THE KNOWLEDGE, ATTITUDE AND BEHAVIORS ON STIS AND HIV/AIDS

(A Case Study among Reproductive Age Peoples of Dalit Community on Banfikot VDC, Rukum District)

By

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LETTER OF RECOMMENDATION

This dissertation work **"The Knowledge Attitude and Behaviour on STIs and HIV/AIDS (A Case Study among Reproductive Age Peoples of Dalit Community on Banfikot VDC, Rukum District)"** is an independent work of Mr. Gopal Khadka and he completed this work under my supervision.

It is prepared for the requirement of the partial fulfilment of master of Arts degree in population studies. To the best of my knowledge this study is orginal and carries useful information in the field of STIs and HIV/AIDS of reproductive age peoples. Therefore, recommend for the evaluation to the dissertation committee.

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LETTER OF ACCEPTANCE

This dissertation entitled **"The Knowledge Attitude and Behaviour on STIs and HIV/AIDS (A Case Study among Reproductive Age Peoples of Dalit Community on Banfikot VDC, Rukum District)"** by Mr. Gopal Khadka has been accepted as partial fulfillment of the requirement for the Master Degree of Arts in Population Studies.

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ABSTRACT

HIV/AIDS has been threatening the human being since last two decades. It has also killed millions of human being and still the care for it is beyond the capacity of the modern medical science. At first it is appeared in the United States and dramatically spread to Europe, America, Africa, Australia and Asia that colonized the whole world STIs and HIV/AIDS have been the crucial public health problem in the world. In Africa, it is the major cause of death, nowadays it has been rapidly increasing in the developing countries. It has also been great barrier for developing countries. Effort in all the aspects like prevention, counselling advocacy and care have been made from an sectors like GOs/INGOs and many international communities such as WHO, DNAIDS, Red Cross and OPEC.

This study on knowledge attitude and behaviour of STDs and HIV/AIDS in Dalit community in Banfikot VDC, Rukum district is carried out on the basic of primary data collected by using purposive random sampling in ward no. 1, 4, 5, 6, 7, 8, 9 (Kami and Damai, Gaun, Gaine, Sunuwar, Tamtta).

The main objectives of this study is to access the knowledge attitude behaviours of STIs and HIV/AIDS in Dalit community. The sample population taken as 120 (males 68 and females 52) respondents from selected households, all of them are Hindus. Damai were 55, Kami 56, Sarki 2, Sunwar 2, Tamrakar 2, Gaine 2. There is electricity facility at all in the study area.

About 50 percent respondents heard about STDs and 49.2 percent heard about HIV/AIDS the major source of information about STIs in Radio (54.2).

Only about 14.2 percent respondents said HIV/AIDS are different and nearly 73.3 percent respondent do not know about different or both are same and 12.5 percent respondent said do not know about it. However, they have confusion on symptoms, mode of transmission and preventive measure.

In the part of behaviour on security condom use nearly 21.9 and Depo 62.5 percent respondents used. 15.8 percent respondent love and respected to infected people and 73.4 percent hated them, 10 percent do not know. However, level of education and occupation affect the behaviour of the respondent.

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ACRONYMS AND ABBREVIATIONS

AIDS	:	Acquired Immune Deficiency Syndrome
CBS	:	Central Bureau of Statistics
CDPS	:	Central Department of Population Studies
CPRT	:	Central for Population Research and Training
FP	:	Family Planning
FPAN	:	Family Planning Association of Nepal
GOS	:	Government Organization
HIV	:	Human Immune Deficiency Virus
ICE	:	Information, Education and Communication
ICPD	:	International Conference on Population and Development
IDPS	:	Internally Displace Persons
IDUS	:	Injecting Drug Users
IPPA	:	International Planned Parenthood Association
ILO	:	International Labour Organization
INGO	:	International Non-Government Organization
MDG	:	Millennium Development Goal
MOH	:	Ministry of Health
NCASC	:	National Central for AIDS and STDs Control
NDHS	:	Nepal Demographic Health Survey
NFHS	:	Nepal Family Health Survey
NGO	:	Non-Government Organization
RH	:	Reproductive Health
SLC	:	School Leaving Certificate
STDs	:	Sexually Transmitted Diseases
STIs	:	Sexually Transmitted Infections
SWs	:	Sex Workers
SHP	:	Sub Health Post
TUCL	:	Tribhuvan University Central Library
UN	:	United Nations
USA	:	United State of America
UNAIDS	:	United Nations Programs on HIV/AIDS
UNFPA	:	United Nations Population Fund
UNICEF	:	United Nations Fund for the Children
VDC	:	Village Development Committee
WHO	:	World Health Organization
WBC	:	White Blood Cell

CHAPTER - I

INTRODUCTION

1.1 General Background

The topic STIs and HIV/AIDS is major public health problem in the world. STIs and HIV/AIDS is stated as the latest and challenging health issues in the medical science which has become a major issues in the 21st century in the world. It has challenged the discipline of medical science more than two and a half decades which has no curable treatment in the world to date.

In STIs deases there are syphill, Gonorrhea HIV/AIDS are major cases of STIs. Except HIV/AIDS is other are less danger than HIV/AIDS. These suffers due to only sexual in trecourse but HIV/AIDS cause of transmitted are broad.

Acquired immune deficiency syndrome (AIDS) is not hereditary. It is characterized by the number of syndromes occurring together. Evidences indicate that HIV does no transmit easily but it transmits by the body fluids such as blood, semen, Vaginal flrids and breast milk. It does not transmits by casual conflict i.e. body contact, sneezing Coughing, by insect bite.

HIV is the Human immune deficiency virus that finally leads to AIDS various evidences cultured that an protected sexual intercourse heterosexual or homosexual either vaginal sex. Oral sex or anal sex, infected blood transmission and production, sharing of contaminated syringes or needles, breast feeding from HIV infected mother to baby are the main routes of HIV transmission from one person to another. The most common way of transmission is unprotected sexual intercourse with HIV positive partner (PRB, 2006).

HIV/AIDS is pandemic is affecting urban youth specially who are involving sex related activities (Aryal, 2004). Which increase the prevalence rate of HIV/AIDS not only urban youth, but also stream of HIV/AIDS pandemic is now spreading from urban to rural area and between rural area

(ICPC, 1994: 71). By late 1991 over 400,000 cases of AIDS had been reported to WHO from 162 countries by taking into account under diagnosis. Under reporting and delay in reporting (UN/WHO, 1991).

HIV/AIDS is a serious illness that slowly attacks and destroys immune systems of human beings. The result is that the body becomes vulnerable to infections the person infected with HIV may not show any sign and symptoms from five to ten years but he/she transmit the virus to others in any mentioned above. There are generally three periods of entering HIV virus enters in to human body as discuss below (Population Journal, 2065, Vol. 2).

a. Window Period

In this period when HIV virus enters into the human body generally cold cough may appear and a gain disappear after some time. In spite of being infected human body seems to be healthy unconsciously infected person may transmit HIV virus to another person through sexual intercourse and by other activities. In this period it is difficult to find out the presence of virus even if blood is checked (Foundat ion of Health, 2065).

b. Carrier Stage

After crossing the window period infected person in this period still seems to be healthy but HIV virus increases inside the body. It takes five to ten years. In this period signs and symptoms can be found if blood is checked up. This types of stage is called carrier stage.

c. AID's Periods

After six months to ten years period symptoms of AIDS are appeared. When signs and symptoms are seen physically or if the test for HIV is positive, then the situation is known as AIDS. Because of poor immunity, person is affected by series of diseases at that times retrovirus is presence in blood and due to his loss immunity power his loss weight ten percent per month.

There are various curiosities regarding the issues of HIV/AIDS like as how the HIV is transmitted various stages from HIV. Infection to AIDS, the principle manifestations of AIDS and the mortality risk associated with AIDS. These considerations involve biological epidemiological and behavioral elements that combine to give the AIDS epidemic which is its unique characteristics when AIDS finally sets in human body then the body may show several signs and symptoms such as fever, lost of weight, diarrhea, persistent and seven fatigue. But sutsymptoms are common in other conditions a well. There is no medical treatment to those who once are infected by this disease. However preventive measure are possible like as stinence from unsafe sex, be faithful between husband and wife in sexual relationship. Consistently use of condoms during sex, similarly not to use drugs and unstrilized syring. Mainly the young people (15-49) are highly infected by HIV/AIDS.

1.2 Historical Perspective of HIV/AIDS and STIs and HIV/AIDS Situation in the World

STIs are eh diseases, which are transmitted through sexual contact during the unprotected intercourse. The infections transmitted from one individual to another through sexual contact are called sexually transmitted infection. Some time they are transmitter from mother to child and through infected blood transfusion. Sexually transmitted infection is serious problem of both developed and developing countries. The diseases like syphills, Gonorrhea, chlgmydia, Chancroids, trichomoniasis, Genital warts and AIDS, are example of indiscipline and Halo heard sexual behavior (Polharel, 2004).

During the past two decades STDs have undergone a dramatic transformation first the change in name from venevai disease to sexually tranmitted diseases. Indicate this transformation most of the recently recognized STDS are now referred to as second generation STDs. AIDS Sabia virus Nipha virus etc. are the most recently recognized disease.

STIs/RTIs are major cause of maternal and infant morbidity and mortality serious complications of some common infections: included like

treating octopice pregnancy pelvic inflammatory diseases pregnancy loss (early and late miscarriage) preterm labor congenital infection of the period.

Scientific evidence suggest that so percent of HIV infection as spread by sexual route and that there are a strong relationship between HIV/AIDS with more than 23 million adults living with HIV/AIDS, sub-Saharan Africa is ravaged by this epidemic an out standing 36 percent of Bost Wanna's 15-19 years old people live with disease out side two sub sahavan Africa. The largest number of people infected with HIV or living with AIDS are in India at 3.5 million. Globally 15.7 millions adult with AIDS are women and 1.3 million are children below age 15 (UNAIDS, 2005).

1.3 Current Situation of STIs and HIV/AIDS in Nepal

1.3.1 STIs and HIV/AIDS Situation in Nepal

AIDS entered in Nepal through the prostitutes either women or girl who were involved in prostitution in Mumbai an other cities of India, they are generally supposed to come back home, which helps AIDS to spread in Nepal (Acharya, 1999).

According to the annual health report ministry of health. Total of 9928 RTI/STI/HIV cases reported out of 56,67,376 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 022 in 1996 – 97, 0.22 in 1997 – 98 and 0.37 in 1998-99 STI prevalence among sex workers (SWS) is notably higher. Data from Pokhara, Kathmandu, and Terai revealed that Syphills, prevalence among SWS was about 18.8 percent in Terai. 19 percent in Kathmandu and 13.8 percent in Pokhara cities of sex workers were found.

5.3 percent syphills prevalence among other STIs bacterial vageinosis was found. Chiamidia in 2.8 percent found Goxorrhea 0.8 percent and 0.8 is HIV. Among sex workers in Pokhara (NCASC, 2004).

Table 1.1 : Cumulative HIV and AIDS Situation of Nepal

Condition	Male	Female	Total	New cases
HIV positives including AIDS	7510	3492	11002	134
AIDS (out of HIV)	1231	478	1709	27

Source: NCASC, 2008.

Table 1.2 : Cumulative HIV Infection by Sub-Group and Sex as of 13 April, 2008

Sub-Group	Male	Female	Total	New cases this method
Sex workers	1	730	731	2
Clients of SWs & STD	5034	104	5138	93
Blood or organ recipients	20	8	28	1
House wives		2455	2455	89
Men having sex with men	43		43	0
Children	370	236	606	26
Sub group not identify	7646	3588	11234	232

Source: NCASC, 2008.

From the above table 1.2, it is revealed that majority of the HIV carrier are the clients of sex workers/STD consisting of 5034 male and 104 female, more over, the must of the male are seen carrying HIV infection in comparison to female.

Table 1.3 : Cumulative HIV Infection by Age Group and Sex as of 13 April, 2008

Age group	Male	Female	Total	New cases other months
0-4	151	83	234	9
5-9	176	117	293	10
10-14	56	41	97	8
15-19	227	237	1064	4
20-24	1082	660	1750	20
25-29	1789	868	2657	38
30-39	3122	1191	4313	90
40-49	861	316	1177	40
50 above	182	67	249	13
Total	7646	3588	11234	32

Source: NCASC, 2008.

From the above table 1.3 shows that most productive age group 30-39 is affected by HIV/AIDS sharing 3122 as male and 1191 as female then after that the age group 25-29 is affected with 1789 male and 869 female persons which is followed by the age group 20-24 consisting of 1750 persons. 1177 are from age group 40-49 the late adolescent (15-19 are seen more affected by HIV/AIDS sharing 277 male and 231 female than early adolescent sharing 56 as male and 41 as female.

1.3.2 Knowledge on STIs and HIV/AIDS in Nepal

A study conduced to 777 adolescents and youth people in various district of FPAN operational area shows that over three-fourths of respondents (76.4%) revel knowledge on STIs. By gender, males (79.3%) are more likely to have knowledge than females (73.5%) respondents with higher level of education (98.4%) are more apparently to be knowledgeable about STIs than respondents with primary and lower secondary level (78.3%). Similarly, the

same study shows that 87 percent have heard of HIV/AIDS, know about it (Pathak, 2005).

Finding from the 2006 NDHS, Nepal show that AIDS knowledge of AIDS varies by background characteristics and this is lower among older respondents especially among respondents age 40-49 and among even marriage women and men knowledge of AIDS among age group 15-19 for women is 81.8 percent and for male is 95.8 percent (NDHS, 2006).

The conclusion shows that education, occupation religion etc. could play key role to examine knowledge and attitude and behavior change on STIs and HIV/AIDS of the all types of population. Similarly respondent age, sex, education also affect the knowledge and attitude and behavior change towards STIs, HIV/AIDS. Furthermore government policy for all types of population to bring changes on then regarding their sexuality an altering them on STIs and HIV/S. It, through IEC materials and orientation also plays vital role in examine the knowledge, attitude and behavior of the people.

1.4 Statement of the Problem

By 2006 nearly 40 million people were living with STIs and HIV/AIDS in the world out of this figure 4.3 million are newly infected and 2.9 millions died due to AIDS out of total HIV infected people, 95 percent are from southern Africa, Eastern Europe or Asia (PRB, 2006). In southern Asia, 7400000 are living with HIV and 480000 have died from the AIDS (PRB, 2006).

HIV is spreading in everywhere with an electricity velocity on day by day because of increasing drug abuse and break down in healthcare system that affect Nepal directly because easy accets open under between Nepal and India, especially after the treaty of 1950 (Pop Mag. Vol. 3).

Seventy-seven percent Nepalese people engage in India with income generating activities like Agriculture and many other low class jobs among migrant. There is illegal trade of Nepalese woman and girls every year 5000-

7000 Nepalese girls are sold in India. For prostitution and pornographic performance and they return after sometime with HIV/AIDS (Pradhan, 1992).

In the Nepalese context, must of the people are the in habitants of rural area 85 percent and out of them 40 percent children suffer from malnutrition and various diseases (CBS, 2003) the urban youth are seemed to get towards drug abuse and unprotected sex due t which have high provability of getting infected by HIV. The employment opportunity and income generating ways are in very limited number. Most of the people are no access to get quality education illiterate percentage is 46 percent (CBS, 2003) in this context. It is essential to know situation of HIV/AIDS attitudes and behaviors for rural area.

Banfikot VDC is one of the middle parts of Rukum district of middle western development region of Rapti zone. Here is heterogeneous social structure with Multiracial caste ethnicity and multi cultural. Dalit community is the one of the old cultural group, they do not wants to cultivate and they have not growing crops and they have been applying traditional occupation Khalo system and in the gap Sijan they have gone to India for earn money and in Dashain and Tihar they have come for Silai work of the Bista. Due to culture, occupation and lack of education they are far from awareness of all kind of information. Other hand these types of racial group are exist in this VDC from the long time period but their status is not increase. So that researcher choice this topic. This village is far from India but 50 percent peoples migrate to India per year for earn money in low class job. There are more than 121 household Dalit family who are not taken higher education and higher job opportunity. The knowledge of HIV/AIDS is new matter for them so that researcher makes plan to find out the situation of them directly and to find and examine their position and compare with national level.

The research is mainly based on the following questions:

i. Do the knowledge, attitude and behaviors of the Dalit about HIV/AIDS and STIs.

ii. What's the role of media to providing knowledge about STIs and HIV/AIDS.
iii. Do they have information regarding modes of transmission and preventive measures of HIV/AIDS by sex and education ?

1.5 Objective of the Study

The specific objectives of this research study will be following :

i. To examines the socio-economic and demographic background of the Dalit community.
ii. To examines the knowledge and attitudes on STIs and HIV/AIDS among respondents.
iii. To identify behavior their view and their attitudes towards STIs and HIV/AIDS.

1.6 Significance of the Study

In the following some years, this types of study has become much an important in the world. Due to the STIs and HIV/AIDS every countries people's are suffering from its high risk. In the context of HIV/AIDS was identified in 1981 in USA. The prevalence of this disease has been rapidly increasing since its occurrence. Today most of the African countries as well as Caribbean countries are mostly affected by this disease. Most of the people are suffering by this problem in the mentioned counties. No one live longer if he/she suffers form it. Therefore it was very much necessary to study or to gain more practical knowledge about it.

This study were attempts to analyze the knowledge, attitude and behaviour on STIs and HIV/AIDS among reproductive age group of Banfikot VDC Rukum district. Reproductive age people are increase song at high risk of contacting and transmitting sexually transmitted disease including HIV/AIDS is they are typically poorly informed about how to protect from them.

This study had supposed to be useful ever for planners, policy makers, NGO/INGOs and other organizations in relation to the introduction and formulation of plans and programs in national level and also helpful for those who had interested about reproductive age Dalit people. It was useful to improve the status of Dalit people specially in rural areas. Thus while formulating policies and programs. It was formulated by giving Keen attention forwards the current situation of Dalit people for over all cases, this study was helpful for those NGO/INGOs and government sectors who are lunching their programs in the case of Dalit and HIV/AIDS because this study attempts to reflect the overall scenario of knowledge, attitude and behaviour on STIs and HIV/AIDS among reproductive age Dalit people. It was also useful as a guide for further research in similar context and findings of the study was useful for planners and policy makers.

In Nepal there are backwards of Dalit caste\ on knowledge, attitude and behaviour about STIs and HIV/AIDS and other social, political, economic, occupational and higher level of occupation they are backwards. Due to the Dalit communities awareness and their activities we have necessary to study and the provides facilities them about all sectors e.g. educational programme, political programme, occupational programme and others.

The lack of the facilities of the Dalit community. They are backwards hence this research was helped to them to examine. Their behaviours and socio-economic background and further research.

1.7 Limitation of the Study

Any research work is hardly without any limitations. This study will based on the variables as age, age at marriage caste ethnicity, media attention, level of education and occupation, educational status, Religion.

The major limitations of the study are given below :

i. The study is limited with small area and simple size. Due to limited time and budget.

ii. Limited on the sample data collected from the Dalit community of Banfikot VDC in Rukum district.

iii. The conclusion/result carried out from this research depend s on the reliability of primary and secondary data collected from various sources.

iv. The result of the study may not be generalized as a whole for the entire region as this study will covers. Only Dalit community who had anent residents of Banfikot VDC of Rukum district.

CHAPTER - II

LITERATURE REVIEW

2.1 Background of the HIV and AIDS

"AIDS is a disease caused by virus that can been down the body's immune system and lead to fatal inflections, some forms of cancer" (UN, 1989).

This virus causes AIDS by disability of destroying certain kind of cell that normally help the body to fight diseases. If these particular cells are destroyed, the body cannot defend itself against infections and certain cancers. AIDS patients are then open to attack from infections and cancers that healthy persons can resist.

AIDS is the most severe illness caused b the AIDS virus HIV, but other milder illness also results from infection with the virus. These usually get worsen with time and develop into AIDS.

When the AIDS virus, HIV enters a person's body, it presents certain cells in the body, where it can remain for the life of the person. In some people who are infected the virus remains quite for ten (10) years or more-before it causes AIDS. They may nevertheless spread the virus to sexual partners during this period.

There are several types of illness, the virus can cause and it may eventually result in the disease lime pneumonia and some cancers. The majority of people with AIDS die within two years of diagnosis. A few persons have survived longer (UN, 1989).

"A quarter century into the epidemic, the AIDS response stands at a crossroads. The AIDS response must become substantially stronger, more strategic and better coordinated. If the world is to achieve the 2010 Declaration of commitment targets, the countries most affected by HIV and AIDS will fail to achieve Millennium Development Goals to reduce poverty,

hunger, and childhood mortality and countries whose development is already flagging because of the HIV, and AIDS will continue to weaken potentially threatening social stability and national security, if the response does not increase significantly" (UNAIDS, 2006).

2.2 Situation of HIV and AIDS in World

The first case of AIDS was reported in Los Angeles in June 9, 1981. The causative organism of AIDS, i.e., HIV was identified in 1983. The epidemic has transcended all seniors including race, ethnicity, geography, gender and socio economic status, and Nepal remain no exception. The first case of AIDS in Nepal was reported in 1988. The challenge in Nepal remain in the fact that HIV is often regarded as a problem in itself rather then incorporating it into a broader developmental agenda. Further, prevention, care and support is yet to reach majority of the vulnerable population leaving aside the immense amount of stigmatization and discrimination that people living with HIVAIDS are facing.

As the end of 2004, 39 million people world wide were living with a symptomatic human immune deficiency virus (AIDS) and more than 20 millions level died of AIDS science the beginning of the epidemic. More than (95%) of people living with HIV and AIDS live in low and middle income countries nearly two-third are in Sub-Saharan Africa and nearly one five live in Southern Southet Asia. In 2004, 7.9 million people were newly infected (23%) millions people died of AIDS (UN, 2005).

The pandemic Natmc and magnitude of the public health problems associated with HIV infection were organized much late when the proportion of person's infected with HIV nose very rapidly. Observing the global epidemic, it is estimated what 38.6 million people were living HIV/AIDS in the world by the end of 2005 and 4.5 million become newly infected with HIV. Out of this, it is estimated that 2.8 million had died due to AIDS (UN AIDS, 2006). One of the total infected children, only (15%) are living one side Africa region. The behaviours of the people and HIV penetrative programs determine the spread of HIV infection. The number of HIV infected

people is increasing continuously because of growing population and life prolonging efforts of artificial therapy (UNAIDS, 2006). More than 58 countries are providing education about HIV and AIDS through primary (74%) and secondary (81%) level school education. However, HIV preventive programs are failing to reach to those who are in the greatest risk (UNAIDS, 2006).

AIDS is the most devastating health disaster in the human history. It continues from individual to family, community, nation and the world. In the context of world, 25 million people are living with AIDS now. 4.9 millions people were infected with it in 2005. Around 95 percent of them in Sub-Saharan Africa, Eastern Europe, and Asian countries throughout the industrialized world face serious challenges from AIDS. Infection rates have not declined significantly in Western Europe and North America where the epidemic has spread from the gay male population to ethnic minorities, the poor and others marginalized groups. Sub-Saharan Africa is the largest hit region in the world. Most of the Africans die with this illness rather then other causes deaths. South Africa has the largest number of people living with HIV and AIDS between (4.5-6.2) million. Swaziland has the highest adult HIV prevalence rate. More than 30 percent of adults are infected with and AIDS (PRB, 2006).

The global statistics published by UNAIDS/WHO in 2006 informed that nearly 39.5 million [range: 34.1 to 47.1 million] have been living with HIV/AIDS since 1981. Similarly, 37.2 million [range from 32 to 44.5 million] adults, 17.7 million [ranges from 15.1 to 20 million] women, 2.3 million [ranges from 1.7 to 3.5 million] children, were living with HIV/AIDS. Moreover, 4.3 million [ranges 3.6 to 6.6 million] people were newly infected by HIV/AIDS. Out of this figure 3.8 million [ranges from 3.2 to 5.7 million] were adult. Youth, less than 25 years old, accounts half of all the new HIV infected population. Worldwide, around 6000 people infect ed with HIV every day. In developing countries, 6.8 million people are in immediate need of lifesaving AIDS drug; of these, only 1.65 million are receiving the drugs (UNAIDS/WHO, 2006).

AIDS is now considered not only a health problem, but also a great threat to development and security. Although the epidemic began at first in developed country, 95 percent of new infections have occurred in developing countries. Moreover, the epidemic is affecting developed and developing countries differently. In industrialized countries, mortality and infection rate have declined dramatically over the past few years, largely due to the availability of antiretroviral medication. AIDS in these countries is now a chronic disease and a manageable health problem. However, in developing countries, AIDS is destroying societies, community and nations. Now only less than 20 percent of the people at risk of HIV infection have access to basic preventive services. There is wider gap in acquiring HIV/AIDS between haves and have not, rich and poor thereby presenting a new ethical and human right (Narain et. al, 2004).

2.3 Regional Situation of HIV/AIDS

South Africa has the world's largest number of patients' co-infection with TB sand HIV. TB is the most opportunitistic infection among persons with HIV. 60000 south Africans has both diseases. South Africa's cure rate for TB changes from (35%) Kwalula – Natal to 70 percent in western cape, according to Health Minister Manto Ishabalata Msimary. The resulting average cure rate is 54 percent WHO's goal is 85 percent (WHO, 2004).

Sub-Saharan Africa is the most heavily affected region by HIV/AIDS where HIV/AIDS victims are more than any other region of the world. It is estimated t hat 24.5 million people were living with HIV/AIDS at the end of 2005 (UNAIDS, 2005) and more African died of HIV/AIDS and HIV/AIDS related illness than of any other causes (PRB, 2005). Between 4.5 million to 6.2 million people were livings with HIV/AIDS in South Africa. During the year of 2005, 4.5 million people were newly infected with HIV/AIDS and out of this figure, 95 percent were from African region (PRB, 2005). HIV/AIDS prevalence rates and the number of people dying from HIV/AIDS are notable in African region. The prevalence rate in the world is only 1.1 percent, whereas in sub Saharan African region, this rate is 7.1 percent (PRB, 2006). In this region, the cumulative death by HIV/AIDS is 2400000 (PRB, 2006).

Based on its extensive antenatal clinic surveillance system, as well as national surveys about HIV/AIDS testing and mortality data from its civil registration system, an estimated that 5.5 million [ranges 4.9 million to 6.1 million[were living is not uniform nor the number of people dying from HIV/AIDS is uniform, even in the African countries. Somalia, Senegal, Botswana Lsotho, Swaziland, Zimbabwe are the high HIV/AIDS infected countries. Somalia and Senegal the HIV prevalence is under 19 percent of the adult population where as south Africa and Zambia around 15-20 percent, Botswana 24.1 (24.1%), Lesotho (23.2%), Swaziland (33.49%) (UNAIDS, 2006). The sub-saharan African region has the high prevalence rate of HIV/AIDS.

The Caribbean's epidemics and countries AIDS response very considerably in extent and intensity HIV infection levels have decreased in urban parts of that and in the Bahamas and have remained stable in neighbouring Dominican Republic and Barbodos. Because of the accessibility of antiretroviral treatment in both Bahams and Barbados appears to be reduction AIDS deaths. It is known as the 2nd most affected region in the world. AIDS is the leading cause of deaths is this regions (WHO/UN, AIDS, 2008).

2.4 HIV and AIDS Situation in Asia

Acquired Immuno Deficiency Syndrome (AIDS) is caused by the Human Immuno Deficiency Virus (HIV), which is spread blood, semen, veginal secretions, and breast milk. The most common method of transmission of unprotected sexual, intercourse with HIV positive partner. Including other major routes are transfusions of HIV infected blood, use of contaminated needles syringes, other transmission during pregnancy or breast feeding (PRB, 2006).

In Asian HIV infection profile shows that 8.3 million [ranges from 5.7 million to 1.5 million] people living with HIV in 2005. In 2006, the figure of HIV infected people has increased to 8.6 million [ranges from 6 million to 13 million]. The cumulative death of AIDS due to HIV infection including those who become newly infected is approximately 630000 [ranges from 430000 –

900000] (UNAIDS, 2006) by the late of 2006 in Asia. Mainly poverty related factors such as separation of martial partners, sex for commercial gain, high prevalence of other sexually transmitted infections, unsafe sexual behaviours plays the chief role in increasing the HIV infection rate. Customs, beliefs and practices like sexual partnership, across age groups, use of intra vaginal desiccants, use of alcohol and drugs and so forth are the major risk factors in contributing to HIV transmission (Narain et. al., 2004).

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HIV infection level of Asian countries comparatively lower than other continents. But in some countries comparatively lower than other continents. But in some countries are very much suffered by this disease. In the context of Asian continents 8.2 million people were living with HIV at end of 2004. Asian countries can be divided into several categories, according to the epidemic prevalence. While some other countries such as Combodia, Myanmar and Thailand are just in starting phase and starting rapid experience of epidemic such Indonesia, Nepal, Vietmnam and several province China. Some countries including Bangladesh, East Timor, Laos, Pakistan and Philippines are experiencing extremely low level of HIV prevalence (Khanal, 2005).

Later estimated show that some 8.3 million people were living with HIV in Asia at the end of 2005, more than two thirds of them in one country, India. India has the largest number of people suffering with this epidemic in the world. In Asia, about one in sex people 16 percent in need of antenatal treatment are now receiving it. While progress have been strong in Thailand. The coverage of treatment still remain below 10 percent in India. China has expanded the HIV surveillance and improved estimating of AIDS pandemic

disease. Approximately 650000 people were living with HIV in 2005 in China. Out of total almost half 44 percent are use infecting drugs. Infecting drugs users and unprotected sex are the main cause of spreading of HIV in Asia. An example is Vietnam, when HIV has spr3ead into LL 59 provinces and all cities. In 2005, and estimated 360000 adults and children were living with HIV n Myanmar and national adult prevalence stood at 1.3 percent. HIV epidemic epidemics remain relatively limited in Bangaldesh, Philippines, Indonesia and Pakistan, although each of these countries risk as more serious epidemic if prevention methods are not improved (UNAIDS, 2006).

South-East Asian region has high number of HIV infected people. The main cause behind it is unprotected paid sex and sex between men among with unsafe injecting drug use. Vietnam is another host country in Asia. In 2005, 260000 (ranges from 150000-430000) where living with HIV and 4000 people become infected with HIV each year (UNAIDS, 2005). Injecting drug users and person who buy sex or sell are highly infected with HIV/AIDS. During 1996, nine percent of injecting drug user were suffered by HIV which rose to 30 percent in 2003. Very low class injected drug users involved in sex market are infected with HIV. The use of condom is higher in brothel based sex (UNSAIDS, 2005). Less than half of young people have comprehensive knowledge of HIV. Moreover, the health policy of this country has given emphasis to strengthen the knowledge and awareness on HIV/AIDS (UNAIDS, 2005).

2.5 Situation of HIV and AIDS in South Asia

South Asia has one of the fastest growing epidemics in the world. Since its entry into the region, every country has been new infections. In south Asia, 7400000 people living with HIV where 990000 people were newly infected in 2005. HIV prevalence is also rising rapidly in many puts of the South Asia. Prevalence rate of HIV is 7 percent of adult infected in South Africa. Around 480000 people was died due to AIDS in 2005 in South Asia (PRB, 2006).

The SAARC courtiers have distinct characteristics such as different ethnic groups with distinct characteristics such as distinct cultures, low health

development indicators, agrarian nature, low economic condition as well as low literacy rate, high infant, child and martial mortality rate, high fertility and poor consumption pattern. The society is being free due to the influence of western culture, norms and values. The influence of urbanization, industrialization and following of European culture is significant in bringing the change in social and cultural pattern (Aryal, 2000). Pre-marital sex, poverty, illiteracy, income inequalities, social translation, gender inequalities, violence, sexual abuse, powerlessness, trafficking of girls and women and so on compel girls and women of reproductive age to be involved in unsafe sexual activities. Consequently, they have greater risk of being infected by HIV/AIDS (UNFPA, 2001). The young girls are more vulnerable because of inability to refuse unwanted or unsafe sex. In the case of Bangladesh around 95 percent of 15-19 years of age do not know even a single preventive method of HIV/AIDS (UNFPA, 2001).

The given information in the table below shows that India has the highest prevalence rate (0.8) among other south Asian countries. Bangladesh and Bhutan has less prevalence as compared to others. In Nepal, HIV prevalence rate is 0.5 percent of the total population.

Table 2.1 : HIV/AIDS Infection in South Asian Region

Countries	Reported AIDS case	% of prevalence among adult with HIV*	Estimated HIV infection
Bangladesh	17	<0.1	13000
Bhutan	13	<0.1	<100
India	48933	0.8	3970000
Maldives	9	<0.1	<100
Nepal	634	0.5	58000
Pakistan	-	0.1	-
Sri-Lanka	405	0.1	4800
Afghanistan	-	-	-

Source: HIV/AIDS in Asia 2005.

* SAARCE Tuberculosis Centre Thimi, Bhaktapur, Nepal, 2003.

There out of every five South Asian women are illiterate, including three quarters of Pakistani women and nearly two-fifths of Nepali women. The school dropout percentage in India is significant (UNFPA, 2001). The first case of HIV positive was detected in 1980 in Bangladesh. due to strengthening the awareness programs, information education and communication campaign about disease, the HIV infection is low in Bhutan. India is highest infected country. Within short period, it has emerged as one of the most serious health problems in India. The first case of HIV was reported in 1991 in Maldives. In this country the prevention and control programs are lunched from grass root level to control the disease. Continuous spread among injecting drug users, trafficking of female for prostitution, changing values among youth people, high rates of migration and mobility and open border and similarly, low awareness among male who have sex with male are t he major risk factors of HIV/AIDS infection in south Asian region (http:/web.worldbank.org).

2.6 Status of HIV and AIDS in Nepal

HIV and AIDS have become a major public health problem in Nepal. Surveillance information about AIDS is scarce in Nepal. However limit ed data indicate that HIV is currently around 0.3 percent in general population. Nepal is one of the developing country as well as medeterrian country because of the low economic status, high level of illiteracy, high level of poverty etc. The large number of population being at high risk of HIV and AIDS.

In Nepal, there were only 4 HIV positive in 1988. But the rate of HIV positive is increasing continuously. In 1996 this number reached to 135. After one year 1997 this number is rapidly rose to 489. Around 1282 people were infected with HIV positive in 2004. By the end of March 2007, this number of AIDS infection rose to 1293 out of 9043 number of people living with HIV around the country (NCASC, 2007). The new case of infection by HIV in March 2007 is 155 and 25 out of total HIV (NCASC, 2007). UNAIDS estimated that 75000 people were living with HIV at the end of 2005. According to the official record, 384 had died by the end of 2nd March 2007. The HIV/AIDS infection varies by sex, working behaviours, personal

attitudes towards sex and so forth. The infection by HIV/AIDS of male population is two times higher then female population in Nepal (NCASC, 2007).

2.6.1 National Response to HIV and AIDS

Government and Institutional Effort

In 1988 the government of Nepal launched the first National AIDS Prevention and Control Program. In 1995, a nation policy was formulated emphasizing the importance of multi-sectoral involvement, decentralized, implementation and partnership between the public non-governmental organizations and the private sector including NGOs.

Towards this effects Nepal established a multi-sector National AIDS coordinating committee (NAC) chained the minister of health in 1992. More recently, a National AIDS council (NAC) chained by the prime minister was established to raise the profile of HIV/AIDS. The NAC was meant to set overall policy, lead national level advanced, and provide overall guidance and direction to program.

The main governmental agencies are responsible for HIV/AIDS and AIDS control in under the ministry of health and population, National Centre for AIDS and AIDS control (NACSC). The NCASC has developed a National Strategy on HIV/AIDS, which has subsequently been translated into five year HIV/AIFS operational plan for 2006-07, the strategy and operational plan seek to address management needs and define the response requirement for are expanded response to HIV/AIDS in the country.

2.6.2 Non-Governmental Organizations and Community: Based Organizations (NGOs and CBOs)

According to sate of world population report t he United Nations Population Fund UNFPA in 1997, an estimated 100000-200000 Nepalese women have been sold to brothels in India and the police and local authorities in some of this trafficking has been reported.

Women are recruited from village and urban areas of Nepal where they have to work in the carpet and garment industries. Some women are sold by their families, whereas other are delivered by false marriage and promise of economic opportunities. Once a sex women is found to be forced to remain in the sex industry as means of survival (Synergy Project, 1999).

For instance, the cumulative HIV/AIDS situation 1996/97 was recorded to be 790 cases where 61.6 percent were female. This situation in 1998/99 has sharply increased to 1108 cases or increase 1.4 percent times as HIV positive in 1996/97, 152 cases recorded have had AIDS. T his figure for 1997/98 was recorded at 25 cases (Khanal, 2005).

2.7 Knowledge of HIV and AIDS

In Nepal, knowledge of AIDS is higher. The Nepali Family Health Survey (NFHS) for first time included questions on the awareness of women about HIV/AIDS. This survey showed that only one forth ever-married women had heard about HIV/AIDS. More than 67 percent of the urban women had heard about AIDS compared to only about 23 percent women heard about AIDS in rural areas. Similarly, knowledge of AIDS was found highest among women in the hill (35%) then among women in terai (21%) and mountains (18%) women from the western regions were found more knowledge with (36%) while women from the far-western development region were found least knowledge (10%) about AIDS (NFHS, 1996).

NDHS showed that the knowledge of AIDS is much higher among male (72%) than the female (50%). It was indicated that the males have knowledge about AIDS (NDHS, 2001). According to UNFPS, majority (99%).

In Nepal, knowledge of AIDS is much higher among male (72%) then among female (50%). Although the percentage of women who have heard of AIDS has nearly doubled in the last five years from 27 percent in 1996. Two fifth of women and two-thirds of men believe that there is a way to avoid HIV/AIDS (NCASC, 2004). As level of education increases, respondents'

knowledge of AIDS also increase: knowledge of AIDS is almost universal among respondents who have passed SLC.

A study by FPAN shows that 85 percent of respondents have knowledge of AIDS, two thirds of respondents reported HIV/AIDS as one kind of STDs, followed by syphilis (20%) and gonorrhoea (13%). Fifty two percent of respondents said that electronic media is the main source of information, followed by school (19%), print media (12%), friends and relatives (10%) and health worker (7%). The role of parents in making their children aware is negligible in the study area. The overwhelming majority (94%) has heard about HIV/AIDS. Ninety three percent of the respondents perceive unsafe sexual intercourse as one of the chief way of HIV/AIDS transmission, followed by unsafe blood transfusion (78%) and sharing injection (74%) (Pathak, 2002).

A KAP survey among 1400 young people in seven different district of Nepal shows that Nepalese are highly aware in HIV risk, but this awareness does not necessarily translate into safe sexual behaviours. Although an overwhelming majority (92%) of teenagers has heard about HIV/AIDS, only 74 percent of teenagers knew that they should use condoms while having sex and only two third (69%) said that they should not have sex with commercial sex workers. The study also reveals that almost 20 percent teenagers considered pre-marital sex experience. The knowledge of HIV/AIDS is limited among adolescents: only 19-24 of married adolescent girls are reported to have heard of HIV/AIDS in Bangladesh and Nepal (UNFPA, 2006).

Roka (2002) has examined the knowledge of HIV/AIDS among school adolescents of Khotang district reveals that the knowledge of HIV/AIDS among students is significant. Majority (90%) of the students has heard about HIV/AIDS and some misconception is also observed mainly about the mode of transmission of HIV/AIDS. By sex female have less knowledge as compared to male students. The pre-marital sex occurs but very few percent of boys and girls use contraception during sex occurred outside marriage. Radio

is the main source of information of HIV/AIDS. The sources of information vary by place of residence.

2.7.1 Knowledge Among the Major High Risk Groups

In the context of Nepal, there is no reliable source of drugs most of the injecting drug users are found in cities like, Kathmandu and Pokhara and other big and small cities. The awareness of HIV/AIDS is very high among drug users.

2.7.2 Female Sex Workers (FSWs)

The level of knowledge about HIV/AIDS among the female workers is very high. Almost are the FSWs and their clients, irrespective of their education profession and the place of residence, have knowledge of condom. Most of the FSWs and their clients are also awarded that use of condom are percent the transmission at STDS and HIV/AIDS (New Era, 2003).

2.7.3 Migrant Workers

The finding of the study conducted in the district of Kanchanpur, Kailali Bardia and Dang, the related Indo-Nepal border point s shows that ever three-quarters of the migrant workers had knowledge about HIV/AIDS, about half of them (48%) also mention about symptom of STDS of HIV/AIDS. Nearly 90 percent migrant workers interviewed in the community and about 80 percent interviewed at the boarder points had knowledge about HIV/AIDS. The survey result was very land use of condom (UARG, 2001).

In the context of Nepal Dalit community is in movement pressing the government to fulfil their demand that includes in constituent assembly. In this process Badi community from 23 different districts are in Kathmandu. For last two months demanding their rights, which have been suppressed by feudal structure of state and society. They under badi right struggle communities have been struggling tolerating different difficulties in Kathmandu. This situation has been very painful because of the police brutality to their protest even after two month protest and continuous struggle,

government has not been serious on their issue rather played with different propaganda. They have been continuing their struggle since BRSC is determined to continue the struggle until the response of government to their demands.

People from the Badi community organize a sit in demanding an end to Deeuki, Badi and Jhuma traditions prevalent in western Nepal at the Maitighar Mandala in Kathmandu. On August 17, 2007 police rounded up 13 women of Badi community when they stage a demonstration in front of the Singadarbar on August 19, 2007. They were arrested for demonstrating at the restricted area.

Due to this types of problem are presented today for all kinds of Dalit community in our country day by day. The Dalit people have made 2nd class native hence it is necessary to study and reduce all types of Dalit concept of society in our behaviours. So that our Banfikot VDC of Dalit community is not far from various kinds of problem of racial. Therefore, it is important issues for STIs, HIV/AIDS and select this topic for study (RDN, 2008).

CHAPTER - III

METHODOLOGY OF THE STUDY

This study was planned to obtain information on the topic "The knowledge, attitude and behaviour in HIV/AIDS and STIs of reproductive age Dalit people." Basically it has focussed to Dalit community of Banfikot VDC of Rukum district in this section. In this section implies the introduction of the study area. Study population, nature of data, questionnaire of the study and volume of sample size, sampling techniques for the selection of respondents, data analysis approach as follows:

3.1 Introduction of the Study Area

Banfikot VDC of Rukum district is chosen purposively as study area of on the research topographically, the district t is categorized as Hilly district. This district is situated between 28°29' to 29° northern latitude and 82°12' to 82°53' eastern latitude in the world co-diagram.

This district is situated in Rapti zone. It is surrounded by Baglung and Myagdi district in east, Jajarkot district in west, Dolpa district in north and Salyan and Rolpa district in south.

However Rukum district is situated in lap of the Sisne Himal. It is popular, the name of Baunna Pokhari Tripanna Takuri. Due to the Sharpujake is popular.

Banfikot VDC is located 10 km far from the district headquarter of Rukum. This VDC is very far from the development parts. Its total area is 28213725 hector.

The climate of this villages is normal not very not and not very cold.

Population

Different caste ethnic group of people are living in Banfikot VDC. According to 2001 census. Total household of the VDC are 913 with the total

population of 6095. Among them 2979 are females 3046 are males population. Average family size of this VDC is 5.23 majority of people are followers of Hindu. Mostly people speak their mother tongue, language is Nepali.

Brahman, Chhetri, Magar, Thakuri and various types of Dalit are main caste living in Banfikot VDC. Around 27.06 percentage literate of males and 70.94 are illiterate and 10.43 literate and 89.57 are illiterate of females. According to 2001 census (Bastugat Bibaran).

Economic Status

Banfikot VDC is one of the remote areas of Rukum district. The main occupation of this VDC is agriculture the people are low working in the government level. The follow of people going India is very high in this VDC. Nowadays people started to go Avabian countries for the search of job.

Physical Infrastructure

There are no transpiration facilities in this VDC. In this VDC have one higher secondary school, two lower secondary school, 8 primary school, one Ilaka health post office, one police post office etc. are running.

People using pipe, Khola's and Kuwa's water, only selected household have toilet facilities so almost people are using Bariko Kuna and Jungle for toilet.

3.2 Selection of Study Population

Study population of this study had selected both male and female of age group (15-49) for females and an age group (15-59) for males.

3.3 Source of Nature of Data

This research is primary base research but both primary and secondary data have been used for the partial fulfilment of its objectives the primary information is collected through direct interview with the respondents

applying pre-structured questionnaire and secondary data have been collected from different published and unpublished document visiting of different organization and individual.

3.4 Volume of Sample Size

The study was targeted to interview about 120 respondents, 15 respondents were selected from each community of Dalit who are Banfikot, VDC.

3.5 Sampling Techniques for Selection of Respondents

Female respondents were from age groups (15-49) for females and (15-59) for males were taken from 7 ward of Banfikot VDC from 8 gaun or community where their resident area. Applying the purposive sampling. Other technique has been not used due to limitation of budget and time.

Table 3.1 : Distribution of Respondents by Word of Study Area

Ward No.	Gaun	No. of respondents	Ward No.	Gaun	No. of respondents
1	Banfikot Takara	15	6	Kanda	15
1	Banfikot Dang	15	7	Shyaru	15
4	Simtaru	15	8	Vhagle	15
5	Badgaun	15	9	Nepane	15

3.6 Questionnaire Design

For this study, the semi-structured questionnaire was developed which was constructed on the basis of knowledge and attitude of Dalit and behaviour of STIs and HIV/AIDS. Most of the questions were pre-coded and some open questions had also been included in the questionnaire. Pre-test was also conducted to make the questionnaire more appropriate. Some modification was made on previous questionnaire before making final print for field study. The whole set of questionnaire was divided in to following four parts.

A. Individual questionnaire

B. Household questionnaire

C. Knowledge, attitude and behaviour of STIs and HIV/AIDS questionnaire

D. Others

In household questionnaire, there was provision for collecting information about respondents parents education and occupation, total family size and facilities.

3.7 Data Collection Method

This study uses both types of primary and secondary sources existing data were collected through primary source whereas literature is review is based on secondary sources. Quantitative technique was used as major approach in collecting information; however, qualitative technique was also used as supplement of quantitative method.

Mainly, this study focuses on people of Dalits community (Kami, Damai, Sarki, Gaine, Sunuwar, Tamrakar etc.) data was collected by taking interview to all respondents.

3.8 Data Processing

The completed questionnaire was coded in coded book and raw data arrange and tabulated in table help of the friends and tabulated data. Frequency distribution and table are main out put of this analysis.

3.9 Data Analysis

The data analysis is simply based on descriptive form. The frequency tables, cross tabulations and other necessary information are based on SPSS edited data. On the basis of table extracted information as well as other necessary information, the analysis and interpretation have been made.

3.10 Operational Definition of Variable

- **Knowledge :** It refers to the understanding, idea and concept of the respondents specially about STIs and HIV/AIDS. Infection, causes, routes of transfusion, symptoms, prevention, and control of HIV/AIDS and pre-marital sex.
- **Attitude :** It refer to the way of thinking and perception of the respondents towards HIV/AIDS and those who are suffering from STIs, HIV/AIDS and pre-martial sex towards positive or negative, favourable or unfavourable response of the respondent defines the attitude.
- **Age of respondent :** The completed age of respondent. This study is limited to the adolescents above or 15-59 only.
- **Marital Status :** There are two options they are married and unmarried.
- **Nuclear family :** The family where only one generation live under one roof together is called nuclear family.
- **Joint family :** The family where more than one generation live under roof and share kitchen, bedroom, property, etc. commonly is called joint family.
- **Sex of respondent :** The respondent can be categorised either male or female which in nominal scale.
- **Caste/Ethnicity of respondent :** Only Dalit caste (Damai, Kami, Sunuwar, Sharki, Gaine, Tamrakar) group was selected for the study other was not included.
- **Place of residence :** All the respondents in this reside in rural area (remote).
- **Religious of respondents :** Religious of respondent is Hindu only.
- **Occupation :** The current major occupation for survival in considered as their occupation in this study.
- **Education :** The highest level of education of respondent.

- **Knowledge on Symptom of STIs :** The major precoded five symptoms of STIs were included in the questionnaire. Other responses that were given by the respondent are also included.
- **Knowledge on mode of transmission of STIs :** The major modes of transmission of STIs were preceded. There were four major modes of transmission found during the study.
- **Knowledge on Preventive measure of STIs :** The major preventive measures of STIs were preceded. They were five major preventive measures found during the study.
- **Knowledge on Modes of transmission on HIV/AIDS :** The major modes of transmission of HIV/AIDS were pre-coded. There were five major modes of transmission found during the study.
- **Knowledge on Prevention measures of HIV/AIDS :** The major prevention measures of STIs were five preventive measures found during the study.

CHAPTER - IV

SOCIO-ECONOMIC AND DEMOGRAPHIC CHARACTERISTICS OF THE RESPONDENTS

4.1 Individual Characteristics of Respondents

Several variables were included in questionnaire to examine the socio-economic characteristics of respondents as well as to find out the relationship between depend and independent variables. The variables uses to collected individual characteristics have been described within this sub-section.

4.1.1 Age-Sex Composition

The age composition of study population were shown in Table 4.1 below. The respondents were selected from age 15 to 60 years of both sex.

Table 4.1 : Percentage Distribution of Respondents by Age Sex Composition

Age Group	Sex		Total Number	Percent		Total (%)
	Male	Female		Male	Female	
15-19	10	9	19	14.7	17.3	15.8
20-24	13	11	24	19.1	21.2	20.0
25-29	7	6	13	10.3	11.5	10.8
30-34	7	7	14	10.3	13.5	11.7
35-39	8	7	15	11.8	13.5	12.5
40-44	5	8	13	7.4	15.4	10.8
45-49	4	4	8	5.9	7.7	6.7
50-54	9	-	9	13.2	-	7.5
55-59	5	-	5	7.4	-	4.2
Total	68	52	120	100.0	100.0	100.0

The Table 4.1 shows that age group 15-19 years both sexes percentage was 13.8 and male and female percentage was 14.7 and 17.3 respectively and other age groups percentage was given below respectively 20-24 years 19.1,

21.2 and total 20.0 percentage. In age group 25 to 29 was 10.3, 11.5 and 10.8, in age group 35-39 was 18.8, 13.3 and 12.5, in age group 40-44 is 7.4, 15.4 and 10.8, in age group 45-49 was 5.9, 7.7 and 6.7 and in age group 50-54 male percentage 13.2 and total was 7.5 and in age group 54-59 male percentage was 7.4 and total is 4.2 were found.

4.1.2 Percentage Sex Composition

Table 4.2 : Percentage Distribution of Respondents by Sex Composition

Sex	Number	Percent
Males	68	56.7
Females	52	43.3
Total	120	100.0

The Table No. 4.2 shows that 56.7 percent were males respondents and 43.3 percent were females respondents.

4.1.3 Caste and Ethnicity

The cast and ethnicity of study population were shown in the table below. The selected respondents are Damai, Kami, Gaine, Sharki, Sunuwar and Tamrakar ethnicity.

Table 4.3 : Percentage Distribution of Respondent by Caste

Caste	Number	Sex Number		Percentage		Total
		Male	Females	Male	Females	
Damai	55	30	35	44.1	48.1	48.5
Kami	56	30	26	44.1	50.0	46.7
Sarki	2	2	-	2.9	-	1.7
Sunuwar	2	2	1	2.9	1.9	2.5
Tamatta	2	2	-	2.9	-	1.7
Gaine	2	2	-	2.9	-	1.7
Total	120	68	52	100.0	100.0	100.0

Source: Field Survey, 2008.

Table No. 4.3 shows that 44.1 and 48.1 males and females and total percentage was 48.5 percentage were Damai. 44.1 percent males and 50 percent females shows the total percentage was 46.7 were Kami 1.7 percentage respondent were Sarki, 2.5 percentage Sunuwars 17 were Gaine and Tamrakar were found.

4.1.4 Religion

All of the respondents were found Hindu.

4.1.5 Marital Status of Respondents

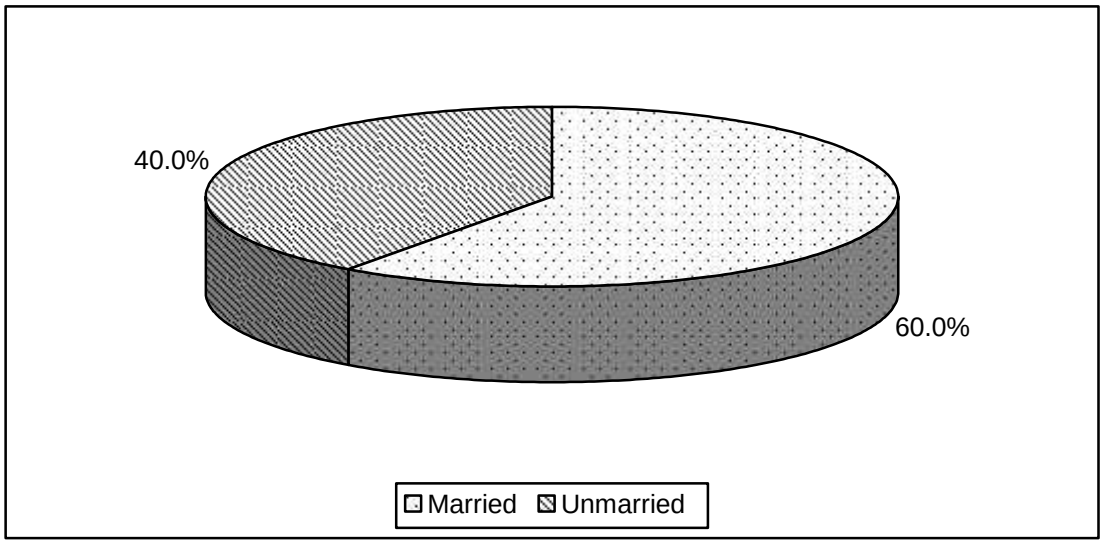
It is also another an important variable which has become very much concerned to get reliable information on attitude of the respondents. The result of this variable is given in following table.

Table 4.4 : Percentage Distribution of Respondents by Marital Status

Marital Status	Number	Percent
Married	72	60.0
Unmarried	48	40.0
Total	120	100.0

Source: Field Survey, 2008.

Figure 4.1 : Percentage Distribution of Respondents by Marital Status



From the above table and Fig. 4.1 shows that 60 percent respondents are married and 40 percent respondent are unmarried.

4.1.6 Educational Status of Respondents

Educational status is an important variable for knowledge on STIs and HIV/AIDS. The following table gives the distribution by educational status.

Table 4.5 : Percentage Distribution of Respondents by Level of Education

Educational level	Respondents	
	Number	Percent
Illiterate	64	53.3
Non-formal	10	8.3
Primary (1-5)	24	20.0
Lower Secondary (6-8)	9	7.5
Secondary (9-10)	8	6.7
SLC and above	5	4.2
Total	120	100.0

Source: Field Survey, 2008.

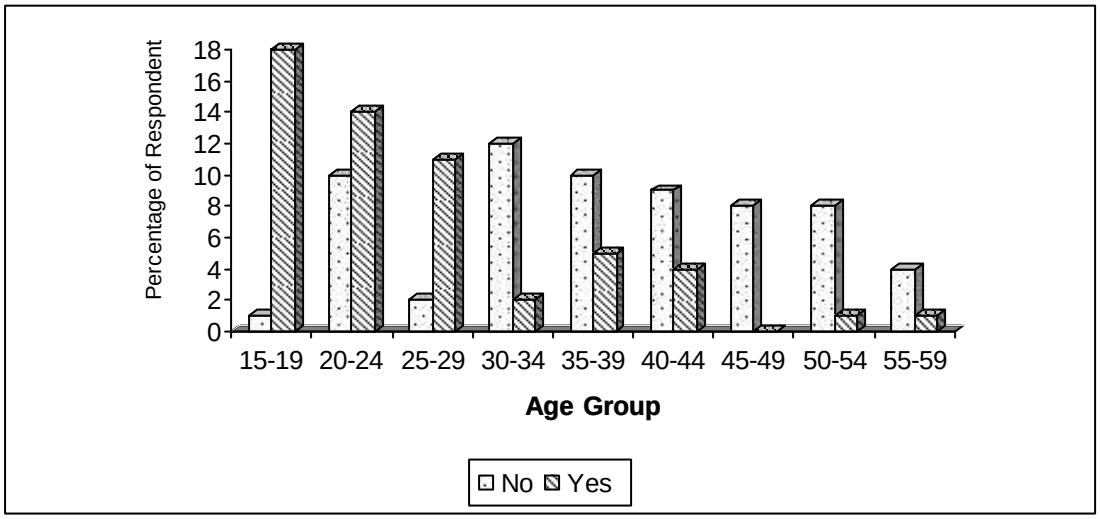
From the Table 4.5 shows that 53.3 percent respondents are illiterate, 8.3 percent non-former, 20 percent primary, 7.5 percent lower secondary, 6.7 percent secondary and 4.2 percent SLC and above.

Table 4.6 : Percentage Distribution of Respondents by Literacy Status by Age Groups

Age Group	Literacy Status				Total	
	Yes		No		No.	Percent
	No.	Percent	No.	Percent		
15-19	1	0.8	18	15.0	19	15.8
20-24	10	8.3	14	11.7	24	20.0
25-29	2	1.7	11	9.2	13	10.8
30-34	12	10.0	2	1.7	14	11.7
35-39	10	8.3	5	4.2	15	12.5
40-44	9	7.5	4	3.3	13	10.8
45-49	8	6.7	0	0.0	8	6.7
50-54	8	6.7	1	0.8	9	7.5
55-59	4	3.3	1	0.8	5	4.1
Total	64	53.3	56	46.7	120	100.0

Source: Field Survey, 2008.

Figure 4.2 : Percentage Distribution of Respondents by Literacy Status by Age Groups



From the above Table 4.6 shows that literacy and illiteracy rate of every age group e.g. total illiteracy percentage were 46.7 and literacy percentage were 53.4 were found.

4.1.7 Occupational Respondents

This variable has been categorized into different parts and holding situation of occupation by respondents in given table.

Table 4.7 : Percentage Distribution of Respondent by Occupation

Occupation	Respondents	
	Number	Percentage
Students	21	17.5
Farmer	10	8.3
Sewing	35	29.2
Making iron material	12	10.0
Making cooper material	1	0.8
Making gold material	1	0.8
Majduri (Portar)	40	33.3
Total	120	100.0

Source: Field Survey, 2008.

The above table shows that 17.5 percent are students, 8.33 percent respondent are farmer who works in agriculture field. 29.2 percent respondent sewing occupation in Khalante system. 10 percent making iron materials in Khalante system. 0.8 percent both copper and gold material respondent and 33.3 percent are porter or Kalapare or they go to India to search for job.

4.2 Household Characteristics of Respondents

4.2.1 Family Size

The family size impact on quality of life. There was tendency of joint and extend family in this society.

Table 4.8 : Percentage Distribution of Respondents by Family Size

Size of family	Number	Percent
Less than 5 person	28	23.3
5 to 10 person	69	57.5
Above 10 person	23	19.2
Total	120	100.0

Source: Field Survey, 2008.

The Table 4.7 shows that 28 respondent (23.3) percent less than 5 person, 69 person or respondent family size was 57.5 percent and 23 respondent percent was above 10 person were found.

4.2.2 Position of the Facilities

All the selected respondents for this purposive study were asked a question in order to know the various household facilities and distribution of facilities is given below.

Table 4.9 : Percentage Distribution of Respondents According to Facilities

Facilities	Have	Percent	Don't have	Percent	Total	Percent
Radio	65	54.2	55	45.8	120	100.0
T.V.	8	6.7	112	93.3	120	100.0

Source: Field Survey, 2008.

Above table shows that 45.8 percent respondent do not have radio only 54.2 percent respondent have Radio and 93.3 percent respondent have not T.V. and only 6.7 percent respondent had T.V. were found.

4.2.3 Fertile Land

The fertile land of study population were shown in table below :

Table 4.10 : Percentage Distribution of Respondent by Fertile Land

Fertile land	Number	Percent
Les than 2 ropani	58	48.3
2 to 5 ropani	50	41.7
5 to 10 ropani	9	7.5
Above 10 ropani	3	2.5
Total	120	100.0

Source: Field Survey, 2008.

This table shows that 48.5 percent respondent had less than two ropani fertile land. 41.7 percent respondent had 2 to 5 ropani. land. 7.5 respondent had 5 to 10 ropani land and 2.5 percent respondent and above 10 ropani land were found.

4.2.4 Sufficiency of Food

This question had been observed on the basis of occupation of household only those who had agriculture. This is indirectly related to household agriculture occupation. As per this question, it has been tried to examine sufficiency of food throughout the whole year. This situation is given below respondents by sufficiency of food.

Table 4.11 : Percentage Distribution of Respondents by Sufficiency of Food

Sufficiency of Food	Through the year	
	Number	Percent
Yes	12	10.0
No	108	90.0
Total	120	100.0

Source: Field Survey, 2008.

4.2.5 Monthly Income

The monthly income of the respondents parents or his/her had categorised is four group. They are below table was shown.

Table 4.12: Percentage Distribution of Respondents in Monthly Income

Monthly income	No. of respondents	Percent
Below 500	68	56.7
500 to 1000	26	21.7
1000 to 5000	20	16.7
5000 and above	6	5.0
Total	120	100.0

Source: Field Survey, 2008.

From the table we can found that below 500 income per month was 56.7 percent. 500 to 100 was 21.7 percent, 1000-5000 was 16.7 percent and above 5000 and above were 5 percent found.

CHAPTER - V

KNOWLEDGE, ATTITUDE AND BEHAVIOUR OF STIs AND HIV/AIDS

Analysis of the knowledge behaviour and attitude towards STIs and HIV/AIDS in the Dalit community are presented in this chapter.

5.1 Knowledge of STIs by Sex

The questions were asked if the respondents have heard about STIs or not.

Table 5.1: Percentage Distribution of the Respondents on Hearing of STIs According to Sex

Heard	Male		Female		Total	
	No.	Percent	No.	Percent	No.	Percent
Yes	42	61.8	18	34.6	60	50.0
No	26	38.2	34	65.4	60	50.0
Total	68	100.0	52	100.0	120	100.0

Source: Field Survey, 2008.

Table 5.1 shows that out of 120 (50%) had heard STIs and remaining (50%) had not heard it. In additional, 42 (61.8%) had heard other had not heard about it. However 18 (34.6%) females had heard and others had not heard about STIs. This information indicates that male had little high knowledge than their female counter part.

5.2 Heard of STIs by Marital Status

Martial status has taken as independent variables for this study.

Table 5.2: Percentage Distribution of the Respondents on Hearing of STIs According to Martial Status

Heard	Married		Unmarried		Total	
	No.	Percent	No.	Percent	No.	Percent
Yes	44	61.1	16	33.3	60	50.0
No	28	38.9	32	66.7	60	50.0
Total	72	100.0	48	100.0	120	100.0

Source: Field Survey, 2008.

The above table shows that above 61.1 percent respondent (married) heard about STIs and 38.9 did not heard about it and 33.3 percent unmarried respondent had heard about STIs and 66.7 percent unmarried respondent did not heard about it.

5.3 Knowledge about Types of STIs Percentage Distribution of all Respondents

Table 5.3: Knowledge about Types of STIs Percentage Distribution of all Respondents

Types of STIs	Number	Percent
Gonorrhea	20	16.7
Syphillis	65	54.2
HIV/AIDS	35	29.2

Source: Field Survey, 2008.

The above table shows that the HIV and syphilis is 54.2 and HIV/AIDS is 29.2 percent respondents. The 16.7 percent respondent heard Gonorrhea.

5.4 Source of Information about STIs

The respondents got information about STIs from following sources :

Table 5.4: Distribution of Respondents According to the sources of Information on STIs

Sources of information	Number	Percent
Teachers	20	20.2
Ratio	41	41.1
Friends	79	79.8
T.V.	5	5.1
Newspaper	4	4.0
Text books	11	11.1
Health personnel	25	25.3
Neighbour	7	7.1

Note : Total percentage may exceed 100 due to multiple response. Total percentage may exceed 100 due to multiple responses.
Source: Field Survey, 2008.

5.5 Knowledge on Symtoms of STIs

It is important to ask the symptoms STIs to evaluate the knowledge about it first of all respondents were asked whether they know about symptoms of STIs or not.

Table 5.5: Percentage Distribution of Respondents by Knowledge on Symptoms of STIs

Knowledge	Number	Percent
Yes	63	52.5
No	57	47.5
Total	120	100.0

Source: Field Survey, 2008.

According to the table 5.5 (52.5%) knew the symptoms of STIs were asked mention the symptoms. The table 5.5 shows the knowledge of different symptoms of STIs.

Table 5.6: Percentage Distribution of Respondents by Symptoms of STIs

Symptoms	Number	Percent
Sores/abrasion around vagina itching	50	71.4
Drop of pus from penis	23	32.8
Foul white discharge from vagina	39	55.7
Lower abolominal pain during inter course	19	27.5
Bleeding other than menstruation period	13	18.5

Note : Total percentage may exceed 100 due to multiple response.
Source: Field Survey, 2008.

According to table 5.6 respondents (71.4%) reported sores abrasion around vagina 1 tching followed of pus from penis (32.8%) lower abdominal pain during intercourse (27.1%) and bleeding other than menstruation period (18.5%) as the symptoms of STIs.

5.6 Knowledge on Transmission of STIs

Table 5.7: Percentage Distribution of Respondents by Knowledge on Mode of Transmission

Knowledge	Number	Percent
Yes	90	75.0
No	30	25.0
Total	120	100.0

Source: Field Survey, 2008.

In questionnaire, the question to assess the knowledge on transmission of STIs was included first of all respondents were asked to they know the mode of transmission of STIs or not according to above table 90 respondent (75.1%) knew the mode of transmission of STIs and only 30 respondents (25%) did not know of mode of transmission.

5.7 Prevention Measure of STIs

It is essential to check whether the respondents have knowledge on preventing measures of STIs or no. The question was included and result indicating acceptance of respondents for each measure is shown below.

Table 5.8: Percentage Distribution of Respondents by Preventive Measure of STIs

Preventive measure	Number	Percent
Use of condoms during sex intercourse	69	86.2
Sex with only one partner	61	76.2
Asstinence during infected period	39	48.7
Always clean own sexual organ	22	27.5
Avoid shoring foods, clothes, and toilet	21	26.2

Note : Total percentage may exceed 100 due to multiple response.
Source: Field Survey, 2008.

It is shown in table 5.7 that use of condom during sexual intercourse was the most preferned way of preventive from sexually, transmitted, infeltion, which had been reported by (86.2%), likewise, sex with only one partner was reported by (76.2%), sexual asstinece during infection period was (48.7%), clean own sexual organs was (27.5%) and avoid sharing food, clothes toilets was (26.6%) it has seen that there is also bad perception about preventive measure of STIs because they felt avoid of sharing foods clothes and toilets is a preventive measures of STIs.

5.8 Knowledge on HIV/AIDS

Question had been asked to the respondents whether they have knowledge about HIV/AIDS first of all very common question have you eve heard about HIV/AIDS is given in the questionnaire similarly other supporting questions such as difference between HIV and AIDS, prevention measures way of tranmitting, treatment are sured further to analyze.

5.9 Heard of HIV/AIDS by Sex

To know the knowledge of HIV/AIDS the question have you heard about HIV/AIDS asked to the respondents from the table 5.8 it shows that about the condition.

Table 5.9: Percentage Distribution of the Respondents about the Knowledge of HIV/AIDs by Sex

Heard	Male		Female		Total	
	No.	Percent	No.	Percent	No.	Percent
Yes	46	67.7	13	25.0	59	49.2
No	22	32.3	39	75.0	61	50.8
Total	68	100.0	52	100.0	120	100.0

Source: Field Survey, 2008.

According to the figure the male respondents were knowledge than female respondents which was 67.7 percent and 25 percent respectively.

5.10 Knowledge Different Between HIV and AIDS

It is important to ask it there is any different between HIV and AIDS or not the question was included in the questionnaire and the result is shown in the following table.

Table 5.10: Percentage Distribution of Respondents by Knowledge on different between HIV and AIDS by Sex

Difference	Number	Percent
Yes	17	14.2
No	15	12.5
Don’t known	88	73.3
Total	120	100.0

Source: Field Survey, 2008.

This table shows that actually HIV and AIDS are not different or not known. Mostly respondents where 73.3 percent respondents are unknown about different they says that is same.

5.11 Knowledge on Transmission of HIV/AIDS

In questionnaire, the question to assess the knowledge on transmission of HIV/AIDS was induced first of all respondent were asked weather they know the mode of transmission of HIV/AIDS or not.

Table 5.11: Percentage Distribution of the Respondents by Knowledge on HIV/AIDs and Sex

Knowledge	Male		Female		Total	
	No.	Percent	No.	Percent	No.	Percent
Yes	52	76.5	35	67.3	87	72.5
No	16	23.5	17	32.7	33	27.5
Total	68	100.0	52	100.0	120	100.0

Source: Field Survey, 2008.

From the table 5.10 out of 120 respondents having knowledge on HIV/AIDS transmission 72.5 percent. Only 27.5 had not know the mode of transmission. According to the sex, male respondents are more knowledgeable (76.5%) than female (67.3%).

5.12 Knowledge on Prevention Measures on HIV/AIDS by Sex

Table 5.12: Percentage Distribution of the Respondents by Knowledge of Preventive Measure of HIV/AIDs by Sex

Respondents	Male		Female		Total	
	No.	Percent	No.	Percent	No.	Percent
Yes	52	76.5	35	67.3	87	72.5
No	16	23.5	17	32.7	33	27.5
Total	68	100.0	52	100.0	120	100.0

Source: Field Survey, 2008.

From the table 5.12 it is clear that out of 120 respondents who were knowledgeable about preventive measures on HIV/AIDS 72.5 percent knowledgeable and 27.5 are unknown.

5.13 Attitude Behaviour Towards the Infected People

Dalit population is backward group of society if they are infected to the HIV (AIDS), their further life is based on behaviour of the society to them thus the question was asked to collect this information and the result is shown in the following table.

Table 5.13: Percentage Distribution of Respondents by their Attitudes Towards Infected Person

Attitudes	Number	Percent
We should love and respect them	19	15.8
We should hate them	88	73.4
Don't know	13	10.8
Total	120	100.0

Source: Field Survey, 2008.

According to the table 5.13 more than one fourth respondents that they should love and respect them also some respondent said that infected person should be hated in society (73.4) and (10.8%) respondent not to response about it. Only 15.8 percent respondent gave the idea about love and respect is necessary for them.

5.14 Information about Sexual Partner

At first to know the information about sexual partners of respondents, do you have sexual partner was asked to both married and unmarried respondents. The information has been got according the following table.

Table 5.14: Distribution of the Respondents having Sexual Partner (Outside marital union for married respondents) by Married Status

Sexual partners	Married		Unmarried		Total	
	No.	Percent	No.	Percent	No.	Percent
Yes	37	51.4	25	52.1	62	51.7
No	35	48.6	23	47.9	58	48.3
Total	72	100.0	48	100.0	120	100.0

Source: Field Survey, 2008.

According to table 5.14 (51.7%) had premarital sexual partner and 58 (48.3%) respondent had no premarital sexual partner. This figure show that there was also prevalence of the premarital sex. This may cause high risk of infection of STIs and HIV/AIDS. The respondents who have sexual partner were also asked question about sexual partner and the result is shown in the following table.

Table 5.15: Distribution of the Respondents by their Sexual Partner

Sexual	Married		Unmarried		Total	
	No.	Percent	No.	Percent	No.	Percent
Partner Wife/husband	23	62.0	-	-	23	37.1
Friends	2	5.4	12	48	14	22.6
Prostitute	7	19.0	7	28	14	22.6
Relative neighbours	5	13.5	6	24	11	17.7
Total	37	100.0	25	100.0	62	100.0

Source: Field Survey, 2008.

From table 5.15, 23 (37.1%) respondents have their own sexual union (husband and wife) and 14 (22.6%) respondent took part sexual intercourse with the friends. 14 (22.6%) are took parts in prostitute and 11 (17.7%) took part with relatives neighbours.

5.15 Information about Contraceptive Use

The aim is to know whether respondent use contraceptive or not while intercourse with their sexual partners. Thus question was asked about contraceptive use is result in shown in the following table.

Table 5.16: Distribution of Respondents by having Sexual Partner use Contraception

Contraceptive user	Number	Percent
Yes	37	59.7
No	25	40.3
Total	62	100.0

Source: Field Survey, 2008.

Out of table 62 respondents having sexual partner. Only 37 respondents (59.7%) had use contraceptive when sexual intercourse on contrary 25 respondents (40.3%) had not use any contraceptive in the sexual intercourse.

Table 5.17: Distribution of Respondents According to Types of Contraceptive

Types of contraceptive	Number	Percent
Condom	7	21.9
Injection (Depo-provera)	20	62.5
Piles	4	12.5
Foam tablets	1	3.1
Out drowril	-	-
Total	32	100.00

Source: Field Survey, 2008.

According to table 5.17 out of total 32 contraceptive users, 7 respondents 21.9 percent, had use condom while the contraceptive injection which was used by 20 respondents and piles users were 4 person (12.5), only one respondent (3.1) used foam tab.

5.16 Purpose of Contraceptive Use

The use of contraceptive is mainly for two purpose one is family planning and anther is preventing from STIs and HIV/AIDS (mainly condom) the table.

Table 5.18: Purpose of Contraceptive use among the Respondents

Purpose	Married		Unmarried		Total	
	No.	Percent	No.	Percent	No.	Percent
For family planning	20	62.5	17	81.0	3	62.5
For protecting from STIs & HIV/AIDS	12	37.5	4	19.0	8	37.5
Total	32	100.0	21	100.0	11	100.0

Source: Field Survey, 2008.

According to the table 5.18 out of total 32 contraceptive users, 20 respondents (62.5%) used contraceptive for family planning purpose while a respondents (37.5%), use contractive for protecting from STIs and HIV/AIDS. According to the marital status, 81 percent of married respondents used contraceptive for family planning and 19 percent used for protecting from STIs and HIV/AIDS. Among unmarried respondents about 63 percent used contraceptive for family planning purpose and others (37.5%) used contraceptive for protecting STIs HIV/AIDS.

Reason on for not using contraceptive

Respondents who have sexual partner but they do not use contraceptive while intercourse were asked for the reason for not using contraceptive and result is shown in table 5.19.

Table 5.19: Percentage Distribution of Respondents According to Reason for not using Contraceptives

Reasons	Number	Percent
No information about method	9	18
Purpose of child bearing	9	18
No necessary	8	16
Tedious	6	12
Can't get pleasure	5	10
Not available everywhere	4	8
Rarely occurs	3	6
Misinformation	2	4
Shyness to buy	2	4
Don’t know the methods for using	2	4
Total	50	100.0

Source: Field Survey, 2008.

According to table 5.19 the total respondents who did not use contraceptive were 50 out of total respondents, 9 respondents (18%) did not use contraceptive because they did not get information about different contractive. Also 9 respondents (18%) did not use contraceptive for the purpose of child bearing, 8 respondents (16%) felt no necessary for using contraceptive and 6 respondents (12%) felt tedious for use followed by 5 respondents (10%) said could not get pleasure, 4 respondents (8%) said not available any where 2 respondents (4%) do not use because they feels shyness to buy and 2 respondents (4%) did not know the methods for using. So they did not use contraceptive.

CHAPTER - VI

SUMMARY, CONCLUSION AND RECOMMENDATIONS

This is the study of knowledge, attitude and behaviour of STIs and HIV/AIDS in Dalit community of Banfikot VDCC Rukum district. This study is based on primary data and total 120 respondents were taken as sample size selected with purposive sampling male and female 15- 49 to 15-59 years population interviewed for this research in Banfkot takura Banfikot Dang, Kanda, Sharpu, Bhagle Nepane, Simtaru, Badagaun where Kami, Damai, Sunuwar, Gaine, Tamrakar are lived in Banfikot VDC Rukum.

6.1 Summary

6.1.1 Individual Characteristics

- The majority of respondents at (20-24) age group are about (20%) and minority of respondents at 45-49 for both sex and for males cases is (55-59) years age group where 6.7 and 4.2 respectively.
- The highest no of respondent are males (56.7%), 68 and females 43.3 percent (52).
- Respondents are Damai, Kami, Sharki, Sunuwar, Tamrakar, Gaine whose percentage are given 48.5, 46.7, 1.7, 2.5, 1.7 and 1.7 respectively.
- All of the respondents 100 percent are Hindu and Nepali languages.
- The majority of respondents are married (60%).

6.1.2 Household Characteristics

- The family size of respondent is large. There is only 23.3 percent respondent having less than 5 person. 57.5 percent respondents having 5 to 10 person, 19.2 percent respondents having above 10 person (Extended or Joint).

- Large proportion of respondents have radio (54.2%) and 6.7 percent having T.V. facilities.

- Must of the respondents have not fertile land. The majority of land had less than two popai abut 48.3 percent respondent and poor monthly income less than 500 (five hundred per month) 56.7 percent respondent.

- Main occupation sewing and iron making but tradisnal system which is 29.2 percent and 10 percent respectively.

- Educational level of respondent is very poor 53.3 percent are illiterate.

- 90 percent respondents have not sufficient food provide.

6.1.3 Knowledge, Attitudes and Behaviours about STIs and HIV/AIDS

I. Knowledge and Attitude about STIS

- Most of the respondents 61.8 percent male and 34.6 percent female have heard about STIs.

- Married respondents are more knowledgeable about STIs 61.1 percent than unmarried respondents (33.63%).

- Most of respondent heard about syphilis and HIV/AIDS 41.7 percent both and 16.6 percent gonorrhea.

- About 52.5 percent respondent have knowledge about symptoms of STIs.

- Among the knowledgeable respondents about symptoms of STIs majority of respondents 71.4 percent scores, abrasion around vagina itching, foul white discharge from vagina 55.7 percent.

- Drop of pus from pens 32.8 percent.

- Lower addominal pain during intercourse 27.5 percent, Bleeding other than merstrution period 18.5 percent of STIs.

- Majority of respondents 86.2 percent said that use of condom during sexual intercourse is the main preventive measures of STIs also 76.2 percent respondent said sex with only one partner is preventive measures. Similarly 48.7 percent respondents abstinence during infected period and 26.2 percent respondents said to avoid sharing of foods, cloths and toilet is the preventive measures of STIs.

6.1.4 Knowledge and Attitudes about HIV/AIDS

- Majority of respondents 72.5 percent heard about HIV/AIDS out of total 120 respondents.

- Male respondents are knowledgeable 76.5 and 67.3 are female respondents, about HIV/AIDS.

- About 14.2 percent respondents said that the HIV/AIDS are difference, which is very low, 73.3 percent respondents said that both are same.

- Respondents having knowledge about 76.5 percent respondents had males and 67.3 were females in total 72.5 having knowledge and 27.5 have not knowledge.

Attitude and Behaviour Towards Infected People

- About 15.8 percent respondents love and respect them and 73.4 percent said that the infected people should be hated in the society and 10.8 percent said that they did not know what to do them.

- About 37.0 percent have their own sexual union, 22.6 percent respondents sexual partner were friend and followed by 22.6 percent prostitute and 17.7 are followed neighbours.

- About 57.7 respondents use contraceptive in sexual intercourse and 40.3 percent did not use any contraceptive in sexual intercourse.

- About 21.9 percent respondents use condom, 62.5 percent deporovera and 12.5 percent use pills.

- About 62.5 percent respondent use contraceptive for family planning purpose and 37.5 percent for protecting from STIs and HIV/AIDS.

6.2 Conclusion

- Respondent's sex, age group, educational level and occupation and traditional culture affect the knowledge and attitude of STIs and HIV/AIDS.

- The communication facilities play important role for knowledge and attitude on STIs and HIV/AIDS.

- The female level of knowledge and attitude towards STIs and HIV/AIDS are poor than males.

- It seems educational status play the vital role for knowledge attitude STIs and HIV/AIDS when the educational status is high there is also high level of knowledge but the educational level is lower the level of knowledge seems also low.

- It seems no any program is implemented in the about STIs and HIV/AIDS.

- Economic status is seems poor which reflect to the low level of education and communication and information.

- Some respondents have misperception to the HIV infected people.

- Some respondents have STIs but they do not respond openly which type of them.

- Most of the respondents know about STIs and HIV/AIDS but they have also confusion about symptoms, mode of transfusion preventive measure about HIV/AIDS.

6.3 Recommendations

- Appropriate health personal with basic training related to pubic health with the specific knowledge of reproductive health is better to be managed.

- GO, NGO and INGO co-operatively provide training concerning the public health and reproductive health areas to the concerned people in the community and mechanism of monitoring should be developed and for remedial improvement timely follow up is to be also managed.

- Dalit (Damai, Kami, Sarki, Gaine, Sunuwar, Tamraka) population of the community is more poor to health related hazards and risk factors as well as they need practical health education that is quite relevant to their necessity effective formal and non-formal education program have to be implemented.

- It should be special program like as peer education, sex education and other cultural education on Dalit community.

6.4 Recommendation for Further Research Issues

- This study is based on Dalit community, the comparative study can done Damai, Kami, Sharki, Sunuwar, Tamrakar, Gaine.

- This is the study of knowledge attitude and behaviour of Dalit community of Banfikot VDC, Rukum.

- Further study can be carried out in order specific community and specific age group as well.

- This study is based on only few parameters with socio-economic and demographic variables using other variable like social, cultural religious, psychological geographical and other many variables which might be useful to evaluate the knowledge and other aspects in this area can be done other similar studies.

REFERENCES

Acharya, L.B. (1999). *Knowledge of HIV/AIDS Case of Married Female of Age 15-19 in Nepal.* In Bal Kumar K.C. (ed.) Population and Development in Nepal.

Acharya, Sunil (2005), "The HIV/AIDS Situation in Nepal", *Population Magazine,* Vol. III, pp. 25-33.

Aryal, R.H. (2000), "HIV/AIDS: An Emerging Issue in the Health Sector with Special Reference to Nepal", in Bal Kumar K.C. (ed.), *Population and Development in Nepal,* Vol. 7, pp. 89-110 (Kathmandu: CDPS).

CBS (1995). *Population Monograph of Nepal.* (Kathmandu: Central Department of Statistics).

CBS (2003). *Population Monograph of Nepal.* (Kathmandu: Central Department of Statistics).

Dahal, M. (2006). *Knowledge, Attitude and Practice on STIs and HIV/AIDS among Youth Student: A Case Study of Manthali VDC of Ramechhap District.* Unpublished M.A. Dissertation Submitted to Central Department of Population Studies (Kathmandu: CDPS).

Khanal, Sharawan K. (2005), *Knowledge and Attitude Towards on STIs and HIV/AIDS Among Higher Secondary School Students,* Unpublished M.A. Dissertation Submitted to the Central Department of Population Studies (Kathmandu: CDPS).

Ministry of Health and Population (2007). *Nepal Population Report* (Kathmandu : MOPH).

Ministry of Health and Population (MOHP) (2006). *Nepal Demographic and Health Survey* (Kathmandu : New Era, MOPH).

MOH, New Era & ORC Macro (2001), *Demographic Health Survey* (DHS), 2001 (Kathmandu: New Era).

MOHP, New Era, Macro Intl. (2007), "HIV/AIDS Related Knowledge, Attitude, and Behaviours", *Nepal Demographic and Health Survey, 2006* (Kathmandu: MOHP/New ERA/ORG Macro Intl.).

Narain, J.D. (2003) (ed.), *AIDS in Asia,* (Regional Office for South East Asia: WHO).

National Centre for AIDS and STD Control (2008). *Cumulative HIV/AIDS Situation of Nepal as of March 13, 2008.* Kathmandu Department of Health Service.

NCASC (2005), *Data, National Public Health Laboratory* (Kathmandu: NCASC).

NCASC (2005), *The Situation of HIV throughout the Country* (Kathmandu: NCASC).

NCASC (2006), *National Strategic Plan for HIV/AIDS, 2002-2006* (Kathmandu: NCASC).

NDC (2005), *Dalit in Nepal,* (Kathmandu: NDC).

NDC (2005), *Dalit in Nepal,* Vol. I (Kathmandu: NDC).

New Era (2003), *A Review of Literature on HIV/AIDS and STIs Respect to Female Sex Workers in Nepal* (Kathmandu: New Era).

Pathak, R.S. (2002), "Why Family Planning Matters in Saving Women's Life: The Nepalese Evidence", in Ram Hari Aryal (ed.), *Nepal Population Journal,* Vol. 10(9), pp. 19-28 (Kathmandu: PAN).

Population Reference Bureau (PRB) (2006), "The Global Challenges of HIV/AIDS", *Population Bulletin,* Vol. 6, No. 1, pp. 1-3.

Population Reference Bureau (PRB) (2006), *The Global Challenges of HIV and AIDS,* Vol. 61 (1) (Washington DC: PRB).

PRB (2002), "Young Adults, Facing the HIV/AIDS Pandemic", *Population Bulletin,* Vol. 57, No. 3, pp. 8-9.

Shrestha, M. (2006). "Situation of HIV/AIDS and Treatment". *Tuki Magazine.* No. 74, Year 24, pp. 3-4.

The Synergy Project (1999), *Nepal and HIV/AIDS*, Prepared by TVT Associates (Kathmandu: The Senergy Project).

The World Bank (2006), *HIV/AIDs in Nepal* (Kathmandu: The World Bank).

The World Book Encyclopedia (1996), *International,* Volume 1, No. A, (London Sydney the Bridge wells Chicago).

UN (1989), "World Health Organization Global Program on AIDS", *AIDS Prevention Through Health Promotion* (New York: UN), p. 5.

UN (2001), "HIV/AIDS in the Caribbean Issues and Opinions", *The Global HIV/AIDS Epidemic* (New York: UN), p. XV.

UN (2005), *Committing to Result: Improving the Effectiveness of HIV/AIDS Assistance* (New York: UN), pp. 5-7.

UN/WHO (1991), *The AIDS Epidemic and its Demographic Consequences* (New York: United Nations/World Health Organization).

UNAIDS (2002), *The HIV AIDS/STD Situation and the National Reponse in Nepal,* Country Profile (Kathmandu: UNAIDS).

UNAIDS/Nepal (2004), *The HIV/AIDS Situation and the National Responsive in Nepal* (Kathmandu: UNAIDS).

UNDP (2004), *Development, Spatial Mobility and HIV/AIDS* (Kathmandu: UNDP).

UNFPA (1997), *AIDS Update 1997* (New York: UNFPA).

UNFPA (2001), *A Force for Change: Young People and HIV/AIDS in South Asia* (Kathmandu: UNICEF).

UNFPA (2001), *Adolescent Reproductive Health in South Asia: Key Issues and Priorities for Action* (New York: UNFPA).

UNFPA (2003), "Overview of Adolescents", *State of World Population* (Kathmandu: UNFPA), p. 1.

UNFPA (2003), *State of World Population* (Kathmandu: UNFPA).

UNFPA (2005), *State of World Population* (Kathmandu: UNFPA).

UNFPA (2006), *Policy and Programming for HIV/AIDS and Reproductive Health of Young People in South Asia* (Kathmandu: UNFPA).