CHAPTER – 1

INTRODUCTION

1.1 General Background

Sexually Transmitted Infection remains major cause of acute illness, mortality and with severe and far-reaching health social and economic consequences for millions of men, women and children all over the world. It is estimated that after maternal causes, STIs are responsible for the health problem greatest number women in developing countries.

Incidence of acute STIs is believed to be high in many countries and failure to diagnose and treat STIs at an early stage may result in serious complications and sequelae including infertility fetal wastage, neonatal infections, entopic pregnancy cervical cancer and death. STIs also account for massive expenditure (WHO, 2001). The first case of AIDS was reported in Los Angles in June 5, 1981. The global HIV/AIDS epidemic has focused more attention on STIs prevention and control due to the evidence of strong co-relation between the spread of STIs and HIV transmission. For example in sub-saharan Africa 70 percent of HIV infection was found in patients with STIs and likewise 15-30% of STIs patient in Thailand were found to be HIV positive (NCASC, 2004).

AIDS (Acquired Immunodeficiency Syndrome) is the later 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 with in 5-10 years (WHO, 1999). AIDS reduces the body's ability to fight against diseases. HIV is the most commonly transmitted through semen and vaginal fluids during unprotected sex. Besides sexual intercourse, HIV can also be transmitted through injecting drugs through sharing needles contaminated with infected blood, through the transfusion of blood products and from infected mother to her babies during pregnancy, and breast-feeding. Epidemiological studies have identified sexual intercourse intravenous drug injection; blood transfusions and infected mother to fetus major rotes of transmission of HIV/AIDS. Shaking hands, mosquito bites, kissing, using same towel and sharing food do not spread HIV virus.

There is currently no vaccine for HIV/AIDS though research is under way to produce an effective 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 (CDC, 2005).

The world's population in this century is facing a serious problem created by AIDS. AIDS has been emerging as burning issues all over the world and more efforts have been made to control the diseases. There are 40 millions (30-40) people living with HIV/AIDS and newly infected with HIV in the year 2004 alone are 5 million (4.3-5.8 million) and AIDS death in 2004 was 3 million (UNAIDS, 2004).

Since the detection of the first AIDS case in Nepal in 1988 Nepal has progressed from a "low prevalence" country to one with so called "concentrated epidemic" in certain subgroup of population with HIV prevalence of 17.3 percent and 68 percent among female sex workers and injecting drug users respectively and a prevalence ranging from 4-10% among labour migrant to India, especially those migrating to Mumbai from western Nepal. It is only a matter of time before we face a generalize epidemic, if expanded response is not initiated immediately (MOH, 2004).

It has been estimated that at the end of 2005, approximated 40.3 million people worldwide were living with HIV/AIDS, of which, a total of 8.3 million people belonged to the Asian region (Kaiser Family Foundation, 2005). Young people bear a special burden in the HIV/AIDS pandemic. Nearly one third of these currently living with HIV/AIDS are aged 15-24. Adolescents are more vulnerable than adults to unplanned pregnancies, STIs and HIV/AIDS. It has been documented that although premarital sex is less common in the Asia region, it is clearly on the rise. It has been observed that when adolescents become sexually active, they tend to have multiple partners and use condoms and other contraceptive inconsistently. Furthermore, younger women are more vulnerable to forced sex and in sex exchange for gifts and money, with increasing risk of contracting STIs, including HIV/AIDS (Ashford, 2001)

Although the HIV/HIDS epidemic is relatively new in Nepal, yet though it is transforming from 'low' to 'concentrated' epidemic. The first case was identified in Nepal in 1988. As of 30 November 2005 a total of 5,647 HIV infection cases were reported in government facilities. Of this number 929 were infected by AIDS of which 273 had already died (NCASC, 2005).

Actual HIV/AIDS infection in Nepal is feared to be many times higher than the recorded cases. In the context of Nepal, estimated number of adults and children living with HIV/AIDS is estimated at 62,000 by the end of 2003 (UNAIDS/Nepal 2004). Current estimated HIV infection rate of 0.5 percent pervades on the adults population between the age cohorts of 15-49. Of the total reported HIV/AIDS infections, NCASC data reveal that males comprise 73 percent and females only 27 percent. Young people (20-29) ages make the highest suffering group from HIV/AIDS.

AIDS is a serious illness that slowly attacks and destroys the body's immune system. The result is that the body becomes vulnerable to infection (opportunistic infection) and cancer Acquired Immune Deficiency Syndrome (AIDS) system deficiency is not hereditary and is characterized by a number of symptoms occurring together.

HIV means Human Immunodeficiency virus that finally leads to AIDS. All body fluids could contain HIV. But it's presence is particularly high in blood, semen of men cerebrospinal fluid and vaginal and cervical secretion of the women. A person infected with the virus becomes a carrier of HIV and can infect others.

A person infected with HIV may not show any sign or symptoms for 5 to 10 years and may transit the virus other when AIDS finally sets in the person may get several sign and symptoms such as fever, loss of weights, diarrhea and persistent the presence of HIV in the body of the infected person. The tests that are at present available detect the presence of antibodies to the HIV in the body of infected person. The body takes three to five months to develop antibodies to the HIV. During this (window) period a virus infected person tests would result in his/her continuing to infect others. The only way to prevents HIV/AIDS behavior, which would expose him/her to the risk of HIV infection. The practice of 'safe sex' through the use of condom could reduce the risk of HIV infection considerably, use of

disposable needles, syringes and ensuring the supply of infection free blood and blood product are other measures needle for reducing the risk of HIV infection. A woman infected with HIV needs to seriously consider the risk of infecting her baby before deciding to go for a pregnancy (Bhende and Kantikar, 2003). As the disease progresses, people gradually lose all natural defense mechanism and finally the immune system collapses. Then the sick people become susceptible to many opportunistic infections. The types of opportunistic infection vary from region of the residence. The most common opportunistic infection are Cryptococcus, Taxoplasma, Phemocostic, Canitcrptosporidosis. Tuberculosis, Herpes simplex virus and Candidezil etc.

1.2 Statement of the Problem

Nepal is a highly heterogeneous country in terms of geography, caste/ethnicity, language and culture. Nepal being landlocked country shares borders with India and China and is made up of 75 districts in five different development regions (Eastern, Central, Western, Mid-Western, Far-Western). The Himalayas cover the northern third of the country from east to west, bordering China. To their south lies a long east-west, stretch of lower mountains (The hilly region) whose southern flanks flatten into the Terai a fertile sub-tropical plain spanning the border with India. These countries have played a major role in helping to determine the geographical and social diversity that characterize Nepal.

In the Human Development Report 2004, it is reported that Nepal is one of the poorest countries in the world both in economic terms as well as socio-cultural parameters. Nepal's social indicators remain well below the average for the south Asian region. More than 40 percent of the Nepali population live below the national poverty line nearly half of all children below 5 years are underweight and nearly 60 percent of all adults are illiterate. Additionally, women have traditionally a lower status than men and gender inequality is deeply rooted. More boys than girls receive any form of education, women generally work longer hours than men and men have better access to services including health.

STIs and HIV/AIDS is spreading day by day in every country. It becomes great problem and burden for the society. As youth are energetic wing of the nation they can change the trend and cultural barriers social lag and traditional.

HIV/AIDS has been a great challenge globally. Researchers have found that at present, young people aged 15-24 accounts for half of all HIV with young women especially at risk. In just over two decades, the AIDS pandemic has claimed 20 million lives and infected 38 million people. Five million new HIV infections occurred during 2003. Women are nearly half of all infected adults, and nearly three fifths of those in sub-saharan Africa. In some areas of those countries 25 percent of the work force is HIV positive (Bandi, Hari, 2005).

Nepal remains a low-prevalence nation for HIV in relation to its neighbors in south and Southeast Asia. The National centre for AIDS and STIs control (NCASC) maintains an HIV/AIDS national reporting system which provides information on official HIV/AIDS cases reported to the ministry of Health. According to NCASC there is estimated total of 2080 HIV infection cases in Nepal out of that 527 were infected by AIDS and by AIDS and 149 have died end of September 2001 (Bista, 2002).

The various sources of information of AIDS transmission and the persisting misconception in the student's level must also be assessed. Training and orientation programmes organized for schoolteachers' community leaders, and women group members, which broaden the total coverage SRH programme in the community. These groups play as core group for further advocating and education the community on SRH issues. Likewise, controlling the HIV/AIDS extensively mobilizes theses groups for the continuation of programme (Bista, 2002).

Adolescent especially those aged 15-20 years are believed to engage in high level of unprotected sexual activity both within and outside marriage leaving them exposed to risk of unplanned unwanted pregnancy and contacting STIs including HIV/AIDS. Such behavior often resulting in early out of wedlock pregnancy constitutes a major threat to health of these adolescents as well as retarding their potential, education carrier and economic development. Nation wide STIs data are scarce and non-specific because they often have short terms sexual relationship and do not consistently use condom to protect themselves.

1.3 Objectives of the Study

The main objective of the study is to reflect the picture of knowledge, attitude and behavior on STDs and HIV/AIDS among adolescent of higher secondary school students in Bhaktapur municipality of Bhaktapur district. The specific objectives of the study are;

1. To examine the knowledge, attitude and perception of STIs and HIV/AIDS among higher secondary school students.
2. To assess the sexual behaviors of the higher secondary school students.
3. To assess the socio-economic context of the higher secondary school students.

1.4 Significance of the Study

For the past 25 years, HIV/AIDS has become an increasing global phenomenon. With AIDS we are confronting an epidemic that began with a whisper only a decade ago and how roars like thunder around the globe. Everyday another 14000 of our brother and sisters, sons, and daughter through the world are infected with HIV. Most of the human faces of this epidemic are of children and youth. Half of all HIV infections occur in people younger than 25. According to recent STI some 7000 young people aged 15-24 infected with HIV everyday. Youth are the pillar of the nation. The higher secondary level school students are important in the society. Some of them will form the future elite of the society. All the students do not rank among so called “high risk” groups in relation to AIDS. The fact, however, that they are adolescents and most likely start to experience and experiment with their sexuality makes them potentially vulnerable to AIDS related risk behavior. I have also chosen in my study the most risky group students (adolescents) of higher secondary students. From my study it will be able to assess the knowledge of STIs, HIV/AIDS and preventive measures among the students of higher secondary level. This study will also be fruitful for policy maker, social workers, planners, implementers and demographers.

The global HIV/AIDS epidemic has focused more attention on STIs prevention and control due the evidence of strong correlation between the spread of STIs and HIV transmission. Both ulcerative and non-ulcerative STIs increase the risk of sexual transmission and

acquisition of HIV (WHO). Scientific evidence suggests that the sexual route spreads 80 percent of HIV infections and there is interrelationship between HIV and STIs. For example, in sub-Saharan Africa 70 percent of HIV infection was found in patients with an STIs and likewise 15-30 percent of STIs patients in Thailand were found to be HIV positive (NCASC, 2004).

1.5 Limitation of the Study

The study is limited only among students of higher secondary level and only 120 samples are taken out from three higher secondary school students of Bhaktapur municipality of Bhaktapur district. So the finding cannot be generalized for other population group and other places.

1.6 Operational Definition of the Terms Used

Knowledge: - According to Oxford Advanced Learners' Dictionary (2001) meaning of knowledge is "the information, understanding and skills that you gain through education or experience" In this study knowledge refers to the understanding of causes of mode of transmission, symptoms, prevention of STIs, HIV/AIDS.

Attitude:- According to Oxford Advanced Learners' Dictionary (2001) meaning of Attitude is "ways of feeling, thinking or behaving" An attitude is a dispositional readiness to respond to certain situation, persons or objectives in a constant manner which has affective cognitive and action components. In this study attitude refers to favourable or infavourable reactions to statement in the attitude scale provided by the researcher.

Behavior:- According to Oxford Advanced Learner' Dictionary (2001) meaning of behavior is "The way that somebody behavior specially towards other people good/bad behavior" In this study behavior refers to the utilization of knowledge about STIs and HIV/AIDS.

Sexuality:- According to Oxford Advanced Learner' Dictionary (2001) meaning of sexuality is "The feeling and activities connected with a person's sexual desire" In this study sexuality

refers to know sexual activities to the students of higher secondary students provided by the researcher.

STIs:- Sexuality transmitted infections major cause of acute illness, morbidity and with server and far reaching health, social and economic consequences for million of men women and children all over the world.

HIV:- Human immune deficiency virus a combination of diseases caused by HIV virus, which affects the immune system of the body.

AIDS:- Acquired Immune Deficiency virus, a combination of diseased caused by HIV virus, which affects the immune systems of symptoms which result from weakness of the body defiance system due to this reason, the body has becomes unable to fight against infections.

STDs:- STDs are diseases transmitted by sexual contact during the unprotected intercourse.

Adolescent:- WHO defines adolescents as individuals between 10 and 19 years of age. The broader term youth encompasses the 15 to 22 years old age group. The transition period between childhood and adulthood individual between the age of 10 – 19 year. The transition period is part of life in which he/she goes through some great change of behavior in their lives great physical change, their body grow faster during this period the research work will deal with the age group of 15 - 20 years.

1.7 Organization of the Study

The presentation of the study is divided into six chapters. The first chapter deals with the introduction focusing on the General background, Statement of the Problems, Objective of the study, Significance of the study, limitation of the study, definition of the terms used and Organization of the study. The second chapter presents the review of literature relevant to STIs and HIV/AIDS with special emphasis on the study and sexual behavior. Likewise, third chapter the research methodology begins with the Introduction of the Study Area, Sampling of the study, Method of data collection School Selection, respondent selection, Questionnaire Design, document research, analysis and interpretation and selection of the study variable. The fourth chapter, socio-economic analysis, is divided into individual and household

characteristics including age, sex, caste/ethnic composition of respondent family size, parents' education, and occupation of parents. In the same way, analysis of STIs-HIV/AIDS and sexual behavior integrated with the Knowledge and attitude on STIs-HIV/AIDS sex knowledge and it also includes involvement in sexual activities and sexual partners, use of preventing method (condom) and impact of knowledge of STIs-HIV/AIDS to the sexual behavior is reveals in fifth chapter. Finally, the last chapter is concluding the study finding, summarize the study and recommendations.

CHAPTER – II

LITERATURE REVIEW

This chapter attempts to present review of literature on sexual behavior, Sexually Transmitted Diseases HIV/AIDS, history of more vulnerable groups for acquiring STIs like Syphilis, and Gonorrhea etc were reviewed to generate the adequate relationship between the variables and to share the other opinion on the issued statement.

2.1 Background of the HIV/AIDS

Human immunodeficiency Virus (HIV) is an infectious agent that causes acquired immunodeficiency syndrome (AIDS) a disease that leaves a person vulnerable to life threatening. Scientist have identified two types of this virus HIV-1 is the primary cause of AIDS worldwide and HIV-2 is found mostly in West Africa HIV belongs to the retrovirus family of viruses.

HIV transmission occurs when a person is exposed to body fluids infected with virus, such as blood, semen, vaginal secretions and breast milk. The primary modes of HIV transmission are 1) sexual relations with an infected person; 2) sharing hypodermic needles or accidental pricking by a needle contaminated with infected blood; and 3) transfer of the virus from an infected mother to her baby during pregnancy, childbirth, or breast-feeding.

When HIV enters the body, it infects lymphocytes white blood cells of immune system. The virus commandeers the genetic material of the host cell, instruction the cell to replicate more viruses. The newly formed viruses break from the host, destroying the cell in the process. The new virus go on to infect and other lymphocytes.

Over a period that may last from few months up to 15 years HIV may destroy enough lymphocytes that the immune system become unable to function properly. An infected person develops that multiple life threatening illness form infection that normally does not cause illnesses in people with a healthy immune system. Some people who have HIV infection may not develop any of the clinical illnesses that define the full-blown disease of

AIDS for an years or more. Doctor prefer to use the terms AIDS for cases where a person has reached the final, life-threatening stage of HIV infection.

2.2 World Situation on STIs and HIV/AIDS Pandemic

STIs continue to be a major and growing public health problem in many parts of the world, especially in developing countries with and estimated annual incidence of 340 million curable STIs in 1999. At present the four most common curable STIs in the world which can be cured easily by adequate antimicrobials are syphilis (12 million) and Trichomoniasis 173 million in the world. The increasing mobility of population across the world, urbanization, poverty socio-demographic changes especially in developing countries, sexual exploitation of women and change in sexual behavior are some of the factor which have placed an ever increasing proportion of population at risk for STIs (WHO, 2001).

The epidemic of STIs in the developing countries is characterized by high incidence and prevalence high rate of complications, increasing problem of antimicrobial resistance due to inadequate treatment and increasing risk of transmission and acquiring HIV infection. The increasing urbanization and industrialization in developing world leads to migration of young men and women in search of employment in urban areas and even in other countries. This growing phenomenon often results in increased unsafe commercial sexual activities that help to the spread of STIs and HIV epidemic. In the context of HIV risk is defined as the probability that person may acquire HIV infection. Certain behaviors create enhance and perpetuate such risk for instance, unprotected sex with a partner whose HIV status is not known multiple unprotected sexual partnership, lack of adherence to infection. Control repeated bill transfusion with shared needles and syringes. Therefore those who have sexual relation with multiple partners are placed themselves at a high-risk group for contacting with HIV/AIDS (UNAIDS, 2004).

Risk arises from individuals engaging in risk talking behavior for a variety of reasons. For example they may have lack of information on HIV, they may be unable to negative safer sex and they may think that HIV/AIDS affects different social strata than their own or they have access to condoms. Religions socio-cultural practices and other traditions rigidities especially

with respect to sex and reproductive health have made talk more difficult in the context or Nepalese society. It is a paradox that sex is one of the commonest things in our life. We talk least about it in our society. It a subject that to be so considered being a very personal and secret matter whenever children ask their parents about sex and sexual organs they either ignore them or scold them or tell them utter lies (Gurubacharya, 1994).

Because of wide spread taboos and wrong impression about sex and sexual organs or children's and even adults are not only ignorant about sex and reproductive health but they also have the misconception that they should not talk abut sex and this should be supposed as much as possible. Thus our adolescents do not have scientific knowledge on masturbation and menstruation. When they reach their age of puberty they can no longer suppress their natural instinct and desire and try to find about sex from peer group, pornography book and magazines as well as blue films are lead to unhealthy sexual practice (Gurubacharya, 1994). The sexual attitude and behavior of young adolescents in Jamaica have already been significantly shaped by socio-cultural and gender norms that send mixed message about sexuality and imposed different standards of behavior for boys and girls (New Era, 1998).

The risk of acquiring high among STIs including HIV infection is especially high among sexual partners if the age if difference among them is signification large and if individual has multiple sex partners of unprotected sex. Also the risk of contacting with sexually transmitted diseases is especially higher for young people who became sexually active in early age and are therefore more likely to change partners. Further more people have very poor knowledge about sex and sexuality contraception and STIs and their prevention (UNFPA, 1998). "HIV transmission through sexual intercourse accounts for about three quarters of all HIV infections worldwide. More than 80 percent of all HIV infection transmitted through sexual intercourse in other words in HIV infection is sexually transmitted diseases (Shahi, 2004).

STIs or RTI increase the chance that any single sexual encounter will transmit the virus. In societies where STIs are wide spread and where people have many sexual partners; the risk of HIV infection is dramatically increases (UNFPA, 1998). The majority of the worlds HIV infection have been acquired through sexual intercourse between men and women (heterosexual transmission) the proportion of HIV infection attribuTable to this mode of

transmission continuous to grow HIV transmission through sexual intercourse between men (homosexual transmission) occurs in most part of the world. Although in the developed countries it has become less common as the result of the adoption of sager sex practices by homosexuals men (UN, 2000).

Anal intercourse carries high risk of HIV transmission because of frequent lesion, although it is often associated with homosexual contacts, heterosexual couples practices it to preserve virginity to protect against pregnancy, for sexual pleasure and in search for sexual variety. Where did the AIDS virus come from? Scientists believe that they have solved this lingering mystery, the answer chimps-"AIDS mystery solved culprit is the chimp." This article was published in Feb. 1999. Dr. Beatrice Hahn, who led the team that, traced the origin of HIV to sub-specific of chimps in Africa with her husbanded Geroge Shah, in their laboratory at the university of Albama in Birmingham, USA. They had convincing proof that the virus spread on at least three separate occasions from chimpanzees to people in Africa. One of these cross species transmission was the start of the epidemic that now infects about 35 million people worldwide. Chimps which have probably carried the virus for hundred of thousands of gears, apparently do not get sick from it, figuring out why it could be important, while chimps have long been suspected as the source, there have been a lot of fuse ends (UN, 2000).

AIDs was first reported in 1981 in USA the causative organism of HIV/AIDS was identified in 1983. The pandemic nature and the magnitude of the public health problem associated by human immunodeficiency virus. Infection were recognized much later when the proportion of person infected with HIV rose vary rapidly, however considerable efforts are being made to contain the spread of HIV as the impact of HIV/AIDS seem to be very serious in a long term aspects. The HIV virus does not respect geographical boundaries so on country of the globe is immune to HIV/AIDS. This is why this issue needs an issue of globe thinking and intervention (Aryal, 2000). UNAIDS and WHO estimates that 40 million 2.5 million are children under the age of 15 and 37 million are adults. The overwhelming majority of people with HIV, some 95 percent of the globe total live in the developing world. Above 5 million were infected with HIV in 2003 along of this 700000 are children under the age of 15 years, UNAIDS expect that epidemic will continue to grow in countries where poverty peer health system and limited resources for the spread of the virus more occurs among young adults

who would normally so their peak productive and reproductive age adding and additional cost to the epidemic.

Studies have found a connection between higher AIDS incidence and lower income. For instance, a study of African American women in North Carolina found that those with HIV infection were more likely than non-infected women to be unemployed; receive public assistance; have had 20 or more lifetime sexual partners; have a lifetime history of genital herpes infection; have used crack or cocaine; or have sex for drugs, money or shelter (CDC, 2005). It is now clear that there is a strong correlation between the spread of conventional STIs and HIV transmission. Both ulcerative and non-ulcerative STIs increase the risk of sexual transmission of HIV. Scientific evidence suggest that 80 percent of HIV infection as spread by sexual route and that there are a strong relationship between HIV and AIDS. More generally, STIs and AIDS interact the risk of acquisition and transmission of HIV second STIs may influence the progress of immune deficiency virus, positive individual, third HIV may change the natural history of the STIs in patient as the insensitivity may be increased and the response to the treatment may be impaired.

With more than 23 million adults living with HIV/AIDS, Sub-Saharan Africa is ravaged by this epidemic an outstanding 36 percent of Botswana's 15-49 years old people live with the disease. In Lesotho, Swaziland and Zimbabwe approximately 25 percent of adults in these prime ages have HIV. South Africa has the highest number of adults living with the virus at above 4.1 million nearly 3 million Ethiopia adults live with HIV. Outside the sub-Saharan Africa the largest number of people infected with HIV or living with AIDS are in India at 3.5 million. Globally 15.7 million adults with AIDS are women and 1.3 million are children below the age of 15 (NCASC, 2004).

According to the United Nations, the number of people now living with HIV/AIDS has reached 38 million, Sub-Saharan countries of Africa has by far the largest number of people living with HIV/AIDS, Just over 25 Million. Out of the 6.5 million HIV/AIDS victims in South/Southeast Asia, 5.1 million in India. It is estimated that the infection rates have begun to decline in a number countries, show that the situation need not to be hopeless.

Table 2.1 Worldwide Distributions of HIV/AIDS on infected Adolescent 15-19 Years

Place	**Population**
World	1.2 million
Affrica	6.1 million
North America	0.6 million
Latian America	0.7 million
Asia	0.4 million
Europe	0.5 million
Oceania	0.2 million

Source: PRB, 2005

2.3 HIV/AIDS in Asia

National HIV infection levels in Asia are low compared with some other continents, notable Africa. But the populations of many Asian nations are large that even low national HIV prevalence means large numbers of people are living with HIV. Latest estimates show some 8.3 million people newly infected in the past year. AIDS claimed some 540,000 lives in 2004. Among young people 15-24 years of age. 0.3 percent of women and 0.4 percent of men were living with HIV by the end of 2004 (CDC, 2005).

Asia is not just vast but diverse and HIV epidemic in the region share that diversity, with the nature, pace and severity of epidemic differing across the region. Overall, countries can be divided into several categories; according to the epidemics they are experiencing. While some countries were hit early (for example, Cambodia, Myanmar and Thailand), others are only now starting to experience rapidly expanding epidemic and need to mount swift, effective responses. They include Indonesia, Nepal, 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 halt the virus' spread. Other countries are STIs seeing extremely low levels of HIV prevalence, even among people at high risk of exposure to HIV, and have golden opportunity to pre-empt serious outbreaks. These include Bangladesh, East Timor, Laos, Pakistan, and the Phillippines.

China, although moving at a varied pace, HIV has spread to all of China's 31 provinces, autonomous regions and municipalities. In some parts such as Henan, Anhul and Shandong, HIV was already spreading a decade ago among rural people who sold blood plasma to supplement their incomes. Elsewhere, the virus has established a more recent but firm presence among injecting drug users and to a lesser extent, sex workers and their clients. Much of the current spread of HIV in China is also attribuTable to injecting drug use and paid sex. HIV prevalence among drug injectors was measured at between 18 percent and 56 percent in six cities in the southern provinces of Guangdong and Guangxi in 2002, while in Yennan province some 21 percent of injectors tested positive for HIV in 2003. Sexual transmission of HIV from injecting drug users to their sex parners looks certain to feature more prominently in China's fast evolving epidemic. Some 47 percent of surveyed female drug injectors in Sichuan province and 21 percent in neighboring Yunnan province reported selling sex for money or drugs in the previous month, accounting to recent studies. Condom use was reportedly quite high but it was hardly the norm. Once HIV becomes well established in commercial sex circuits, onward spread of the virus could be quite rapid if current behavior trends persist. In 2003, almost one quarter of surveyed sex workers in Guangxi never used condoms and about one half used them only occasionally. In Sichuan, only around 40 percent of sex workers reported using condoms with all their clients in the previous month, according to a 2001 study. Little is know 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.

Most new HIV infections in Asia occur when men buy sex and large number of men does so. Household-based in a number of Asian countries suggest that between 5 percent and 10 percent of men buy sex, which makes commercial sex a large and lucrative industry in Asia. Many sex workers especially very young women from rural areas are either coerced into the industry or join it under duress, because the lack of other employment opportunities. Nepal has reported earning around 2200 rupees or US$ 30 a week, six times the average wage income (UNAIDS, 2004).

2.4 HIV/AIDS Situation in South Asia

Though there is wide variation with South Asian region, there are many similarities. Different ethnic groups reside in this region with distinct culture but some of the characteristics are very similar. Basic development and the health indicators of the countries of this region are almost similar. All countries are basically agrarian in nature and economic status is low as well as the literacy rate. The health indicators are very much similar with high infant, child and maternal mortality rates. The services in general are poor including reproductive health services. It is a taboo to talk about issues related to sex or sexuality. Nevertheless the social norms and values are rapidly in this region. Widespread media exposure both electronic and print has stimulated the change in this region.

The first HIV infection in south Asian region was reported in India in 1986. This means that the endemic was introduced in the region somewhat later than other parts of the world. The infection rates in South Asia are lower than Africa but the spread of HIV is rapid. However, current trends show that this region will be severely affected very soon. The epidemic in south Asia is newer and many countries are yet to develop a proper monitoring system. For this reason the estimates of HIV in south Asia are often made on the basis of inadequate information (Aryal, 2000).

The first HIV infection in South Asian region was reported in India 1986 and second goes to Pakistan 1986, Srilanka 1987, Nepal 1988, Bangladesh 1989 and Maldives 1991. The latest estimate shows that about 5.1 million people were living with HIV in India in 2003. Serious epidemic are underway in several states. In Tamil Nadu, HIV prevalence of 50 percent has been found among sex workers while in each of Andra Pradesh, Karnataka Maharastra and Nagland, HIV prevalence measure at antenatal clinic in the Manipur cities of Imphal and Churachand has risen from below 1 percent to over 5 percent with many of the women testing positive appearing to be the sex partners of male drug injectors. Several factors look set to sustain Manipur's epidemic, including the large proportion about 20 percent of female sex workers who inject drugs and the young ages of many injectors (UNAIDS, 2004). The government of the India recognized the seriousness of the problem and took a series of important measures to tackle the epidemic. A high powered national AIDS committee was

constituted in 1986 itself and a National AIDS control programs various preventive measure have been launching in India. To prevent HIV/AIDS in Bangladesh, A National AIDS Committee (NAC) is established. NAC is advisory body to the ministry of Health and family welfare on all aspect of HIV/AIDS including legal ethical, Managerial, Financial and technical issues. The Bhutanese Government is fully aware of the potential of its rapid spread. The approach towards the control and prevention HIV/AIDS in also a broad based of the HIV virus. The Strategic approaches include improved surveillance; increased information, education and communication campaign about the disease and strengthened laboratory services so that timely and appropriate screening is carried out.

Although the reported HIV cases are very small in Maldives, Maldives is highly vulnerable to the AIDS Pandemic. A sustained rapid economic growth to 7.2 percent has exposed Maldives to the outside world. HIV/AIDS prevention and control activities are given higher national priority under the National AIDS Council (NAC) Programs. National AIDS prevention and control program. The Government of Srilanka established a National Task Force (NTF) in 1987 and a short-term plan of action was formulated in July 1987. A multicultural, multidisciplinary National AIDS Committee (NAC) first formed in 1988. NAC has four sub-committee on laboratory services and surveillance, HIV care and counseling legal and ethical issues on HIV/AIDS and information, education and communication (IEC) functioning under it (Aryal, 2000).

Table: 2.2 HIV Situations of the SAARC Countries

Country	HIV Prevalence	Antiretroviral treatment needing people	People on antiretroviral treatment in 2003
Bangladesh	130	1950	5
Bhutan	<100	14	5
India	4580000	19500	13000
Maldives	<100	15	-
Nepal	6000	9000	100
Pakistan	670000	100500	13000
Sri Lanka	4800	720	25
Total	6 million	881699	27635

Source: NCASC, 2004

2.5 STIs-HIV/AIDS Situation in Nepal

Nepal being landlocked 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 STI and HIV. Nationwide STIs data are scare and non-specific. The annual National RTI/STI/HIV data is collected from all the health services facilities by HMIS (Health, Management Information System) of Department of Health services. This data combines any case of STI/RTI and HIV and not specific data of STI or type of STIs.

According to the annual report of HMIS, total 9928 of RTI/STI/HIV was reported out of 5667376 OPD cases which was 0.19 percent of total OPD cases in 1995-1996. The percentage of RTI/STI/HIV cases of total OPD cases were 0.22 percent in 1966-97, 0.22 percent in 1997-1998 and 0.34 percent in 1998-1999. A number of survey studies carried out in different part of country among different population group give some indication of incidence and prevalence of STIs/HIV among different population groups. A prevalence survey conducted by BCASC/UHO STI/HIV project among 18.2 percent women in urban areas of Nepal, revealed that 4.7 percent of them had previous syphilis and 1.3 percent

suffered from acute syphilis. HIV infection rate was 0.2 percent. One third 33 percent of women reported to have at least are STI related symptoms. Study among symptomatic STI patients syphilis rate was higher 17.8 male and 18 percent female DV patient and 10.7 percent in female gynoe patient. The rate of gonorrhea (DNA probe) was found to be 1.8 percent in female gynoe patients 4 percent in female DV and 13.6 percent in male DV patients. HIV positive were 0.6 percent (NCASC, 2004). Syphilis prevalence rate was 1.2 percent among sentinel surveillance STI patients in six surveillance sites. Mahendranagar, Nepalgunj, Pokhara, Birganj, Kathmandu (Maternity Hospital) and AMDA, hospital Damak. HIV prevalence among STI patients was 2.4 percent in the year 2002.

STI prevalence among sex workers (SWs) is notably higher. Data from Pokhara, Kathmandu and Terai revealed that syphilis prevalence among SWs was 18.8 percent in Terai, 19 percent in Kathmandu and 13.8 percent in Pokhara. Clients of sex workers (truckers) were found to have 5.3 percent syphilis. Among other STIs bacteria vageinosis was found in 21.6 percent trichomoniasis in 21.1 percent Chlamydia in 2.8 percent gonorrhoea in 0.8 percent and HIV in 0.8 percent among SWs in Pokhara. Trichomonas infection in female STI varied from 6 percent in FP attendees, 9.3 percent in female STI patients, 9 percent in female SWs of Terai and 21 percent in SWs of Pokhara. Similarly among family planning attendees, trichomoniasis was 6.0 percent Chlamydia was 1.7 percent gonorrhea was 1.7 percent active syphilis was 1.0 percent and HIV was 0.3 percent as per results of study conducted in (NCASC, 2004).

Beside the several studies the STI case reports collected and complied from referral centers for STI and 5 project STI clinics revealed increasing number of STI cases coming to health facilities in the year 1997, a total of 2118 cases were reported which increased to 3250 cases in 1999 and 5547 cases in 2000. The percentage of STIs cases to total OPDs were 4 percent, 2.3 percent, 3.2 percent respectively with overall percentage of 3.02 percent. The percentage of STI cases was high in mid and far western Nepal fro example 8.5 percent in Nepalgunj and 4.8 percent in Mahendranagar one year record of STI cases in Kaski district showed that 9261 cases contacted at different places, hospital, medical halls private clinics on 1999.

One research by Zeeb (1996) also estimated a total of 6000-8000 annual STI client in Kaski. Report of peripheral health facilities indicate low prevalence of STI 0.77 percent in Trishuli, 0.8 percent in Dhalkebar health post, 0.3 percent from DPHO, Kaski but slightly higher from FPAN, Kaski 1.58 and 2.29 percent from FPAN Banke. Many research result and evidence have made it clear the early and correct diagnosis and effective treatment can not only prevent the serious complications and sequence but also reduce the chance of HIV spread to a great extent. But it is not easy to ensure that easily accessible early and correct diagnosis is available in resource poor country like Nepal.

Conventionally two methods for diagnosing STI are practiced in Nepal. The first is clinical diagnosis based on the clinical acumen and experiences of clinicians. This is best educated guess but unfortunately diagnosis by this method was found to be wrong in half of the time by many researchers. This method of diagnosis also misses the concurrent mixed infection by multiple organisms. The second type of diagnosis is etiological diagnosis to identify the specific causative organisms by laboratory investigation that may be accurate but expensive, time taking and trained manpower. In addition for certain test patients are required to return one or two days later. It is feasible in many setting where patients have to travel long distance to receive health care and even if patients come back, period of infectivity is prolonged by delay in starting treatment. Besides, there are only few health facilities where laboratory facilities are available. In the light of all these limitations in developing nations, WHO developed and recommended a simple, cheap and effective approach for diagnosis and treatment of STIs, which called syndromes approach (NCASC, 2004).

Table 2.3 Cumulative HIV/AIDS Situation of Nepal

Condition	Male	Female	Total	New cases in Feb 2005
HIV positive (Including AIDS)	3469	1286	4755	75
AIDS (out of total HIV)	612	244	856	856
HIV/AIDS cases by population sub-group and sex				
Sex Workers (SW)	-	567	567	1
Clients of SWs/STIs	2489	61	2550	39
Housewives	-	607	607	11
Blood or organ recipients	7	2	9	-
Injecting drug use	910	13	923**	24
Children	63	36	99	-
Total	3469	1286	4755	75
Cumulative HIV infection by age group				
0-4	33	21	54	
5-9	24	15	39	
10-14	17	7	24	
15-19	172	173	345	2
20-24	674	323	997	13
25-29	899	332	1231	20
30-39	1283	320	1603	30
40-49	308	83	391	9
50+	59	12	71	1
Total	3469	1286	4755	75

Source: NCASC, Feb 2005

*Death - 237 (New death cases in Feb 2005-3) ** Mode of transmission - IUD or sexual

Acquired immune deficiency syndrome (AIDS) was first recognized internationally in 1981. as of 2000, an estimated 36 million adults and children around the world were living with the human immunodeficiency virus(HIV) and AIDS . AIDS is caused by HIV, and when infected with HIV, a large proportion of people die with in 5-10 years. The HIV/AIDS

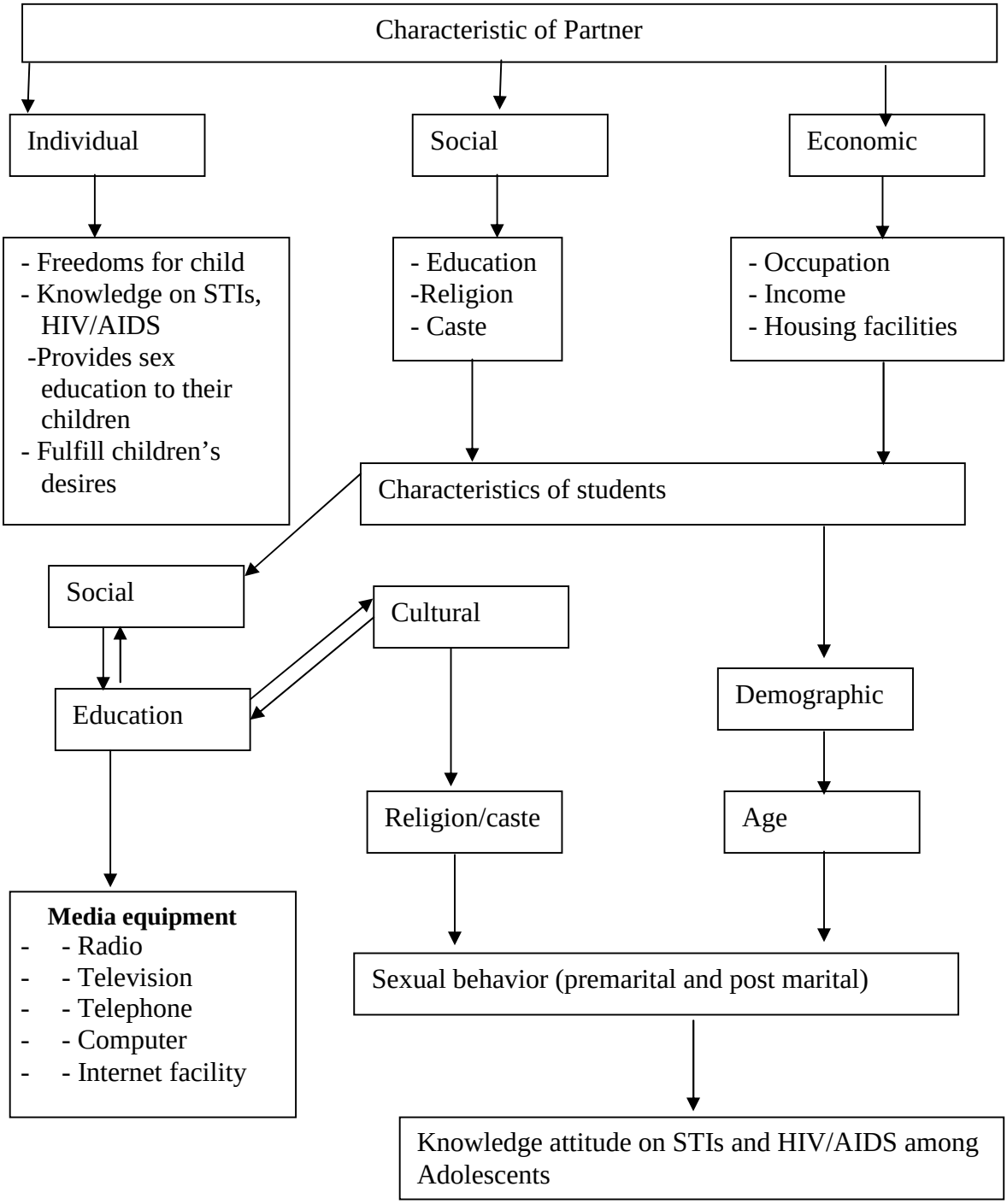
pandemic is one of the most serious health concerns in the world today because of the high case-fatality rate and the lack of a curative treatment or vaccines. Epidemiological studies have identified sexual intercourse, intravenous injections, blood transfusions, and fetal transmissions from infected mother as the main routes of transmissions of AIDS. Studies have also indicated that HIV cannot be transmitted through food, water, insect vectors, or casual contact. (NDHS, 2001).

The first HIV infection in Nepal was identified in 1988. The potential for the spread of HIV in Nepal is large because of extensive use of commercial sex workers, high rates of transmitted diseases, and low level of condom use and pockets of intravenous drug users. As of October 2001, a total of 533 AIDS cases and 1,564 cases of HIV infection were reported to the Ministry of Health, National Center for AIDS and STD Control. However, these figures are probably grossly underestimated given the current medical and public health infrastructure and limited HIV/AIDS surveillance system in Nepal. (NDHS, 2001)

2.6 Conceptual Framework of the study

From reviewed literatures, it is cleared that human behavior is influenced by social, economic, culture, and demographic condition and behavior in turn play vital role in transmitting the STI/AIDS. The conceived chain of relationship of STIs-HIV/AIDS with other factors thus includes socio-economic, demographic variables such as IEC, income, employment, cultural and religious norms, and knowledge on STIs-HIV/AIDS, prevalence of contraception, migration place of residence, psychology, marital status and age. It is to summarize the connection of these variables as following conceptual framework.

Figure 2.1 Conceptual framework of the study



CHAPTER - III

METHODOLOGY

This chapter deals with the research methodology employed to collect the primary as well as secondary data needed for the present study. Specially, this chapter discusses the introduction to the study area, research design, sample selection, simple size, techniques of data collection, document research, data processing and analysis and the limitation of the study.

3.1 Introduction to the Study Area

The research is the case study of adolescent students of higher secondary school in Bhaktapur municipality of Bhaktapur district. Here the term adolescent of higher secondary school refer to those persons who were studying in higher secondary school at the time of survey and were with in the range of age 15-20 years. Bhaktapur district is the smallest district of the country and situated in the Katmandu valley. There are 16 Village Development committee and 2 municipalities in Bhaktapur district. According to 2001 census, the total population of this district was 225461 and the population growth rate was 0.97 percent per annum. Bhaktapur municipality is the major urban area of this district. Some of the VDCs are located at hilly region. There are various natural and cultural heritages in this district. Some of them are listed under the world cultural heritage. Durbar Square is the main place of this district. Nagarkot is another natural place, which is also situated in this district.

Bhaktapur municipality is the main study area of this district. Information on educational institutes was collected during the time of study. In Bhaktapur district 9 campuses and 16 combined higher secondary school. The standard and the physical infrastructure of school are very greatly with some schools and campuses.

3.2 Sampling of the Study

From the three higher secondary school of Bhaktapur district, altogether 120 students were selected for this study. Among Them 60 boys and 60 girls were selected in the age group 15-20 years.

3.2.1 School Selection

This study used to the primary data collected in February 2006. Three higher secondary school were selected by purposive sampling method among all higher secondary school in Bhaktaput municipality, selected school are:

1. Shree Bageshori higher secondary school, Chyamhanshnsi , Bhaktapur
2. Aadarsha Aajada higher secondary school, Bhaktapur
3. Shree Padma higher secondary school, Darbarsquare Bhaktapur

3.2.2 Respondents Selection

In this study respondents were selected by using systematic random sampling the terms respondents reefers to the higher secondary students. Total numbers of the students of these 3 schools were 366. Among those students every 10 boys and 10 girls were taken from 11 and 12 classes from the selected three higher secondary school. From grade 11 and 12, 10 boys and 10 girls students were selected from each and every school respectively. First the enrollment register was taken from office and listed boys and girls' students than after presented students were listed and chosen any one-roll number from bounded number and followed same difference all of the selected student. For this, adolescent who were chosen at the time of survey will be interviewed by giving them to fill the questionnaire. This method was applied among selected school students. The total respondents were divided gender equalities in age group 15-20 years' adolescent students.

Table 3.1 Distribution of study population by school, grade and sex

School/College	Students						Total Sample Size
	Class 11			Class12			
	Boys	Girls	Total	Boys	Girls	Total	
SBHSS	10	10	20	10	10	20	40
AAHSS	10	10	20	10	10	20	40
PHSS	10	10	20	10	10	20	40
Total	**30**	**30**	**60**	**30**	**30**	**60**	**120**

Source: Field Survey 2006

From the Table 3.1, it is clear to see that, from class 11 and 12 forty and forty students were selected. From grade 11 and 12, 10 boys and 10 girls students were selected from each and every school respectively. Total numbers of the students of these 3 schools were 366. Among them only 120 students wee selected by using systematic random sampling method.

3. 3 Method of Data Collection

This study is preliminarily based on the primary data as a main source of information. Primary data were collected from the field study through surveying the higher secondary school students. Students were using structured questionnaires. Structured questionnaire is based on closed and open-ended questions. During the time of data collection respondents were planed in such environment that made them to feel them they were in exam hall so that they could not talk each other and could not able to copy from others persons answers. Then the questioners were distributed to the respondents. The respondents were carefully supervised during the distribution of questionnaire to minimize the error. Self-administered technique was used to collect the information.

3.4 Questionnaire Design

Questionnaire constitutes is the major tool of this study. It was designed to explore the necessary information with respect to higher secondary school students about

knowledge attitude and behaviour of STIs and HIV/AIDS and sexually preventive measures of some attempts to identify the source of information about STIs and HIV/ASIDS. This Study is used both qualitative and quantitative research method to collect information from the respondents questionnaires are mainly constituted into three parts.

1. Individual Schedule
2. Household Schedule
3. Knowledge and Attitude on STIs and HIV/AIDS

Individual schedule was designed to collect the information on marital status, sexually behavior of the respondents and their knowledge, attitude and behavior of adolescent to STIs and HIV/AIDS and sexuality. Similarly household schedule was designed to collect the information about the socio-economic status, demographic status about the respondents such as level of education, occupation status of parents, caste, religion etc.

3.5 Document Research

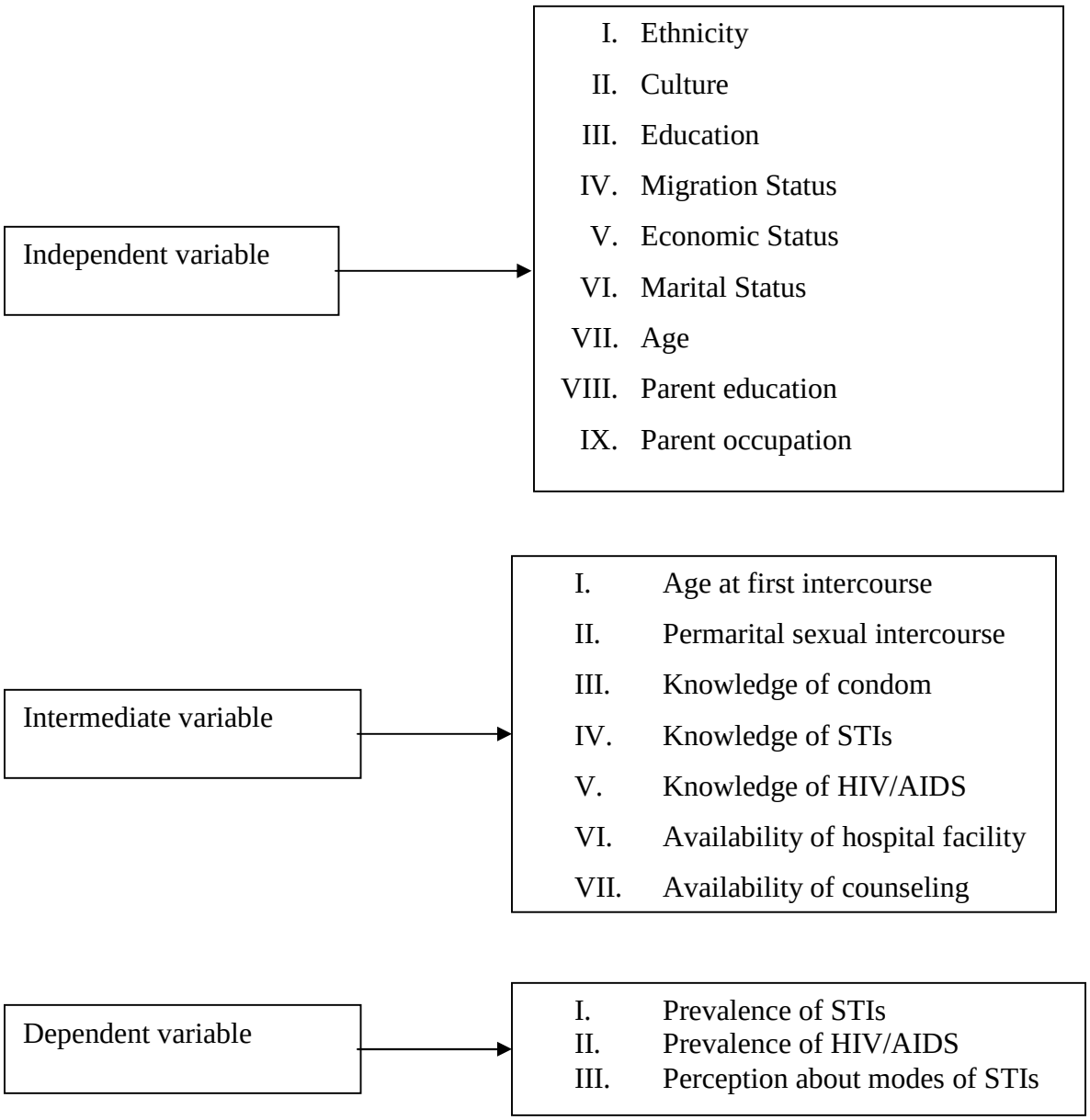
Secondary data have been employed also taken from annual reports and publication of various case study reports STIs and HIV/AIDS reports and literatures. Various documents are reviewed and basically focused on documents produced that are specific to Nepal. These included reports and papers produced by government agencies, UN agencies, International agencies such as Save the Children Norway and NGOs.

3.6 Analysis and Interpretation

The analysis is simply based on descriptive type of analysis. The collected information through various methods and techniques have been put together and analyzed in separate chapter of interpretation according to the nature of data. They are further splited into separate section as well as sample frequency table, cross table etc. obtained from appropriate statistical tools and percentages were used to analysis data related to the study.

3.7 Selection of the Study Variable

According to the nature of study research, the study variables are categorized in independent variable, intermediate variables and dependent variables as shown in following figure.



CHAPTER – IV

ANALYSIS OF SOCIO-ECONOMIC AND DEMOGRAPHIC CHARACTERISTICS

This chapter presents the socio-economic and demographic characteristics of the respondents. Socio-economic background provides the information about caste/ethnicity, religion, and level of education, occupation, income, and housing facility of the respondents. Demographic characteristics provide the information about age, sex, and marital status of the respondents.

4.1 Individual Characteristics of the Respondents

Individual characteristics include age, sex, caste/ethnicity, religion, level of education, and marital status of the respondents at the time of survey. To obtain the information about these individual characteristics, the questionnaire was given to the respondents about it.

4.1.1 Age and Sex Composition

Age and sex are the strong determining factors for the knowledge, attitudes and sexual behavior of the respondents towards sexuality and sexually transmitted diseases. For the purpose of analyzing the research problem, age and sex composition should be considered. In order to know the age and sex of the respondents, the questionnaire were asked about it and distributed of the respondents. The distribution of the respondents by age and sex composition is shown in Table 4.1.

Table 4.1 Distributions of the Respondents by Age and Sex

Age Group	Respondents					
	Boys		Girls		Total	
	No.	%	No.	%	No.	%
≤16	9	15.00	14	23.33	23	19.17
17	34	56.67	39	65.00	73	60.93
19	17	28.33	7	11.67	24	20.00
Total	**60**	**100.00**	**60**	**100.00**	**120**	**100.00**

Source: Field Survey 2006

Table 4.1 it is clear to see that most of the respondents (60.9%) are of 17-18 years of age. By gender the highest percentage of the female (65%) belonging to the age group 17-18 years. The male percentage of that age is only 56.7. The lowest percentage of the respondents is in the age group 16 or less then 16, its percentage is 19.2. In that age group 15 percent are boys and (23.4 %)are girl. Similarly, Table 4.1, also clear that (28.4%) of boys are in the age group 19-20 and (11.7%)of the girls are in the same age group. In conclusion only 20 percentages of the respondents are in the age group 19-20.

4.1.2 Caste/Ethnicity Composition

Caste/Ethnicity, in the context of Nepal is important social factor affecting attitude and standard of people. In order to obtain the information about caste/ethnicity of the respondents, the question was asked about it at the time of survey. Table 4.2 shows that the caste/ethnicity composition of the respondents.

Table 4.2 Distribution of Respondents by Caste/Ethnicity and Sex

Caste/Ethnicity	Sex					
	Boys		Girls		Total	
	No.	%	No.	%	No.	%
Newar	31	51.67	41	68.33	72	60.00
Brahmin	8	13.33	7	11.67	15	12.50
Chhetri	7	11.67	6	10.00	13	10.83
Tamang	5	8.33	2	3.33	7	5.83
Magar	4	6.67	1	1.67	5	4.17
Other	5	8.33	3	5.00	8	6.67
Total	**60**	**100.00**	**60**	**100.00**	**120**	**100.00**

Source: Field Survey 2006

Table 4.2 shows that majority of the respondents (60%)are from Newar community, which is followed by Brahamin (12.5 %), Chhetri (10.8 %), (5.8 %)Tamang, (4.2 %)are Magar and other castes are (6.7 %).

By gender about (68.4 %) of the girls are from Newar ethnic group, (11.7 %) girls are from Brahimin community, 10 percentage of the girls are come from Chhetri ethnic group, Magar and other community girls are come from 1.7 and (5%) respectively. Similarly, among boys respondents (51.7 %) are higher from Newar ethnic group, (13.4 %) boys are from Brahmin, and (11.7 %) are from Chhetri and lowest (6.7%) from Magar ethnic group.

4.1.3 Religious Composition

Caste/ethnicity system has close relationship with religion system. In the context of Nepal, religion is influenced by caste system. The impact of religion on the characteristics of a person is greater. To get the information of the respondents about religion the question was given about it to give the response and the response obtained form the field is presented in Table 4.3.

Table 4.3 Distributions of Respondents by Religion and Sex

Religion	Respondents					
	Boys		Girls		Total	
	No.	%	No.	%	No.	%
Hindu	34	56.67	36	60.00	47	58.33
Buddhist	24	40.00	23	38.33	70	39.17
Christian	2	3.33	1	1.67	3	2.50
Total	**60**	**100.00**	**60**	**100.00**	**120**	**100.00**

Source: Field Survey 2006

From the Table 4.3, it is clear to see that majority of the respondents (58.3 %) are from Hindu. Followed by Buddhist 39.2 and (2.5%) are from Christian. By gender, the highest 60 percent of girl's respondents are from Hindu religion and then followed by Buddhist (38.3%) and only (1.7 %) of the girl's respondents are from Christian religion. Similarly, this Table also shows that (56.7%) of boy's respondents are from Hindus, followed by Buddhist (40%) and only (3.3%) are come from Christian religion.

4.1.4 Marital Status of the Respondents

Marital status of the respondents also determines the knowledge, attitude and behavior towards STIs and HIV/AIDS. Therefore, in the questionnaire, respondents were asked about their marital status. The response is tabulated below;

Table 4.4 Distribution of Respondents by Marital Status and Sex

Marital Status	Respondents					
	Boys		Girls		Total	
	No.	%	No.	%	No.	%
Married	3	5.00	5	8.33	8	6.67
Unmarried	57	95.00	55	91.67	112	93.33
Total	**60**	**100.00**	**60**	**100.00**	**120**	**100.00**

Source: Field Survey 2006

Above table reveals that majority of the respondents, (93.3 %) are unmarried and only (6.7%) of respondents are married. In the other way, marital status of respondents by gender (5%) boys are married and rest of them are unmarried. Likewise, marital proportion of girls respondents, (8.3 %) and (91.7%) are married and unmarried respectively.

4.1.5 Nature of Residence of the Respondents

In the survey, respondents were asked about their housing status where they are staying at the time of survey in order to know that the variable is responsible to determining the knowledge, attitude and behavior of STIs and HIV/AIDS or not. Table 4.5 shows that the highest percent of the respondents live at home.

Table 4.5 Distributions of Respondents by the Living Place and Sex

Living Place	**Respondents**					
	Boys		**Girls**		**Total**	
	No.	**%**	**No.**	**%**	**No.**	**%**
At home	39	65.00	44	73.33	83	69.17
Rented house	18	30.00	11	18.33	29	24.17
Relatives house	3	5.00	5	8.33	8	6.67
Total	**60**	**100.00**	**60**	**100.00**	**120**	**100.00**

Source: Field Survey 2006

Table 4.5 shows that the highest percentages (69.7 %) of the respondents live at their own home and (24.2 %) respondents live at rented house and (6.7 %) of the respondents live at relative's house. Table also shows that the majority of girls respondents (73.3 %) live at home and followed (18.3 %) live at rented house and (8.3%) live at relatives house. Similarly, the highest (65 %) of boys respondents live at home and followed by (30 %) rented house and (5 %) respondent's boys live at relative's house.

4.2 Household Characteristics

In this section identified about the socio-economic status of the adolescent's parents such as level of education, occupation, family size etc.

4.2.1 Parents Educational Status

Education is the most influencing factor for all most all dependents variables. Education may be dependent variable, independent or intermediate variable depending upon the research problem. Education does not only help to healthy life but also helps to meet the goal of the government program. Respondents were asked whether their parents could read and write with small behavioral calculations in their mother tongue if not in Nepali language. The respondents, who said that they could, further asked grade passed.

If the parents are well educated then children will be provided parental responsibility, which may determine their knowledge and perception on STIs and HIV/AIDS. Considering this fact, the respondents were asked about their parents' literacy and education. The responses were presented in Table 4.7.

Table 4.7 Distribution of Respondents by Parents Educational Status

Literacy /Education	**Father**		**Mother**	
	No.	**Percent**	**No.**	**Percent**
Literate	103	85.83	60	50.00
Illiterate	17	14.17	60	50.00
Total	120	100	120	100.00
Educational Attainment				
Primary	35	29.17	4	3.3
Lower Secondary	12	10.00	24	20.0
Secondary	10	8.33	4	3.3
SLC	24	20.00	4	3.3
Intermediate	18	15.00	24	20.0
Bachelor and above	4	3.33		
Total	**103**	**85.83**	**60**	**50.00**

Source: Field Survey 2006

Table 4.7 Shows that, the majority of respondent's fathers are literate which is accounted for (85.8%) and remaining (14.7%) are illiterate. Which talking about their educational status, most of the literate father's of respondents have attained primary level of education (29.5%), followed by SLC (20%), intermediate (15%), lower secondary (10%), secondary (8.3%), and bachelor and above (3.3%). Similarly, Table 4.8 Shows that the exactly half of respondent's mothers are literate which is accounted for (50%) and remaining (50%) are illiterate. Which talking about their educational status, most of the literate mother's of respondents have attained lower secondary level of education (20%), followed by SLC (3.3%), intermediate and above (20%),

4.2.2 Parental Occupation

Parent's occupation may play an immense role in determining the behavior of the children on sexuality and perception on STIs and HIV/AIDS because the occupation determines the economic level of the family, which may be result of education of parents as well. Therefore,

the respondents were asked about the parent's occupation in which four types of occupation were reported as the major occupation as shown in Table 4.8.

Table 4.8 Distribution of Respondents by Parental Occupation

Occupation	Father		Mother	
	No.	Percent	No.	Percent
Agriculture	42	35.00	52	43.33
Service	34	28.33	23	19.17
Business	35	29.17	10	8.33
Daily Wage	2	1.67	26	21.67
Others	7	5.83	9	7.50
Total	**120**	**100.00**	**120**	**100.00**

Source: Field Survey 2006

It is evidences from Table 4.8 that (35%) of the respondents' father's are engaged in agricultural occupation while (29.2%) are engaged in the business, (28.4 %) are engaged in service and other remaining percentage of respondents father's are engaged in daily wage and other occupation.

Similarly, it is notable to say from Table 4.8 that only (43.4 %) of respondent's mother's are engaged in agriculture or housewives. It is rather a low percentage; because in Nepal most of women's are engaged in the agricultural and house wives work. This may because of urbanization and less availability of agricultural land and good opportunity for income generating activities for women. Twenty percent of the respondents' mothers were engaged in daily wage work, (19.7%) in service, (8.3%) in business and the remaining (7.5%) in other occupation.

4.3 Family Size

Family size determines the economic, health, nutrition, and other living standard of the family. These variables may contribute in determining knowledge, attitude and behavior of

STIs and HIV/AIDS. Considering this fact, the study has included the question of family size in the household where the survey was conducted.

Table 4.9 Distributions of Respondents by Family Size

No. of Family member	**Respondents**	
	Number	**Percent**
2-4	28	23.33
5-7	72	60.00
8-11	13	10.83
11+	7	5.83
Total	**120**	**100.00**

Source: Field Survey, 2006

Table 4.9 shows that the majority of respondents have 5-7 members in the family, which percent is 60. Similarly, (23.33%) of the respondents have 2-4 members in the family. Only (5.8%) of the respondents have more then 11 members in the house. It is clear shows that highest percent of the respondents have only 5-7 members in the house.

4.4 Place of Residence

The respondents are classified by permanent residence of rural and urban. Table 4.10 shows that (80.8 %) of the respondents stated that permanent place of residence was urban and rest of other respondents (19.7 %) are from rural area.

Table 4.10 Distribution of Respondents by place of Permanent Residence

Place of Residence	**Respondents**					
	Boys		**Girls**		**Total**	
	No.	**%**	**No.**	**%**	**No.**	**%**
Urban	46	76.67	51	85.00	97	80.83
Rural	14	23.03	9	15.00	23	19.17
Total	60	100.00	60	100.00	120	100.00

Source: Field Survey, 2006

By gender, (76.7%) of boy's respondents are from urban and (23.3 %) of boys is form rural area. Similarly, majority of girls respondents (85%) are from urban and only (15%) girls are from rural area.

4.5 Availability of Physical Facility in Household

From the Table 4.3, it is shows that (94.7 %) of the respondents have electricity in their household. Similarly, cent percent of the respondents have radio, (84.7%) have television facility in their house and only (24.7%) of the respondents have computer facility in their house, which is clearly shown in Table 4.11;

Table 4.11 Distribution of Respondents by Availability of Physical Facility

Physical Facility	**Respondents**					
	Boys		**Girls**		**Total**	
	No.	**%**	**No.**	**%**	**No.**	**%**
Electricity	56	93.33	57	95.00	113	94.67
Radio	60	100.00	60	100.00	120	100.00
Television	51	85.00	50	83.33	101	84.17
Telephone	42	70.00	45	75.00	87	72.50
Computer	15	25.00	14	23.00	29	24.17
Total	**60**	**100.00**	**60**	**100.00**	**120**	**100.00**

Source: Field Survey 2006

Table 4.11 indicates that (93.3%) boys respondents have electricity facility, cent percent boys respondents use radio in their house, where as cent percent girls respondents have electricity facility and (94 %) girls respondents have radio facility in their house and all most equal percent use television, telephone and computer facility respectively.

CHAPTER – V

KNOWLEDGE AND ATTITUDE OF STIS AND HIV/AIDS AMONG THE ADOLESCENTS

This Chapter examines the extents the knowledge about STIs and HIV/AIDS among adolescent and it also discuss their attitude and behavior on the respect issue. In the context of knowledge, heard of STIs, HIV/AIDS and their names, knowledge on transmission, knowledge on preventive measures and sources of knowledge are described Similarly, regarding the attitude and behavior of the respondents their opinion on HIV/AIDS, whom they think the most vulnerable from STIs, their opinion on sexual education, status of their sexual partner and opinion on sex are describe.

5.1 Knowledge of STIs

The worldwide spread of sexually transmitted diseases has been of the major disappointment in public health, in the past two-decade. STIs are not hyper endemic in many countries like as rural country Nepal where the facility for diagnosis and treatment are usually inadequate. Hearing about any thing is a basis for knowledge however only hearing about topic does not change the behavior of a person on that issue. Like wise only hearing about STIs is not top level of knowledge but it is the basic for knowledge. In order to fond the adolescent knowledge on STIs , respondents were asked whether they have heard STIs. The responses are presented in Table 5.1.

Table 5.1 Distribution of Respondents by Sex and Knowledge of STIs

Knowledge of STIs	**Respondents**					
	Boys		**Girls**		**Total**	
	No.	**%**	**No.**	**%**	**No.**	**%**
Yes	60	100.00	60	100.00	120	100.00
Total	**60**	**100.00**	**60**	**100.00**	**120**	**100.00**
Knowledge on type of STIs						
Syphilis	55	91.67	58	96.67	113	94.16
AIDS	60	100.00	60	100.00	120	100.00
Gonorrhea	54	90.00	57	95.00	111	92.50
Tricomonasis	7	11.67	6	10.00	13	10.83
Chalmydia	5	8.33	5	8.33	10	8.33
Genital warts	13	21.67	18	30.00	31	25.83
Candiasis	4	6.67	5	8.33	9	7.50
Hepatitis-B	48	80.00	51	85.00	99	82.50
Total	**60**	**100.00**	**60**	**100.00**	**120**	**100.00**

Source: Field Survey, 2006

Note: The numbers and percentages are multiple answers

Table 5.1 shows that all the respondents have heard about sexually transmitted diseases and table 5.1 also shows that cent of the respondents have heard about AIDS. Similarly, Syphilis, Gonorrhea, and Hepatitis-B have heard about (94.6%), (92.5%) and (82.5%) respectively. Where as, only (10.8%) had heard about Tricomonasis, (25.8 %) and (7.5%) respondents had heard about Genital warts and Candiasis respectively.

Analysis by sex indicates that levels of knowledge of STIs among adolescents are different for particular STIs. Table 5.1 show that girls are more knowledgeous than boys about STIs. All boys and girls respondents have had the knowledge about HIV/AIDS. But the knowledge of other STIs were found different among boys and girls.Ninty percent boys have had knowledge about Syphilis and Gonorrhea but it was around (95 %) for girls.

Similarly, more girls (85%) have had knowledge about Hepatitis-B than boys (80%). But least percentage has had knowledge about Triconomisis and Candiasis among boys and girls due to lack of proper information these diseases.

5.1.1 Knowledge of STIs by Level of Education

Paulo Freiro had said that "Without dialogue there is no communication and without communication there can be not true education". So education is a crucial factor to determine the respondent's level of knowledge on STIs.

Table 5.2 Distribution of Respondents by Knowledge of STIs and Level of Education

STDs	**Respondents**					
	Class 11		**Class 12**		**Total**	
	No.	**%**	**No.**	**%**	**No.**	**%**
Syphilis	54	90.00	56	93.00	110	91.67
AIDS	60	100.00	60	100.00	120	100.00
Gonorrhea	55	91.67	55	91.67	110	91.67
Tricomonasis	6	10.00	7	11.67	13	10.83
Chalmydia	5	8.33	6	10.00	11	9.17
Genital warts	15	25	16	26.50	31	25.50
Candiasis	4	6.66		8.33	9	7.50
Hepatitis-B	49	81.6		84.67	100	83.33
Total	**60**	**100**		**100.00**	**120**	**100.00**

Source: Field Survey, 2006

Note: The numbers and percentages are multiple answers

Table 5.2 clearly shows that the level of knowledge on STIs is comparative higher in class 12 than class 11. Cent percent of respondents have knowledge about HIV/AIDS. Thirty two percent respondents have knowledge about Gonorrhea. Grade 12 has more knowledge about Syphilis (93 % vs. 90 %). Hepatitis-B (84.7 vs. 81.7%), genital warts (26.0% vs. 25%). Thus we can say that knowledge of STIs have increased with increased in the level of education.

5.1.2 Knowledge of STIs by place of Residence

In the analysis of knowledge of STIs by place of residence indicate that urban respondents have more knowledge than rural counter parts. Table 5.3 clearly shows that (93.5%) urban resident have knowledge about Gonorrhea, (90.9 %) urban residents have knowledge about Syphilis. Similarly Hepatitis-B (77.9 %) and (12.9 %) have the knowledge about Genital warts. About (11%) and (8%) respondents have knowledge about Chalmydia and Candiasis respectively. Similarly, the knowledge among the rural resident respondents have knowledge about Syphilis, Gonorrhea, Tricomonasis,Chalmydia, Genetal warts,Candiasis and Hepatitis-B are (76.7%), (88.7%), (4.6%), (9.3%), (1.9%), (6.9%), and (86.6%) respectively.

Table 5.3 Distribution of Respondents by Knowledge of STIs and place of Residence

STDs	**Respondents**					
	Rural		**Urban**		**Total**	
	No.	**%**	**No.**	**%**	**No.**	**%**
Syphilis	33	76.34	70	90.91	103	85.83
AIDS	43	100.00	77	100.00	120	100.00
Gonorrhea	38	88.37	72	93.51	110	91.67
Tricomonasis	2	4.65	5	6.49	7	5.83
Chalmydia	4	9.30	8	10.33	12	10.00
Genital warts	6	13.95	10	12.99	16	13.33
Candiasis	3	6.97	6	7.79	9	7.50
Hepatitis-B	37	86.05	60	77.92	97	80.83
Total	**43**	**100.00**	**77**	**100.00**	**120**	**100.00**

Source: Field Survey 2006

Note: The numbers and percentages are multiple answers

Thus we can say that the level of knowledge of STIs have increased in the urban area's respondents than rural area's respondents. The causes may be the availability of education, information of mass media and awareness program conducted by different NGO/INGO's etc. in urban area.

5.2 Sources of Information about STIs and HIV/AIDS

The sources of information are crucial factor for the adolescents to achieve knowledge regarding STIs and HIV/AIDS. The adolescent acquire different sources of information for knowledge on STIs and HIV/AIDS. The information collected by respondents to know their sources of knowledge on STIs is given in the Table 5.4, in fact respondents were asked to indicate their first source of information only but most of the respondents were confused about the first sources. So they choose for multiple chances. Therefore, multiple respondents were accepted converting the first source of information as source of information.

Table 5.4 Distribution of Respondents by sources of information on STIS and HIV/AIDS

Sources of Information	**Respondents**					
	Boys		**Girls**		**Total**	
	No.	**%**	**No.**	**%**	**No.**	**%**
Radio	57	95.00	60	100.00	117	97.50
Television	56	93.33	60	100.00	115	96.67
Magazine	47	78.33	55	91.67	102	85.00
NGO/INGO	24	40.00	27	45.00	51	42.67
Doctor	38	63.33	36	60.00	74	61.67
Friends	39	81.67	51	85.00	100	83.33
Partners	32	53.33	35	58.33	67	55.33
Textbooks	54	90.00	52	86.67	106	88.33
Teacher	51	85.00	49	81.67	100	83.33

Source: Field Survey 2006

Note: The numbers and percentages are multiple answers

Table 5.4 is clear that radio, television, teacher, textbook and friends are the major sources of information about STIs and HIV/AIDS. Among these source radios is the major source of information as (97.5%) followed by television (96.7%), textbook (88.33 %), friend and teacher (each 83.33%) and magazine (85 %). Similarly doctor (61.7 %)were reported the

main sources of information. While parents and NGO/INGO were reported (55.5%) and (42.5%) respectively.

Table 5.4 also shows that (95%), (99 %) and (85%) boy's respondents have got information from radio, television and teacher respectively where as (90 %) boys respondents have got information from textbook, only the lowest boy's respondents or (40%) heard from NGO/INGO. Similarly cent percent girl's respondents have got information from radio and television. (91.7 %), (86.7 %), (85 %), (81.7%), (60 %) and (58.3%) girl's respondents have heard the STIs and HIV/AIDS from magazine, textbook, friend, teacher, doctor and parents respectively.

Table 5.4 also revealed that the girl's respondents have hurried to gain knowledge about STIs and HIV/AIDS and their tendency from different media shows relatively higher than boys.

5.3 Knowledge on Modes of STIs Transmission

To know about the way of transmission of STIs is higher level of knowledge on STIs. Respondents were asked about the transmission of STIs in order to know the perception. Table 5.5 clearly shows that the knowledge on modes of STIs transmission.

Table 5.5 Distribution of Respondents by Mode of Transmission of STIs

Knowledge on Modes of STIs Transmission	**Respondents**					
	Boys		**Girls**		**Total**	
	No.	**%**	**No.**	**%**	**No.**	**%**
Yes	55	91.67	58	96.67	113	94.17
No	5	8.33	2	3.33	7	5.83
Total	60	100.00	60	100.00	120	100.00
Sexual contact	54	90.00	55	91.67	109	90.83
Living together	2	3.00	3	5.00	5	4.17
Others	4	6.67	2	3.33	6	5.00

Source: Field Survey 2006

Note: The numbers and percentages are multiple answers

Table 5.5 clearly shows that, the knowledge on modes of transmission STIs among the respondents is fond high, which is (94.2 %). The above Table also shows that (5.8%) respondents said that they do nit have the knowledge about the mode of transmission of STIs. Table also indicates that among the respondents (113), who have knowledge about the knowledge of modes of transmission of STIs, 109 respondents are conformed that STIs are transformed through sexual contact and only (4.7%) of the respondent believe that STIs are transmitted easily by living together.

5.4 Knowledge on Mode of AIDS Transmission

AIDS was first, recognized internationally in 1981. in Nepal, it was first identified in 1988. HIV/AIDS had been emerging as one of the burning issue all over the world. In this study data had been collected to identify the knowledge of HIV/AIDS of higher school students, as being are the main objective. All of the respondents have heard about HIV/AIDS and also all have knowledge on modes of AIDS transmission, which presented in the following Table;

Table 5.6 Distribution of respondents by Knowledge about mode of AIDS transmission

Knowledge on Modes of AIDS Transmission	**Respondents**					
	Boys		**Girls**		**Total**	
	No.	**%**	**No.**	**%**	**No.**	**%**
Yes	60	100.00	60	100.00	120	100.00
Total	**60**	**100.00**	**60**	**100.00**	**120**	**100.00**
Sexual contact	58	96.67	60	100.00	118	98.33
Sharing razor	35	58.33	34	56.00	69	57.50
Unsterlized neddles	49	81.67	50	83.33	99	82.50
Blood transfusion	57	95.00	58	81.67	115	95.83
Mosquito Bite	3	5.00	5	8.33	8	6.67
Kissing	2	3..33	2	3.33	4	3.33
Sleeping Together	1	1.67	4	6.67	5	4.17
Infected mother to her baby	51	85.00	55	91.67	106	88.33
Breast feeding	8	13.33	10	16.67	18	15.00

Source: Field Survey 2006

Note: The numbers and percentages are multiple answers

Table 5.6 shows that most of the respondents are familiar about the HIV/AIDS because cent percent of respondents conformed that HIV/AIDS is transmitted from sexual contact and (95.8%) respondents believe that HIV/AIDS is transmitted through blood transfusion. Similarly, (88.8 %) believe that transmission through infected mother to baby and (82.5 %) believe that unsterilized needles. Similarly, (57.5%) believe that transfusion through using some recur by different person and (15 %) of the respondents believe through breast-feeding. In contrast, (6.7%), (4.7%) and (3.3%) respondents have misconception that HIV/AIDS is transmitted through mosquito bite, sleeping together and kissing respectively. By gender, Table 5.6 also reveals that (96.7%) boys and cent percent girls believe on sexual contact as the main mode of HIV/AIDS transmission. In overall situation girls are aware than boys as well as girls have more knowledge about the main modes of HIV/AIDS transmission. However, more girl have confuse that AIDS is transmitted by mosquito bite, kissing and sleeping together. The voice of (96.7%) of the boys respondents clear that HIV/AIDS is transmitted through sexual contact. The trends for saying the modes of HIV/AIDS by girls and boys are same. The result indicates that through they have high knowledge about the main modes of transmission of HIV/AIDS but they have also misconception about the mosquito bite, kissing and sleeping together are also modes of HIV transmission.

5.4.1 Knowledge on AIDS Transmission By the place of Permanent residence of the Respondents

From the Table 5.7, it is clear that level of knowledge on transmission mode is high (98.7%) among respondents in urban area. Similarly, Knowledge in transmission is high (95%) among the respondents in urban area then the rural area. Almost (98.7%) respondents from urban area believe that AIDS is transmitted from sexual contact and blood transfusion are major modes of AIDS transmission but this percentage of rural area have (95.3%) and (93%) respectively.

Table 5.7 Distribution of Respondents by their Knowledge about mode of AIDS Transmission and Place of Permanent Residence

Knowledge on Modes of AIDS Transmission	**Respondents**					
	Rural		**Urban**		**Total**	
	No.	**%**	**No.**	**%**	**No.**	**%**
Sexual contact	41	95.00	76	98.70	117	97.50
Sharing razor	28	65.17	57	74.00	85	70.83
Unsterlized neddles	35	81.33	70	90.91	105	87.50
Blood transfusion	40	93.00	76	98.71	116	96.67
Mosquito Bite	4	9.33	2	4.61	6	5.00
Kissing	3	6.67	2	4.61	4	3.33
Sleeping Together	2	4.67	1	1.31	3	2.50
Infected mother to her baby	35	81.67	57	74.00	99	76.67
Breast feeding	5	11.67	11	14.29	16	13.33
Total	43	100.00	77	100.00	120	100.00

Source: Field Survey, 2006

Note: The numbers and percentages are multiple answers

Another noticeable fact shown from Table 5.7 is that the more rural residence respondents have the misconception about the mode of transmission of AIDS then urban residence. Among the rural residence (9.3 %) believe that mosquito bite can transmit AIDS. Similarly, kissing and sleeping together reported the modes of AIDS transmission by (9.7%) and (4.7%) respectively. On the other hand, among the urban resident (4.7 %) believed equally in mosquito bite and kissing and only (1.2%) sleeping together are the mode of AIDS transmission.

5.5 Knowledge of HIV/AIDS Prevention

Respondents were asked about the knowledge on preventive measures of AIDS among the respondents who have heard about AIDS because, the cent percent of the respondents have

heard about AIDS. So, all the respondents are included. The result founded from the field among the respondents is presented below;

Table 5.8 Distribution of Respondent by True Method for Prevent AIDS

Variable	Respondents					
	Boys		Girls		Total	
	No.	%	No.	%	No.	%
Don't Have sex all	28	46.67	30	50.00	58	48.33
Don't have sex with unknown person	50	83.33	51	85.00	101	84.17
Use condom	58	96.67	56	93.33	114	95.00
Unsterilized Surgical Instruments	40	66.67	43	71.67	83	69.17

Source: Field Survey 2006

Note: The numbers and percentages are multiple answers

By analyzing the information from the Table 5.8, it is formed that preventive knowledge on HIV/AIDS is high among respondents according this study. Ninety five percent respondents said use of condom during intercourse is the true method for preventive AIDS transmission. Similarly, (84.7%) said that don't have sex with infected person. Seventy percent said improper use of surgical instrument and (48.3%) said not have sex at all for preventing AIDS transmission. According to gender, Table 5.8 shows that (96.7 %) boys respondent said use of condom during the intercourse is the true method for preventive AIDS transmission, where as (93.3%) girls respondents give same voice for this method. The above result shows that preventive knowledge for respondents of boys have more knowledge about that the true method for preventing AIDS transmission then girls.

5.6 Perception towards HIV/AIDS Infected Person

Form the Table 5.9 clearly shows that among the respondents 60 percent said that all AIDS infected person will die. Thirty three percent respondents said that not die at all. Similarly (1.7%) respondents reported that they don't know either they die or not, the proper result behind this may be lack of proper knowledge of AIDS.

Table 5.9 Distribution of Respondents by Perception about AIDS Infected Person

AIDS infected person	Respondents					
	Boys		Girls		Total	
	No.	%	No.	%	No.	%
All of them die	35	58.33	37	61.67	72	60.00
Some of them die	22	36.67	17	28.33	39	32.50
Not die at all	3	5.00	4	6.67	7	5.83
Don't Know	-	-	2	3.33	2	1.67
Total	**60**	**100.00**	**60**	**100.00**	**120**	**100.00**

Source: Field Survey 2006

By gender, Tables 5.9 indicate that majority of the boys respondents (58.44%) believed that HIV/AIDS infected person die. But same of the boy's respondents believed that some of them die and not die at all which percent is (36.7) and (5) respectively. Similarly in the side of the girl's respondents more then 60 percent believed that HIV infected person will die.

5.7 Opinion about AIDS

In order t know the respondent's attitude on AIDS, a question on opinion of AIDS was included in the questionnaire. The responses are tabulated in the following Table;

Table 5.10 Distribution of Respondents by opinion about AIDS

Opinion	No. of respondent s	Percent
Fatal disease	9	7.67
Sexually Transmitted Disease	31	26.33
Communicable disease	11	9.33
Dangerous	60	50.83
Immune deficiency syndrome	72	61.00

Source: Field Survey 2006

Note: The numbers and percentages are multiple answers

It is evidence from the Table that majority of the respondents (61%) said, it is an immune deficiency syndrome, (50.8 %) said it is dangerous, (26.3%) said sexually transmitted disease and only (9.3%) said to be a communicable disease

5.8 Intention of Marriage

Marriage can be defined "as a relation of one or more men to one or more women which is recognized by custom or law and involves certain rights and duties both in the case of parties entering the union and in the case of children of it". Similarly, according to Horton and Hunt, 1968, "Marriage is the approved social pattern by two or more person established a family". Intention of marriage may play an immense role in determining the behavior of the children on sexuality and perception on STIs and HIV/AIDS. Therefore, the respondents were asked about their intention of marriage in which four types of age group were reported as the major intention of marriage age. Among those who were unmarried at the time of survey, those responses are shown in Table 5.11.

Table 5.11 Distribution of Respondents by Intention of Marriage

Indented age for marriage	**Respondents**					
	Boys		**Girls**		**Total**	
	No.	**%**	**No.**	**%**	**No.**	**%**
22-24 year	6	10.53	22	40.00	28	25.00
24-26 year	29	50.88	27	49.00	56	50.00
26-28 year	15	26.34	5	9.01	20	16.87
28+ year	7	12.29	1	1.89	8	7.14
Total	**57**	**100.00**	**55**	**100.00**	**112**	**100.00**

Source: Field Survey 2006

By gender (49 %) of girls respondents have desired to be married in 23-25 years of age, Similarly, (40 %) that 20-22 year for marriageable age, (9.2 %) girls desired to be married at age of 26-28 years and (1.89 %) desired to be married in 29 years and above. Similarly, (50.9 %) boys respondents desired to be married at the age of 23-25 year and followed by (23.3 %) desired to be married at the age of 26-28 years and (1.8 %) desired to be married in

age 29 years and above. Only (10.5 %) boy's respondents have desired marriage in age group 20-22 years.

5.9 Opinion about Sex

In order to know about the attitude of the respondents towards sexuality, a question on the opinion on sex was included in the questionnaire. The responses are tabulate in Table 5.12.

Table 5.12 Distribution of Respondents by Opinion about Sex

Opinion	**Respondents**					
	Boys		**Girls**		**Total**	
	No.	**%**	**No.**	**%**	**No.**	**%**
Basic need	28	46.67	33	55.00	61	50.83
Need for propagating generation	22	36.67	24	40.00	46	38.33
Absurd	6	10.00	3	5.00	9	7.50
Entertainment	4	6.67	-	-	4	3.33
Total	**60**	**100.00**	**60**	**100.00**	**120**	**100.00**

Source: Field Survey 2006

Question was asked to the respondents what is sex? , To know their view about sexuality. More than (50 %) respondents said it is basic need, (38.3 %) respondents said it is needed for propagating generation, and also (7.5 %) said that it is done for only entertainment.

Table 5.12 also indicates that (46.7%) and (36.7%) boy's respondents said it is basic need and need for propagating generation respectively. Similarly, (55%) and (40%) girls respondents said that sex is a basic need and needed for propagating generation respectively.

CHAPTER – VI

SUMMARY, CONCLUSION AND RECOMMENDATIONS

6.1 Summary of the Findings

This case study is based on the small-scale study carried out in three higher secondary school of Bhaktapur municipality of Bhaktapur districts. Selecting process of school is purposive method and selecting respondents is systematic sampling method. This study is fully based on the primary data. 120 respondents were selected in this study and among them 60 were girls and 60 were boys with in the age 15-20 years. For the analysis of socio-economic and demographic factors affecting, knowledge and attitude on STIs and HIV/AIDS frequency Tables, cross Tables are applied to fulfill the objectives.

Some of the major findings are presented as below;

- Fifty percent of the respondents are from class 11 and 50 percent of the respondents are from class 12.
- The highest proportions of the respondents (60.9%) belong to age group 17-18.
- Most of the respondents (93.4%) are unmarried, more then 50 percent of the respondents thought they would marriage in between 23-25 years of age and 25 percent indented to marry in between 20-22 years of the age.
- Majority of the respondents are Hindus (58.4%) and 39.17percent are Buddhist.
- Most of the respondents are living in their own house, which percent is more then 60 and some of the respondents are living in rented house which percent is only 24.2.
- Sixty percent of the respondents are Newar and followed by Brahman are 12.50 percent.
- Most of the respondent's father (85.8%) are literate and under S.L.C. while (50%) of the respondent's mother are literate.

- Most of the respondent's father (29.2%) and (28.4%) engaged in business and service respectively. While (43.4%) and (8.3%) respondent's mother are engaged in housewives and business respectively.
- Sixty percent of the respondent's have family size of 5-7 people.
- Most of the respondent's (80.8 %) live in urban and only (19.2%) live in rural area respectively.
- All respondents have radio facility while (24.7%) have computer facility.
- All of the respondent's have heard at least one name of STIs. Cent percent have heard about STIs.
- Radio and television are the main source of information having heard of STIs, which is the accounted (97%) and (96 %) respectively.
- Girl's respondent's are more knowledgeable then the boys about the symptoms of STIs.
- Grade 12 respondents' have higher knowledge on symptoms of STIs than those studying in grade 11.
- Almost all respondent's (98.4%) know the mode of transmission of STIs.
- The respondent's whose father is in service cent percent are knowledgeable compared to those whose father in other sector.
- Large proportion of respondent's 98.4 percent stated that sexual contact with infected person is the most important mode's of STIs transmission.
- Respondent's living in urban area have comparatively higher knowledge than their counterparts in rural among those who reported having known of ways of transmission of STIs.
- Girls than boy's respondents are more likely to know about preventive method of STIs.
- Majority sources of STIs information are radio (97.5%) and followed by television (96.7%) etc.
- The highest number of respondent's (60%) reported that AIDS infected person all of them die.

6.2 Conclusion of the Study

Adolescent sexual and psychological heath is a matter of great concern since adolescent is the responsible citizens of a country in the future. Today, the changing social norms and values regarding sex and the increasing age out marriage are attributed. To adolescent premarital sexual activities. Due to such activities they may have risks of various heath hazards, socio-economic and demographic consequences namely unwanted pregnancy, unmarried mother and HIV infection. In situation, they must be supported by correct information to dispel the mental stress and help them practice responsible sexual behavior.

The study points the current level of knowledge of higher secondary school adolescents on STIs and HIV/AIDS, opinion on HIV/AIDS, sex and vulnerable group transmitting from AIDS. Finding from the study shows that there is no 100 percent of the knowledge about STIs and HIV/AUDS because only hearing about HIV/AIDS may not imply to change one's attitude and behavior on AIDS. The situation may be rather less in the higher secondary school because of shyness of teachers and lack of sufficient knowledge of them. Again, parents do not use to talk about the matter in front of their breaking knowledge. Because, they have curiosity on sexuality but can not get sufficient knowledge, which lead them unhygienic or unhealthy sexual practice. In the study area, it is also observed that, the respondents who have their sexual partner, most of them do not use any contraceptives; some married in their young age. This trend shows the impractical behavior even if they have knowledge.

6.3 Recommendations for further Study

Based on the findings of the study and the conclusion drawn, it is attempted to recommend some points for the improvement on knowledge, attitude and behavior among the school adolescent.

- In Nepal, the HIV/AIDS cases are raised day by day due to poverty open conflict, low age at marriage, per-marital sexual behaviors and so further study should be centralized to eliminate on this predominated topics of the study.

- Population, Health and sex education course should be incorporate in higher secondary level school, because of lack of the teachers who are expert on the subject matter. It seems necessary to manage the teachers who are expert on this course.
- Most of the adolescents reported that use of condom is the true method of preventing method of preventing AIDS and STIs; therefore it is necessary to make them more knowledgeable in the context to condom use. Condom should be accessible for them and it is necessary to provide special attention them about method of safe use and disposal to it.
- Social and cultural norms are obstacles in the society of discuss about STIs and HIV/AIDS. Therefore, sex education should be provided cultural and social group of the society.
- The world AIDS, Condom and Population Day programs should be conducted to only in the central or urban areas but in rural areas, as awareness campaign programs should be conducted together.
- Government should make district vision about awareness making process of cure and implementation process should be strict in health sector of the government.
- The interacting programs should be lunched between male and female students and teacher, which enhances the batter knowledge and awareness of STIs and HIV/AIDS so that good massage prevalent among the students regarding STIS and HIV/AIDS, can be avoided from their mind.
- Among the urban and rural resident respondents it has no knowledge about the mode of transmission there for it is necessary to give the proper knowledge about the mode of transmission.

6.4 Further Research Issue

Because of individual study, this study has not covered every issue related to STIs and HIV/AIDS. Even the area of the study is small. Therefore, covering wide area with broad information can be conducted in different level students such as higher secondary and college level students.

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Annex I

Tribhuvan University

Central Department of Population Studies (CDPS)

Kirtipur, Kathmandu

Knowledge, Attitude and Behavior on STIs and HIV/AIDS among Adolescent Student of Higher Secondary School (A case study of Bhaktapur Municipality)

A. Individual Characteristics

1. Respondents number ……...
2. School …… 3 Class ……
4. Age…… 5. Sex : Male…..1 Female….2
6. Caste …… 7. Religion ……
8. Marital Status: Married…….1 Unmarried……2
9. If married, in which age did you get married?
10. If unmarried, indicate age of choice marriageable age
11. Place of permanent residence
12. Where do you living now?

    At home……1 Hostile……..2 Rented house…….3

    Relatives……...4 Others……5

B. Household characteristic:

13. Can your father read and write?	Yes …….1 No …….2
14. If yes, which class has he completed?	Under SLC …….1 S.L.C. …….2 Inter ……3 Bachelor and above ……4
15. Can your mother read and write?	Yes ……..1 No ……..2

16. If yes, what is her educational level?	Under SLC …….1 S.L.C. …….2 Inter ……3 Bachelor and above…..…….. 4
17. What is your father's occupation?	Agriculture …….1 Service ……...…2 Business …….3 Daily wage …….4 Other ……..5
18. What is your mother's occupation?	Agriculture …….1 Service ……...…2 Business …….3 Daily wage …….4 Housewife ……..5 Other ……..6
19. Do you have following facilities at home?	Electricity ……..1 Radio …….2 Television ……..3 Telephone …….4 Computer ……..5
20. Can you talk about your personal problems with your parents?	Yes …….1 No ……..2
21. Do your parents response your problems?	Yes …….1 No ……..2
22. How many members are there in your family?	Male……1 Female…….2

C. Knowledge, Attitude on STIs and HIV/AIDS

23. Have you heard about STIs?	Yes ……1 No …….2
24. If yes, which STIs have you heard?	Syphilis …….1 Gomorrah ……. 2 Challamydia ……..3 Tricomonasis …….4 Gonital Warts ……5 Cadiasis …… .6 AIDS ……. 7 Hepatitis 'B' …….. 8
25. From what sources have you heard about STIs?	Radio ……. 1 T.V. …… . .2 Magazine ……. 3 Doctor ……..… 4 Friends ……. 5 Parents ……..… 6 Teacher ……... 7 Textbook …….…. 8
26. Do you know about the way of transmission of STIs?	Yes ……..…1 No ……..….2
27. If yes, how is STIs transmitted?	Sexual contacts ……..….1 Living together ……..2 Unhygienic practice …….……..3 Don't know …….…...4
28. Have you heard about HIV/AIDS? Write the full form of HIV/AIDS	Yes …….…….1 No …….……..2

29. If yes, through which sources have you heard about AIDS?	Radio ……..……..1 T.V. ……..…...2 Magazine ……..…...3 Doctor ……..……4 Friends …….……5 Parents ……..……6 Teacher ……..……...7 Textbook ……..…….8
30. If yes, How is the HIV/AIDS transmitted?	Sexual contacts …….……1 Blood transfusion …….……2 Sleeping together …….…….3 Infected mother to her baby …….4 Don't know ……...5
31 Is the lesson of STI and HIV/AIDS included in your course?	Yes ……1 No ……..2
32. If included, does teacher explain all of STIs and HIV/AIDS?	Yes ……1 No ……..2
33. If teachers do not explain, what is main reason behind it?	Shy ……....1 Don't know sub matter ……..2 Negligence ……..3 Don't know ……..4
34. In your opinion, what is AIDS?	…….
35. Do you know the method of preventing AIDS transmission?	Yes ……1 No ……..2
36. If yes, which of the following are the true methods for preventing AIDS transmission?	No to have sex at all ……....1 Not to have sex with unknown person...2 Use condoms …….….3 Use sterilized surgical instruments only .4

37. In your opinion, do the entire AIDS infected people die or some of them die or do not die?	All of them die ……1 Some of them die ……2 Not die at all …… 3 Don't know …… .4
38. Are there any AIDS related programme conducted in your school?	Yes …… 1 No ……. 2
39. In your opinion, is it necessary for students to have knowledge and awareness about AIDS?	Yes …… 1 No …….. . 2
40. Have you acquired knowledge about sex from your parents?	Yes ……1 No …….2
41. Do you need knowledge about sex?	Yes ……1 No …….2
42. In your opinion, what is sex?	Basic needs ……1 Needs for propagating generation ….2 Absurd ……..…3 Others ……..4
43. Have you talked about sexual activities with your friends?	Yes ……1 No …….2
44. Are you experienced in sex?	Yes ……...1 No …….2
45. If yes, who were sexual partners?	Friends …….1 Husband/wife ……...2 Relatives ……..3 Teacher ……4 Prostitutions …….5 Other ……6
46. If yes, what was the age you have intercourse?	…… ……..