIV and AIDS. In terms of life skills, the study revealed a high degree of self-awareness among Nepalese teenagers. Although few teenagers consumed alcohol on a regular basis, more than one in ten teenagers (13%) admitted that they had taken drugs. The findings show that Nepali teenagers are highly aware of HIV risk, but the awareness does not guarantee safe sex behavior. Although an overwhelming majority (92%) of teenagers had heard of HIV and AIDS, only 74 percent of teenagers knew that they should use condoms when having sex, and only two thirds (69%) could say that they should not have sex with commercial sex workers. The study further showed that almost 20 percent of teenagers considered premarital sex as proper; and one in five boys and nearly one in 10 girls interviewed had a sexual experience. Sixty percent of boys said they had used condoms while 74 percent of girls said that their partners used a condom. Unprotected sex led to a 14 percent pregnancy rate and a 22 percent STD rate in boys and 13 percent rate in girls. The number of boys who had sex was far higher than the number of girls, suggesting a high number of boys visiting commercial sex workers, constituting high risk behavior. Most teenagers interviewed said that they were interested in learning more about sex and sexual health, including on STD, HIV and AIDS and safe sex. Radio and television were the best sources of information on HIV and AIDS (UNFPA, 2006).

Mahat and Scoloveno (2003) reported that, the majority of the adolescents had a moderate level of overall HIV/AIDS knowledge, but lacked

knowledge in the areas of mode of transmission and prevention of HIV/AIDS. Approximately 79% thought that AIDS was a big problem and 67% were afraid of getting AIDS. However, only 16.7% reported that they were likely to get AIDS, and 18.7% did not perceive living in Kathmandu as a risk for HIV/AIDS. The study was carried out in 2003 in a private school in Kathmandu, Nepal. A total of 150 adolescents participated in the study. Two instruments were used: a demographic questionnaire and the Youth Survey, which included questions on knowledge, attitudes and beliefs.

A KAPs survey among 1400 young people in seven different districts of Nepal shows that Nepalese teenagers are highly aware of the HIV risk but that this awareness does not necessarily translate into safe sexual behaviour. Although, an overwhelming majority (92%) of teenagers have heard of HIV/AIDS, only 74% of teenagers knew that, they should use condoms when having sex and only two-thirds (69%) said that they should not have sex with commercial sex workers. The study also shows that almost 20% of teenagers considered premarital sex as proper. One in five boys and nearly one in 10 girls interviewed had had a sexual experience. 65% of boys said that they had used condoms; while 74% of girls said that their partners used a condom during sexual intercourse. Unprotected sex led to a 14% pregnancy rate and a 22% sexually transmitted diseases (STD) infection rate in boys and 13% rate in girls. Pregnancy rates were high in districts where girls were pressured into having sex. The number of boys who had had sex was far higher than the number of girls. Furthermore, the survey showed that 13% had taken drugs, although only 5.4% injected the drugs (UNICEF, 2001).

CHAPTER THREE

RESEARCH METHODS

This chapter deals briefly with the research methods which were applied by the researcher and this is purely academic research.

3.1 Study site and area

Birendranagar Municipality-8 was selected for study which is located at district head quarter, Birendranagar, Surkhet. There are five secondary schools in this Municipality but Shree Krishna Sanskrit and General Higher Secondary School was selected for the study of this research by purposive sampling method.

3.2 Research Design

To achieve the goal of the study, both descriptive and explorative techniques have been adopted. The nature of the study based on qualitative and quantitative approaches where, obtained data were analyzed and interpreted descriptively. Descriptive, exploratory, research design was used for this study to find out the knowledge and attitude of adolescent on HIV/AIDS.

3.3 Universe and Sampling

This study has followed non-probability purposive sampling design. The universe of this study is those boys and girls who are studying Class 9-10 and age of 13 to 19 years. There are 191 students in Class 9 and 10. Out of these, 40 students (20.9 %) including boys and girls are selected from Class 9 and Class 10 for the study.

3.4 Nature and Source of Data

Nature of the data was both qualitative and quantitative. The source is primary as well as secondary. Primary data has been collected by the survey, observation, questionnaire and interview. Both published, unpublished materials related the subject matter were secondary sources.

3.5 Data collection technique

A semi-structured questionnaire was developed for interview, to obtain necessary information according to objective and it was given to the respondents to fill it. This was written in Nepali language.

3.6 Data processing and analysis

The collected data were analyzed by using computer software program as well. A descriptive analysis was carried and results are presented in the forms of tables and chart.

3.7 Limitation of the Study

There are some limitations of this study:

-) This study is conducted with especial group that is known as secondary school students (age group 13 to 19 years). Finding of this study may not represent other age group.
-) This study is conducted in selected Higher Secondary School of Surkhet district. The sample size is small in comparison to professional researchers. So it may not represent national level scenario.

CHAPTER FOUR

SOCIO-ECONOMIC CHARACTERISTICS OF THE RESPONDENTS

This Chapter describes the overall background characteristic of the respondents. Information on age, sex, caste/ethnicity, religion, marital status, place of residence.

4.1 Age and Sex Composition

Age-sex structure determines the factors for the knowledge, perception and behavior of respondents towards the HIV/AIDS. Age-Sex indicates the maturity of the person. In order to know the age-sex of respondents, the questions were asked about it and the distribution of the respondents by age and sex obtained from the field is presented in Table 2.

Table 2: Distribution of Respondent by Age and Sex

S. No.	Age (years)	Respondent					
		Girl		Boy		Total	
		No	%	No	%	No	%
1	13-15	6	30	12	60	18	45
2	16-18	14	70	8	40	22	55
Total		20	100	20	100	40	100

Source: Field Survey, 2008

From Figure 2, it is clear that the highest numbers of respondents are from age 16-18 years, 55 percent of the respondent belong to the age group of 16-18 years. Among them 63.63 percent are boys and 36.36 percent are girls. Similarly, 45 percent of the respondents belong to the age group of 13-15 years. Among them 33.33 percent are boys and 66.66 are girls.

4.2 Caste/ Ethnic Composition

Caste/Ethnicity determines the knowledge and attitude about HIV/AIDS. There are different types of values and norms in different caste/ethnicity. So, caste/ethnicity plays measure role in this context. In order to obtain the information about caste/ethnicity of the respondents the question was asked to the respondents is presented in Table 3.

Table 3: Distribution of Respondent by Caste and Ethnicity.

S. No.	Caste/ Ethnicity	Respondent					
		Girl		Boy		Total	
		No.	%	No.	%	No.	%
1	Brahmin	8	40%	7	35%	15	37.5%
2	Chettri	2	10%	4	20%	6	15%
3	Magar	5	25%	6	30%	11	27.5%
4	Gurung	2	10%	2	10%	4	10%
5	Tharu	2	10%	1	5%	3	7.5%
6	Dalit	1	5%	-	-	1	2.5%
Total		20	100%	20	100%	40	100%

Source: Field Survey, 2008

Table 3 shows that majority of the respondent belongs to Brahmin with 37.5%, which followed by Magar 27.5%, Chettri 15%, Gurung 10%, Tharu 7.5%, Dalit 2.5%. So, majority of the respondents are of Brahmin followed by Magar and Chettri and minority of respondents are Dalit and Tharu.

4.3 Religion

Religion is considered as an important factor in our society. Nepal is dominated by Hindu religion however, there are different religions are

prevailing in Nepalese society. Distribution of respondents by religion-sex is presented in Table 4.

Table 4: Distribution of Respondent by Religion and Sex

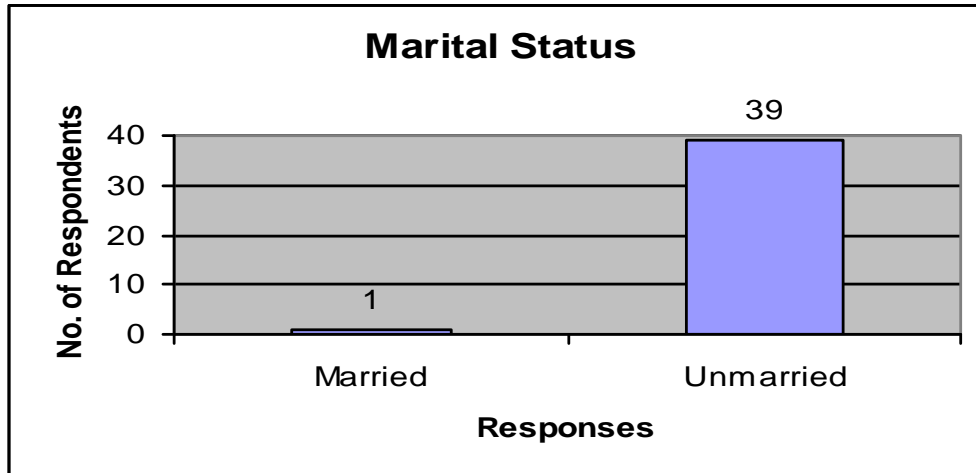
S. No.	Religion	Respondent					
		Girl		Boy		Total	
		No	%	No	%	No	%
1	Hindu	19	95	19	95	38	95
2	Buddhist	1	5	1	5	2	5
Total		20	100	20	100	40	100

Source: Field Survey, 2008

Table 4 shows that the majority of the respondents are Hindu (95%) followed by Buddhist (5%). By gender wise, the highest 95% of the boy's are Hindu Religion and 5% are Buddhist. Similarly, 95 % of the girls are Hindu religion and 5% are Buddhist.

4.4 Marital Status

Marital Status determines the knowledge and attitude about STDs and HIV/AIDS. In order to obtain the information about marital status of the respondents the question was asked to the respondents is presented in Figure 2.



Source: Field Survey, 2008

Figure 2: Marital Status of the Respondents

It is clearly seen that 2.5% of the respondent was found married and 97.5% of the respondents were found unmarried. The respondent who is married is a girl and she had married at 16 years of age.

4.5 Living place of Respondents

Current living status also plays the major role to determine the knowledge and attitude towards HIV/AIDS. Respondents were asked about their housing status where they are staying at the time of field study in order to know that whether the variable is responsible to determining the knowledge, attitude and behavior on HIV/AIDS or not. Distribution of respondents by Current living Status is present in Table 5.

Table 5: Distribution of Respondents by Living Place and Sex

S. No.	Living Place	Respondents					
		Girl		Boy		Total	
		No.	%	No	%	No	%
1	At Home	15	75	14	70	29	72.5
2	Rented House	3	15	3	15	6	15
3	With Relative	2	10	3	15	5	12.5
Total		20	100%	20	100%	40	100%

Source: Field Survey, 2008

It is clearly seen in Table 5 that highest percent (72.5%) respondents live at home, followed by 15 percent live at rented house and 12.5 percent live with relative's house. Among boys, 70 percent were live at home, 15 percent lived at rented house and 15 percent were lived with relatives. Similarly 75 percent girls were live at home, 15 percent girls lived at rented house and 10 percent girls were lived with relatives.

4.6 Household characteristics

This section deals with the social status of the respondents parents, level of education and occupation.

4.6.1 Parent's Education Status

Education is a key factor for almost all variables. Parent's education may play an important role in determining the knowledge and attitude on HIV/AIDS because educated parents may have proper knowledge on children's physical and biological change and may open with their children in providing information. Education doesn't only help to healthy life but also helps to meet the goal of government program.

4.6.1.1 Distribution of Respondent by Father's Education

Nepalese Society is male dominant society so father's education and decision in the family is followed by the mother and family. Father's education is also one of the social factors that influence the overall status of the adolescents towards HIV/AIDS. Distribution of respondents by father's educational level is presented in Table 6.

Table 6: Distribution of Respondent by Father's Educational level

S. No.	Father's Education	Respondent					
		Girl		Boy		Total	
		No.	%	No.	%	No.	%
1	Uneducated	5	25	4	20	9	22.5
2	Adult Education	-	-	2	10	2	5
3	Under SLC	8	40	7	35	15	37.5
4	Above SLC	7	35	7	35	14	35
Total		20	100	20	100	40	100

Source: Field Survey, 2008

Table 6 clarifies that around 22.5 percent respondents' father's are uneducated, 5 percent respondents' father's are taking adult education, 37.5 percent respondents' father's are under SLC and 35 percent respondents' father's are above SLC (i.e. Intermediate and Bachelor pass) level.

4.6.1.2 Distribution of Respondents by Mother's Education

Mother's are considered as the source of inspiration. Most of the women in Nepal are housewife and engaged in agriculture. The care for children is mainly done by mother. So, children are very close to mothers rather than fathers. Therefore mother educational level plays vital role in this study.

Distribution of respondents by mother's educational level is presented in Table 7.

Table 7: Distribution of Respondent by Mother's Educational level

S. No.	Mother's Education	Respondents					
		Girls		Boys		Total	
		No.	%	No.	%	No.	%
1	Uneducated	8	40	7	35	15	37.5
2	Adult Education	5	25	4	20	9	22.5
3	Under SLC	7	35	8	40	15	37.5
4	SLC Above	-	-	1	5	1	2.5
Total		20	100	20	100	40	100

Source: Field Survey, 2008

Table 7 shows that around 37.5 percent respondents' mother's are uneducated, 22.5 percent respondents' mother's are taking adult education, 37.5 percent respondents' mother's are under SLC and 2.5 percent respondents' mother's are above SLC pass (i.e. Intermediate level). In Table 6 it is also shows that, most of the respondent mothers are uneducated in the study area. Similarly the proportion of taking higher education is too low in the study area.

4.6.2 Parent's Occupation

Parent's occupation determines the economic level of the family. This factor also determines the knowledge and behaviour of the children about HIV/AIDS.

4.6.2.1 Father' occupation

Father's occupation may play an immense role to determine the economic level of the family. Distribution of respondents by father's occupation is presented in Table 8.

Table 8: Distribution of the Respondent by Father's Occupation

S. No.	Father Occupation	Respondents					
		Girls		Boys		Total	
		No.	%	No.	%	No.	%
1	Agriculture	3	15	3	15	6	15
2	Service	10	50	12	60	22	55
3	Business	3	15	2	10	5	12.5
4	Daily Wages	4	20	3	15	7	17.5
Total		20	100	20	100	40	100

Source: Field Survey, 2008

Table 8 clarifies that around 55 percent respondents' father's are engaged in service (government and private sector) followed by Daily wage, agriculture and business with 17.5 percent, 15 percent and 12.5 percent respectively.

Among boy's respondents, 60 percent are from service background, 15 percent are from agriculture background, 15 percent are from Daily wage background and 10 percent are from business background. Similarly in case of girl's respondents, 50 percent are from service background, 20 percent are from Daily wage background, 15 percent are from agriculture background and 15 percent are from business background.

4.6.2.2 Mother' occupation

Mother's occupation also plays important role to determine knowledge and attitude towards HIV/AIDS of the children in the family. Distribution of respondents by mother's occupation is presented in Table 9.

Table 9: Distribution of the Respondent by Mother's Occupation

S. No.	Mother's occupation	Respondent					
		Girl		Boy		Total	
		No.	%	No.	%	No.	%
1	Agriculture	5	25	5	25	10	25
2	Service	-	-	1	5	1	2.5
3	Daily Wages	6	30	4	20	10	25
4	Housewife	9	45	10	50	19	47.5
Total		20	100	20	100	40	100

Source: Field Survey, 2008

Table 9 indicates that around 47.5 percent respondents' mother's are housewife followed by Daily wage and agriculture and service with 25 percent, 25 percent and 2.5 percent respectively.

Among boy's respondent mother, 50 percent are housewife, 25 percent are engaged in agriculture, 20 percent are engaged in Daily wage and 5 percent are engaged in service. Similarly in case of girl's respondent mother, 45 percent are housewife, 30 percent are engaged in Daily wage and 25 percent are engaged in agriculture.

4.6.3 Comfort level between parents and children

Comfort level plays vital role in knowledge and attitude of adolescent towards HIV/AIDS. So easiness and shyness behavior is much more important in this context.

Table 10: Distribution of Respondent by the Level of Easiness with Parents

S. No.	Easiness	Respondents					
		Girl		Boy		Total	
		No.	%	No.	%	No.	%
1	Yes	15	85	11	55	26	65
2	No	5	25	9	45	14	35
Total		20	100	20	100	40	100

Source: Field Survey, 2008

According to the above Table 10, in comparison to boys, girls have much easiness with their parents. 85 percent girls can talk to their parents about their personal problem but only 55 percent boy feel comfort with their parents to talk about their personal problem. Still, 25 percent girl and 45 percent boy don't want to share their problem with parents.

On the above statistical description majority of the respondent (65%) can talk with their parents about their personal problem and minority (35%) don't do this.

4.6.4 Response of parents

The response of parents to their children about HIV/AIDS is equally important for the children knowledge and attitude of adolescent towards HIV/AIDS.

Table 11: Distributions of Respondents by the Parent’s Responses

S. No.	Responses	Respondents					
		Girls		Boys		Total	
		No.	%	No.	%	No.	%
1	Yes	11	73.33	3	27.27	14	53.85
2	No	4	26.67	8	72.73	12	46.15
Total		15	100	11	100	26	100

Source: Field Survey, 2008

Previous questionnaire shows that only 65 percent of the respondents are comfort with their parents about their personal problems. But, among them, 46.15 percent parents do not response at all. According to respondents their parents do not want to hear any such type of problems. While, in the Table 11, majority (53.85%) of respondents said their parents show interest about their matters.

CHAPTER FIVE

5.1 Knowledge and attitude of Respondents on HIV/AIDS

This chapter presents the knowledge and attitude of the respondent on HIV/AIDS. In order to assess knowledge and attitude, a structured questionnaire was used while interviewing the respondents.

5.1.1 Adolescents knowledge about HIV

In order to examine the knowledge about HIV, the respondents have been asked “What is HIV?” Cent percent respondents said that HIV is a virus. So, on the basis of their responses, we can say that they have good knowledge in this type of general information.

5.1.2 Adolescents knowledge about AIDS

The knowledge of the respondents on AIDS is important. In order to find out their responses about AIDS a question “What is AIDS?” was asked and the respondent’s responses are summarized in the Table 12 below.

Table: 12 Distributions of Respondents by Knowledge about AIDS

S. No.	Responses	Respondents					
		Girl		Boys		Total	
		No.	%	No.	%	No.	%
1	Communicable Disease	3	15	2	10	5	12.5
2	Dangerous Disease	2	10	4	20	6	15
3	Both	15	75	14	70	29	72.5
Total		20	100	20	100	40	100

Source: Field Survey, 2008

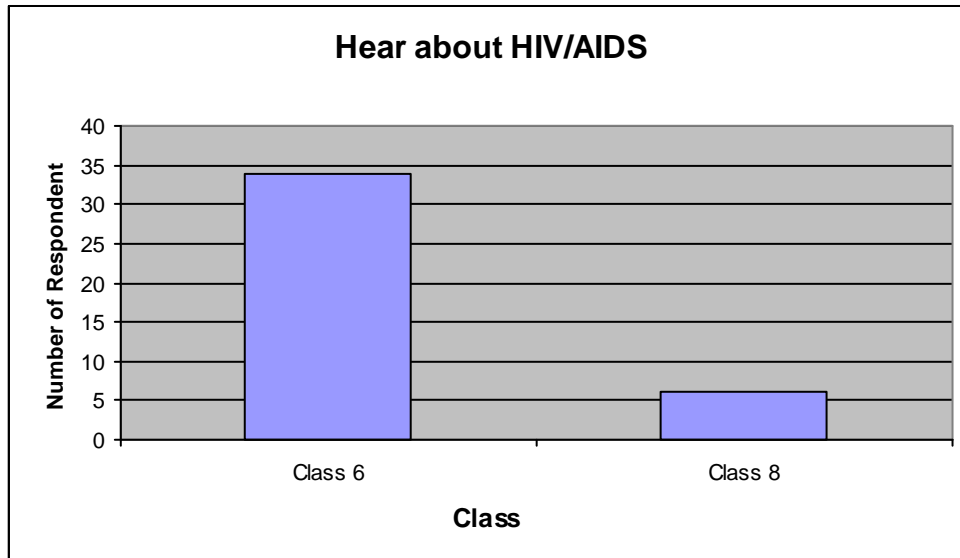
As shown in above Table 12, out of 40 respondents 72.5 percent of the respondents have given correct answer about AIDS. 12.5 percent respondent said AIDS is a communicable disease it means it is not dangerous and 15 percent said it is dangerous disease. On the basis of above statistical situation, it has been concluded that majority (72.5%) of the respondents have knowledge about AIDS. 27.5 percent respondent have not actual knowledge about AIDS.

5.1.3 Source of information about HIV/AIDS

The source of information is an important factor for the adolescents to get proper knowledge about HIV/AIDS. In order to examine the source of information about HIV/AIDS, the respondents asked ‘Have you heard about HIV/AIDS?’ and cent percent of respondents said that they heard about HIV/AIDS. Another question have been asked to the respondent is ‘In which sources have you heard about HIV/AIDS?’ Cent percent of respondents said that they heard about HIV/AIDS by means of different modes of communication/media i.e., Radio/Television, News paper, Text book, Pamphlets, Teacher, Parents and Friends.

5.1.4 Class heard about HIV/AIDS

In order to find out the knowledge about HIV/AIDS, the question “In which class do you heard about HIV/AIDS?” is asked to the respondents and the responses of the respondents is shown in Figure 3.



Source: Field Survey, 2008

Figure 3: Hear about HIV/AIDS by the Respondents

It is clearly seen in Figure 3 that majority (85%) of the respondents heard about HIV/AIDS in Class 6 and 15 percent respondents heard about HIV/AIDS in Class 8.

5.1.5 Modes of transmission of HIV/AIDS

HIV virus is mainly transmitted by sexual intercourse, contaminated instruments (needle, syringe, razor etc), and infected blood and from an infected mother to new born baby. In order to examine the modes of transmission of HIV/AIDS the respondents have been asked “which of the following way HIV/AIDS can be transmitted?” The responses given by the respondents are show in Table 13.

Table 13: Distribution of Respondents by Knowledge on Modes of Transmission of HIV/AIDS

S. No.	Ways of Transmission	Respondents					
		Girl		Boys		Total	
		No.	%	No.	%	No.	%
1	Sexual contact	20	100	20	100	40	100
2	Mother to fetus	19	95	20	100	39	97.5
3	Contaminated needles and blood	20	100	20	100	40	100
4	Breast feeding	18	90	20	100	38	95
5	Sharing razor	5	25	9	45	14	35
6	Kissing	-	-	-	-	-	-
7	Sleeping together	-	-	-	-	-	-

Source: Field Survey, 2008

Note: The number and percentage are the multiple answers of the respondents.

Table 13 shows that most of the respondents (100%) have known the sexual contact, contaminated needles and blood with infected person transmitted the HIV/AIDS to healthy person. Where as 97.5 percent of the respondents said that it could be transmitted by infected mother to fetus. Similarly, 95 percent of the respondents said that it could be transmitted by infected mother by breast feeding to children and 35 percent of the respondents said that it could be transmitted by sharing razor with infected person. It is also seen in Table 13 that respondent do not believe the transmission of HIV/AIDS from infected person to healthy person by means of kissing and sleeping together.

5.1.6 About Sex Partner and Use of Contraceptives

This is one of the most important factors about knowledge and attitude of adolescent towards HIV/AIDS. The questions “Do you have a sex partner?” have been asked to the respondents. 97.5 percent of the respondents said that they have not sex partner and only 2.5 percent (one of the girl respondent) of the respondents said that they have a sex partner and the partner is her husband. She also said that they use contraceptives at the time of intercourse.

5.1.7 Most Vulnerable Group of HIV/AIDS in the Society

In order to examine the vulnerable group of HIV/AIDS in the society, the respondents have been asked “Who are the most vulnerable groups of HIV/AIDS in the society?” Cent percent of the respondents said that the most vulnerable groups are: youth adolescents, drivers, drug addicts and commercial sex workers. Though, I found that, the respondents have good knowledge about the most vulnerable group of HIV/AIDS in the society.

5.1.8 Knowledge of HIV/AIDS Prevention

As we know that ‘Prevention is better than cure’ we have to analyze the level of knowledge of the respondents to prevent HIV/AIDS. Moreover, HIV/AIDS is non-curable so it is more important to know how to protect ourselves from HIV/AIDS infection.

Table 14: Distribution of Respondents by the Knowledge on HIV/AIDS Prevention

S. No.	Method of Prevention	Respondents					
		Girl		Boys		Total	
		No	%	No	%	No	%
1	Use of Condom	20	100	20	100	40	100
2	Do not have Sex at all	8	40	2	10	10	25
3	Sex with faithful person	14	70	14	70	28	70

Source: Field Survey, 2008

Note: The number and percentage are the multiple answers of the respondents.

Table 14 clarifies that majority of the respondents (100%) reported that ‘use of condom’ is the most preventive measure of HIV/AIDS. Where as 70 percent respondent believe in ‘sex with faithful person’ and 25 percent respondents believe in ‘no sex at all’ is a preventive measure from HIV/AIDS.

5.1.9 Perception about AIDS Infected Person

AIDS is considered as dangerous disease in our society. Most of the people in our country are not aware about AIDS. In order to know the perception of respondents towards AIDS infected person, this question “What is your perception about AIDS infected?” was asked to the respondents. The response of the respondents is shown in Table 15 below.

Table 15: Distribution of Respondents by the perception about AIDS Infected

S. No.	Perception about AIDS Infected	Respondents					
		Girl		Boys		Total	
		No.	%	No.	%	No.	%
1	All of them die	13	65	14	70	27	67.5
2	Some of them die	7	35	6	30	13	32.5
3	Nobody dies at all	-	-	-	-	-	-
Total		20	100	20	100	40	100

Source: Field Survey, 2008

Table 15 shows the perception about AIDS infected person, the majority of the respondent (67.5%) reported that ‘all of them die’ while 32.5 percent said ‘some of them die’.

5.1.10 Behaviour towards HIV Positive

HIV is transmitted by sexual intercourse, using infected blood, syringe and infected mother to her newly born child but not transmitted by shaking hands, hugging, sharing toilets, soap and bathroom etc. Having knowing this fact, our society does not easily accept HIV Positive people and avoid them. To support the HIV positive first of all we have to change our attitude towards them.

Table 16: Distribution of Respondents by their Behaviour towards HIV Positive People

S. No.	Behaviour	Respondents					
		Girl		Boys		Total	
		No.	%	No.	%	No.	%
1	Like other person	16	80	19	95	35	87.5
2	Avoid him/her	-	-	-	-	-	-
3	Don't know	4	20	1	5	5	12.5
Total		20	100	20	100	40	100

Source: Field Survey, 2008

According to above Table 16, majority of the respondents (87.5%) said that, they do equal behaviour to HIV Positive people as other normal people. Few numbers of the respondents (12.5%) said they still confused 'what should they do?'

5.1.11 Helping to HIV Positive Friends

The helping behaviour of school adolescent towards HIV infected person is equally important. So, respondents have been asked the question 'If you know your friend is suffering from HIV/AIDS, do you help them?' this question is asked to find out the behaviour of respondents towards HIV infected friends who know them well. The attitude of the respondents is clearly found out by this question. The response of the respondent is mentioned in the Table 17 below.

Table 17: Distribution of Respondents by their Behaviour towards HIV Positive Friends

S. No.	Behaviour with HIV Positive Friends	Respondents					
		Girl		Boys		Total	
		No.	%	No.	%	No.	%
1	Yes	18	90	19	95	35	92.5
2	No	-	-	-	-	-	-
3	Don't know	2	10	1	5	5	7.5
Total		20	100	20	100	40	100

Source: Field Survey, 2008

Table 17 shows that, majority of the respondents (92.5%) said that, they must help to his friend if he is infected with HIV Positive. They also know that ‘we have to help HIV Positive person in our society’ and they need love rather than hate Little numbers of the respondents (7.5%) said they still confused ‘what should they do?’ if his friend is suffering from HIV Positive.

5.1.12 Teachers effort to explain about STDs and HIV/AIDS

Teacher’s description about STDs/HIV to the students is the most important factor about the knowledge and attitude of school adolescent towards HIV/AIDS. If the teachers have described on sexually transmitted disease (STDs) and HIV to their students, then the student have sound knowledge on STDs/HIV. In order to find out the descriptions about STDs/HIV by the teacher in the class, the respondents have been asked the question ‘Do your teacher describes about STDs and HIV/AIDS?’ Cent percent of the respondents said that, their teachers describe about STDs and HIV/AIDS in the class. And the other question have been asked to the respondents is ‘Does your teachers feel shy to teach about sexual and reproductive health

issue? And cent percent of the respondent said that, their teachers do not shy to describe about STDs and HIV/AIDS. Though, we can say that, the teachers describe about STDs/HIV in the class and students were satisfied by their teacher behaviour in the matter of description of sexually transmitted diseases (STDs) and HIV.

5.1.13 Opinion about Sex and Reproductive Health Education by the Respondent

Sex and reproductive health education in the secondary school adolescent is one of the most important issues at present days. Student opinion about the need of ‘sex and reproductive health education’ in their school is the most important factor about the knowledge and attitude of school adolescent towards HIV/AIDS and STDs. This issue may help to know the preventive measure of HIV/AIDS and STDs to the adolescents. The questions ‘In your opinion, is it necessary for students to have sex education?’ have been asked to the respondents and the cent percent of the respondent said that, sex education is necessary for students. Similarly, another question ‘Are you support to study sexual and reproductive health issue in your class?’ have been asked to the respondents and cent percent of the respondents agreed about this question. So, we can say that almost all respondents said they do need sex education for the secondary school adolescents and they are highly support to study reproductive health issue in their class.

CHAPTER-SIX

SUMMARY, CONCLUSION AND RECOMMENDATION

6.1 Summary

This is the study on knowledge and attitude on HIV/AIDS among the secondary school adolescents of Birendranagar Municipality-8, Ittram Surkhet. Main objective of this study are to find out the socio-economic and household characteristics of the school adolescents especially class 9 and 10 students and another objective is to identify the knowledge, attitude and preventive measures of HIV/AIDS among the secondary school adolescents. Study area is selected by using purposive sampling. The primary data were collected by interview and secondary data were from published and unpublished materials. Among total student in grade 9 and 10, 40 students including boys and girls with in the range of age 13-18 years are selected as a respondent. Descriptive, exploratory, and analytical research design was applied in this study. Some of the major findings of the study are presented below.

- 50 percent of the respondent are from grade 9 and 50 percent of the respondent were from grade 10 among them the number of boys and girls are equal.
- Most of the respondents (55%) are from age 16-18 years, among them 63.63 percent are boys and 36.36 percent are girls and 45 percent of the respondents belong to the age group of 13-15 years, among them 33.33 percent are boys and 66.66 are girls.
- Majority of the respondent belongs to Brahmin with 37.5%, which followed by Magar 27.5%, Chettri 15%, Gurung 10%, Tharu 7.5%, and Dalit 2.5%.

- The most of the respondents are Hindu (95 %) followed by Buddhist (5%).
- The most of the respondents are unmarried (97.5 %) and only 2.5 percent of the respondent found married.
- Majority of the respondent (72.5%) live at home, followed by rented house (15%) and with relative's house (12.5%).
- Majority (37.5%) respondents' father's are under SLC followed by 35 percent are above SLC (i.e. Intermediate and Bachelor pass) level, 22.5 percent are uneducated and 5 percent are taking adult education.
- Similarly, 37.5 percent respondents' mother's are under SLC and uneducated respectively followed by 22.5 percent are taking adult education and 2.5 percent respondents' mother's are above SLC pass (i.e. Intermediate level).
- Around 55 percent respondents' father's are engaged in service (government and private sector) followed by Daily wage, agriculture and business with 17.5 percent, 15 percent and 12.5 percent respectively. Similarly, majority (47.5%) of respondents' mother's are housewife followed by Daily wage and agriculture and service with 25 percent, 25 percent and 2.5 percent respectively.
- In comparison to boys, girls have much easiness with their parents. So, majority of the respondent (65%) can talk with their parents about their personal problem and minority (35%) doesn't share their problems.
- About 65 percent of the respondents are feeling comfort with their parents about their personal problems. And majority (53.85%) of respondents said their parents show interest about their matters and 46.15 percent parents do not response at all.

- Cent percent respondents said that HIV is a virus.
- Majority (72.5%) of the respondents have knowledge about AIDS. 27.5 percent respondent have not actual knowledge about AIDS.
- Cent percent of respondents said that they heard about HIV/AIDS by means of different modes of communication i.e., Radio/Television, News paper, Text book, Pamphlets, Teacher, Parents and Friends.
- Majority (85%) of the respondents heard about HIV/AIDS in Class 6 followed by 15 percent in Class 8.
- Majority of the respondents (100%) believes in the transmission of HIV/AIDS to healthy person by means of sexual contact, contaminated needles and blood, 97.5 percent believes in the transmission by infected mother to fetus. Similarly, 95 percent believes in the transmission by infected mother to children by means of breast feeding and 35 percent believes in transmitted by sharing razor with. Respondents do not believe the transmission of HIV/AIDS from infected person to healthy person by means of kissing and sleeping together.
- Majority (97.5%) of the respondents said that they have not sex partner and only 2.5 percent of the respondent said that with have a sex partner i.e. her husband and she use contraceptives at the time of inter course.
- Cent percent of the respondents said that the most vulnerable groups of HIV/AIDS are youth adolescents, drivers, drug addicts and commercial sex workers.
- Most of the respondents (100%) said that 'use of condom' is the most preventive measure of HIV/AIDS and 70 percent believe in 'sex with

- faithful person’ and 25 percent of respondent believes in ‘no sex at all’.
- According to the perception about AIDS infected person, the majority of the respondent (67.5%) reported that ‘all of them die’ while 32.5 percent said ‘some of them die’.
 - About 87.5 percent of the respondents said they do equal behaviour to HIV Positive people as normal people and minority (12.5%) said they still confused ‘what should they do?’
 - Majority of the respondents (92.5%) said that, they should help to his friend if he is infected with HIV Positive and some of the respondents (7.5%) are still confused in this matter. Majority also said that HIV infected person ‘needs love rather than hate’.
 - Cent percent of the respondents said that, their teachers describe about STDs and HIV/AIDS and their teachers do not shy to describe about STDs and HIV/AIDS in their classes.
 - Almost all of the respondents said that, sex education is necessary for students and respondents also said that, they need sex education for the secondary school adolescents and they are supported to study the reproductive health issue in their class.

6.2 Conclusion

On the basis of above analysis and results the study has concluded that the level of knowledge on HIV/AIDS among secondary school adolescents is satisfactory. Though, AIDS is not a new word for them, some of them have misconception about it. Minority of the respondents (12.5%) have not sufficient knowledge of AIDS. We assess those knowledge and attitude aspect separately and they have sufficient knowledge in those aspects.

Health, Population and Environment course included in the secondary level is benefited for the secondary school adolescents. Most of the respondents strongly demand the sex education in their curriculum. And most of the respondents strongly supported to study reproductive health and the sex education in their class.

So, adolescent sexual and psychological health is a matter of great concern since adolescents are the responsible citizens of a Country in the future. Now -a-day, the changing social norms and values regarding sex and the increasing age at marriage are attributed to adolescent's premarital sexual activities. In such a situation, they must be supported by correct information to dispel the mental stress and help them practice responsible sexual behaviour.

6.3 Recommendation

Any single study may not be enough to explore the desire result on a particular subject. This study also is not exception. But, on the basis of the findings, some recommendation is given below.

- The knowledge about HIV/AIDS among secondary school adolescents is not worse. They have known about it to a reasonable extend. However, it does not mean that they don't need any further more information and awareness program. The knowledge they already have can be strengthened by awareness program and some misconception can be clarified.
- Though, various NGOs and INGOs are already involved in this field to aware people about HIV/AIDS it needs more intervention to aware and to help those people who need urgent attention.

- Awareness programs for the parents should also launch because some of the respondents have hesitation to talk their personal problems to their parents and even if they talk, their parents don't response.
- It is strongly recommended that parents of each family should educate their child to be aware of HIV/AIDS and its' risk.
- Keep record of those vulnerable girls and boys to ensure their safety.
- Update data at least once in a year.

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Annex-1
Questionnaire

A. Individual questionnaire

- 1) Name of the student:
- 2) Age:
- 3) School:
- 4) Class:
- 5) Sex: (A)Boy (B)Girl
- 6) Caste/Ethnicity:
- 7) Religion: (A)Hindu (B)Buddhist (C)Muslim
 (D)Christian (E)Others (Specify)
- 8) Marital status: (A) Married (B) Unmarried
- 9) If married, in which age did you, marry.....?
- 10) Where do you live/stay at present?
 (A) At home (B) at hostel (C) independently (D) with relative
 (E) others (specify)

B. Household characteristic

- 11) Can your father read and write?
 (A) Yes, (B) no (if no skip Q.No.14)
- 12) If yes, what is yours father's educational level?
 (A) No schooling, (B) primary (C) secondary (C)
 S.L.C (D) intermediate (E)bachelor and above (F) Adult
 education
- 13) Can your mother read or write?
 (A) Yes, (B) no (if no skip Q No 16)
- 14) If yes, what is your mother's educational level?

(A) No schooling, (B) primary (C) secondary (C) S.L.C (D) intermediate (E) bachelor and above (F) Adult education

15) What is your father's occupation?

- (A) Agriculture
- (B) Service
- (C) Business
- (D) Daily wages
- (E) Other (specify)

16) What is your mother's occupation?

- (A) Agriculture
- (B) Service
- (C) Business
- (D) Daily wages
- (E) Others (specify)

17) Can you talk about your personal problem with your parents?

- (A) Yes (B) no

18) Do your parents respond your question?

- (A) Yes (B) no

C. Knowledge and attitude on HIV/AIDS

19) Have you heard about HIV/AIDS?

- (A) Yes (B) no

20) If yes from which sources have you heard about HIV/AIDS?

- (A) Radio
- (B) TV
- (C) Newspaper
- (D) Textbook
- (E) Teacher
- (F) Relatives
- (G) Friends
- (H) Others (specify)

21) In which class did you hear about HIV/AIDS?

.....

22) What is HIV?

.....

23) What is AIDS?

.....

24) How is HIV/AIDS transmitted?

- (A) Sexual contact
- (B) Mother to fetus
- (C) Contaminated needles and blood
- (D) Breast feeding
- (E) Sharing razor
- (F) Kissing
- (G) Sleeping together
- (H) Others (specify)

- 25) Do you have sex partner?
(A)Yes (B) no
- 26) If yes who is he/she?
(A) Wife/husband
(B) Boy friends/ Girl friend
(C) Relative
(D) Others (specify)
- 27) If yes, do you use any types of contraceptives at time of intercourse?
(A) Condom
(B) Pills
(C) Foam tablet
(D) Injection
(E) Others (specify)
- 28) In your opinion, who are the most vulnerable group in our society from HIV/AIDS?
(A) Youth adolescents
(B) Driver
(C) Drug addicts
(D) Commercial sex workers
(E) Others
- 29) Do you know how is HIV/AIDS prevented?
(A) Use condom
(B) Do not have sex at all
(C) Sex with faithful person
(D) Others (specify)

- 30) What is your perception about AIDS infected?
- (A) All of them die
 - (B) Some of them die
 - (C) Nobody dies at all
- 31) How do you treat a HIV positive person?
- (A) Like other person
 - (B) Avoid him/her
 - (C) Don't know
- 32) If you know your friend is suffering from HIV/AIDS, do you help them?
- (A) Yes (B) no (C) don't know

If yes how do you do?.....

- 33) Do your teacher describe about STDs and HIV/AIDS?
- (A) Yes (B) no
- 34) If not what may be the reason for not describing?
- (A) Shy
 - (B) Don't know about subject matter
 - (C) Negligence
 - (D) Don't know
- 35) In your opinion, is it necessary for students to have sex education?
- (A) Yes (B) no (C) don't know
- 36) Are you support to study sexual and reproductive health issue in your class?
- (A) Yes (B) no

37) Do your teachers feel shy to teach about sexual and reproductive health issue?

(A) Yes (B) no

Any comment

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

Thank you for your kind support.

Annex-2

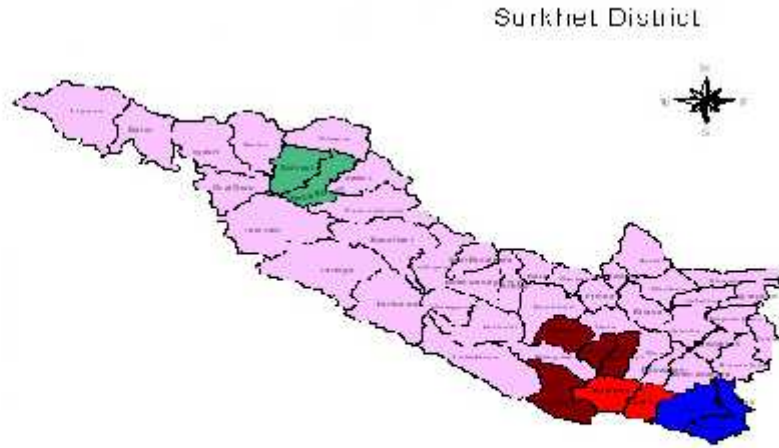


Figure 1.1: Map of Surkhet District



Figure 1.2: Map of Nepal