

CHAPTER-I

INTRODUCTION

1.1 General Background

Nepal is the mountainous and landlocked country situated in south-central Asia. It extends about 800 km from east to west and about 190 km from north to south. The country extends from 26° 22' N to 30° 27' N in latitude and from 80° 4' E to 88° 12'E in longitude. It covers an area of 1; 47,181 sq km. Nepal is divided into three major physiographic zones viz: Himalaya, Mid-Hill and Terai. Different regions are dominantly inhabited by the people of different ethnic groups and castes.

Nepal is rich in socio-cultural and traditional landscape such as multi culture, multi-caste, multi- religious, etc. From the Vedic period Hindu religion divided people into different Varna system i.e. Brahmin, Chhetri, Vaishay and Sudras. Those categorized at the bottom of this Hindu social organization, system have been designed at “Untouchable” or *Dalits*, despite thirty years having past since the ratification of the international convention on the Elimination of all form of Racial Discrimination (ICERED) half of the countries have passed the resolution since a declaration of the “universal human right” the *Dalits* in this sub-continent has not achieved social justice. Nepali law has declared castes discrimination a crime, but those who would implement those laws they themselves practices the untouchables. However, on the other hand, deeply rooted ingrained sense of inferiority within Dalits has been difficult to eradicate among them, Dalits practices untouchables argue and fracture their own unity (Kisan, 2005).

Caste system is the basic foundation of the Hindu society. The formation of Nepal as hegemonic state in mid-eighteen country was to create Hindu heave against Muslim Menace from Mugal India .The Muliki Ain (Civil Law) of 1954 was return version such social code derived from the manusmriti tradition. The classical Varna (order) model had for occupational category (1) Brahman Priest (2) Kshatrya warrier (3)Vaisya Farmer/Trader&(4) Sudra Laborers. In Malla period, the untouchable (Paninachalne tatha Chhuna-nahune) Sudra was kept on the outside of the city (Gurung, 2006).

More than hundreds caste/ethnicity live in Nepal. According to National Dalit Commission (NDC), there are 22 cultural groups within the Dalits. Unidentified caste/ethnicity is also the notable number 231,641(1.02%) of national population where, Dalits caste/ethnicity group might also be included (NDC, 2005).

Acquired Immune Deficiency Syndrome (AIDS) was first recognized internationally in 1981. As of 2006, an estimated 40 million adults and children around the world were living with human immunodeficiency virus (HIV) and AIDS (Lamptey et al., 2006). AIDS is cause by HIV and once infected with virus, a large proportion of those infected die within 5-10 years. Epidemiological studies have identified sexual intercourse, intravenous, blood transfusions, and fetal transmission from infected mothers as the main routes of transmission of HIV. HIV cannot be transmitted through food, water, insect vectors or causal contact (NDHS, 2006).

1.1.1 What is HIV?

The human immunodeficiency virus (HIV) attacks the body's immune system. A healthy immune system provides a natural defense against disease and infection. If the immune system is damaged by HIV, it increases the risk of developing a serious infection or disease, such as cancer.

HIV infects particular cells, called CD4 cells that are found in the blood. CD4 cells are responsible for fighting infection. After they become infected, the CD4 cells are destroyed by HIV. Although the body will attempt to produce more CD4 cells, their numbers will eventually decline and the immune system will stop working.

1.1.2 How is HIV Spread?

HIV is spread through the exchange of bodily fluids. This most commonly happens during unprotected sexual contact, such as vaginal, oral and anal sex. People who inject illegal drugs and share needles are also at risk of catching HIV. The condition can also be spread from a \mother to her unborn child.

There is no cure for HIV and no vaccine to stop you becoming infected. However, since the 1990s, treatments have been developed that enable most people with HIV to stay well and live relatively normal lives.

1.1.3 What is AIDS?

AIDS, acquired immune deficiency syndrome, is a term used to describe the late stage of HIV. This is when the immune system has stopped working and the person develops a life-threatening condition, such as pneumonia (infection of the lungs).

The term AIDS was first used by doctors when the exact nature of HIV was not fully understood. However, the term is no longer widely used because it is too general to describe the many different conditions that can affect somebody with HIV. Specialists now prefer to use the terms advanced or late-stage HIV infection (NHS, 2010).

Population of the present world is facing a serious problem created by the pandemic called Acquired Immune Deficiency Syndrome (AIDS). AIDS has emerged as a burning issue all over the world and many attempts have been made to control the problems. It has become a global phenomenon which is considered to be known by all health but conscious and general people today (Acharya 2001). The first cases of AIDS were recognized in the United States of America in 1981. The causative organism of AIDS i.e. HIV/AIDS was identified in 1983 (Adhikari and Adhikari, 2002/03).

Since HIV/AIDS first emerged globally, the role of behavior change has been recognized as critical to the control of the pandemic. The phrase “**education is the only vaccine against AIDS**” was commonly aired during the early years to control the epidemic (Liskin et. al., 1989). Considerable efforts and energy were devoted to implementing communication programs to educate people about HIV/AIDS transmission mode and prevention strategies. The underlying assumption of these early activities was that improving people’s knowledge about the infection and disease would lead to avoidance of risky behaviors.

HIV/AIDS is also an area of great concern. The target is to have halted and begun to reverse the spread of the epidemic by 2015. Overall, however, the prevalence among those aged 15-49 in the average Asian country rose from 0.39 to 0.45 percent. As of 2004, the Asia-Pacific region has over 9 million people living with HIV/AIDS and each year half a million people die.

The highest prevalence among adults aged 15-49 are all in South-East Asia; Cambodia 2.6 percent, Thailand, 1.5 percent and Myanmar, 1.2 percent though the first two of those have already achieved their MDG targets, since they have reduced the prevalence. The highest numbers of infected people, however, are to be found in India and the Russian Federation, where the prevalence is rising, china has kept the prevalence fairly stable, so can be considered “On track”.

Every year, there are over half a million deaths from malaria worldwide and over a quarter of a million deaths from HIV/AIDS that are related to environment and occupational causes. Targeted environmental interventions could reduce the impact of major diseases such as these and help to achieve the MDG. Environmental interventions could also reduce the number of deaths from diarrhea and lower respiratory infections by over three million each year. With the exception of HIV/AIDS all of these diseases affect children in large numbers and even HIV/AIDS can have a major indirect impact on the health of children. (WHO, 2006 Preventing disease through healthy environment)

1.1.4 Mode of Transmission

A person can get infected with HIV/AIDS through following ways:

1 .Unprotected Sex: If a person engages in sexual intercourse with an infected person without using a condom, he/she can get infected. The sexual act can cause infection by both vaginal and oral. Theoretically, oral sex without condom (on men) or barriers like dental dam, vaginal dams or plastic wrap (on women) can also transmit the infection.

2. Sharing of needles: If a person shares the needles or syringe used by an infected person, either for injecting drugs or drawing blood or for any other purpose involving piercing and tattooing also carry a small risk of infection.

3. Unsafe Blood: A person can get the infection, if he/she is given transfusion of infected blood.

4. Improperly sterilized Hospital Tools: If surgical devices like syringes and scalpels or even certain instruments, used on an infected person, are used on another person without proper sterilization they can transmit the infection.

5. Mother to child: An HIV/AIDS positive mother can transmit the virus to child during pregnancy or birth. Breast feeding can also act as a transmission medium

1.1.5 Symptoms of HIV/AIDS:

- Lack of energy.
- Weight loss
- Long lasting bouts of diarrhea
- Swelling or hardening of glands located in throat, armpit or groin.
- Frequent fever and sweat.
- Periods of continued, deep, dry coughing.
- Increasing shortness of breath.
- Recurring or unusual skin rashes.
- Rapid loss of more than 10 pounds of weight that is not due to increased physical exercise or dieting.
- Severe or recurring vaginal yeast infections.
- An altered state of consciousness, personality change or mental deterioration etc.(Jha Ashok Kumar 2004)

1.1.6 Prevention & treatment against HIV/AIDS

In this third decade of the epidemic, there is still neither a cure nor vaccine for AIDS. Life prolonging drugs have become more affordable and accessible yet treatment is still largely unavailable to most people who need it in developing countries.

As HIV/AIDS continue to spread, prevention remains the backbone of programs to curb the epidemic for the foreseeable future. However, there is a need for more comprehensive

programs that encompass prevention & treatment. Comprehensive prevention programs for people living with HIV/AIDS include.

- General education about the risk of sexual transmission.
- Counseling and testing for HIV/AIDS
- Preventing mother to child transmission.
- Needle exchange programs, and
- Reducing the stigma attached to HIV/AIDS.

According to the information, education, and communication (IEC) model, “clear information presented in an appropriate format and language would persuade those at risk to protect themselves from the virus” (UNFPA, 2001).

Lower socio-economic status (SES) people, defined partly by educational level, have little or no knowledge about public affairs issues, are disconnected from news events and important new discoveries, and usually aren't concerned about their lack of knowledge.

Adolescents in Nepal covers almost one fourth (23.26%) of the total population CBS (2003). Current estimated HIV/AIDS infection rate of 0.5% prevalence of the adult population between the age cohorts of 15-19 of the total reported HIV/AIDS infections, NCASC data reveals that male comprise 73% and female only 27%. Young people (20-29) make the highest suffering group from HIV/AIDS.

The word adolescence has been derived by the WHO as the period of life spanning the ages between 10 to 19 years. Adolescence is the period of transition from childhood to adulthood.

The health of adolescent is the outcome of several factors such as socio-economic status, environment in which they live and grow, good guidance from families and communities and opportunities for education and employment. Therefore the world health assembly passed a special resolution in May 1989 to highlight the health of young people. And furthermore, the International Conference on Population and Development (ICPD) in Cairo in 1994 also emphasized the special need of adolescent and youth.

Adolescent, especially those aged 15-19 years are believed to engage in high level of unprotected sexual activities both within and outside marriage living them exposed to risk of unplanned unwanted pregnancy and contracting sexually transmitted disease.

UNFPA ,UNICEF and WHO defined "Adolescents "as the population aged 10-19 .The age of adolescents divided two periods' early adolescents & late adolescents. Adolescents aged 10-14 is known as early adolescents & 15-19 age groups as late adolescents. Adolescents are the second decade of life& it is a period of rapid development. Moreover, it is time when growth is accelerated major physical changes take place & difference between boys & girls are accentuated (WHO, 1998). Late adolescent is period of physical, psychological and social maturing from childhood to adulthood. These are the formative years when the maximum physical ,psychological and preparation for undertaking greater responsibility, a time of exploration, widening horizons and a time of ensured healthy, all round development can be felt.

Nepal is a multi ethnic nation. More than hundreds caste/ethnicity live in Nepal. According to National Dalit Commission (NDC), there are 22 cultural groups within the Dalits. Unidentified caste/ethnicity is also the notable number 231,641(1.02%) of national population. Where Dalits caste/ethnicity group might also be included (NDC, 2005).

1.2 Objectives of the study

The main objective is to examine the knowledge and attitude about HIV/AIDS among late adolescent in Dalit community of Hemja VDC, Kaski.

The specific objectives are:

- To describe the Socio-Economic and demographic characteristics,
- To study the knowledge on HIV/AIDS among late adolescent and
- To identify and assess the attitude on HIV/AIDS of late adolescent.

1.3 Significance of the study

This study was next in the series but fundamentally different because of the adolescents was divided 14-19 years in the selected study area. Therefore, this study gives new dimension&

attempts to provide the information about the knowledge & attitude on HIV/AIDS in Dalit community among adolescents of Hemja VDC of Kaski district. The findings of the study will be useful for planners & policy makers to develop & improve the knowledge & attitude on HIV/AIDS among late adolescent of Dalit community, when they are well known about HIV/AIDS, they can easily cope with their problem which is created by unprotected sexual intercourse.

Dalit community has great responsibility for developing the society in future. Dalits are vulnerable and they have high risk of increasing and transmitting HIV/AIDS due to lack of awareness and education. That is why, the research study will help to know that knowledge and attitude of Dalits regarding HIV/AIDS. Moreover there are not been conducted any studies regarding knowledge and attitude of HIV/AIDS in Hemja VDC. This study will be the first study in that community. This study will also help to know the prevention as well as transmission knowledge of HIV/AIDS of Dalit and this research has great significance for policy makers and planners.

Previous studies about Dalit's knowledge and attitude of HIV/AIDS are not done. Again such study is the first study in Dalit community. So, it is expected that this study would provide specific information of Dalit peoples' Knowledge and attitude on HIV/AIDS. This will be helpful to formulate policy and program in related field of district and Nepal.

Especially, this study is based on late adolescents in Dalit community, it has more significant about the level of knowledge about HIV/AIDS among Dalit people, which are known as the backward people recently. Thus this study has more significance as it will be generalized all the Dalit people throughout the kingdom.

This study also provides & will be beneficial for development of long term strategy on HIV/AIDS preventions. As it is not enough, the government has adopted policy to control HIV/AIDS through formal and informal education, street drama and adolescence education. This research also makes attempts to play an important role to find out necessity of the sex, STIs with HIV/AIDS prevention education and awareness programme at community level.

1.4 Limitation of the study:

Basically, this study is the academic study. This study attempts to analyze the knowledge & attitude on HIV/AIDS among late adolescents of Dalit community in Hemja VDC, Kaski.

The limitations of this study are:-

- This study is limited to adolescents of age 14-19 years only.
- This study is limited to sample size of 140 respondents; therefore the findings may not generalize to the adolescents of the whole nation.
- This study has been limited only in the subject of their knowledge & attitude on HIV/AIDS.

CHAPTER-II

LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK

Literature review is one of the most important aspects of any research; any study is not possible without literature review. It is a kind of tools which provide a proper guidelines and idea to the researchers in many studies.

2.1 Theoretical Literature Review

Acquired Immune Deficiency Syndrome; AIDS, was first reported in 1981 in United States of America. The causative organism of AIDS, Human Immune Deficiency Virus (HIV) was identifying in 1983. The pandemic nature and magnitude of public health problems associated with Human Immune Deficiency Virus (HIV) infection were recognized of much later when the proportion of person infected with HIV rose very rapidly. As the impact of HIV/AIDS seems to very serious in a long term aspect, the HIV virus does not respect geographical boundaries so no country of the global is immune to HIV/AIDS (Aryal, 2000:89-110).

Condoms, used properly and consistency are one of the leading methods of protection against HIV infection. Condom use as an effective means of protection against HIV/AIDS has been promoted in many parts of the world. (United Nations, 2002)

Scientists have identified two types of this virus; HIV-1 is the primary cause of AIDS worldwide, HIV-2 is found mostly in West Africa. HIV enters in the blood, it infections C4 lymphocyte, white blood cells of the immune system. The virus commands destroy the genetic materials of the host cell, instructing the cell to replicate more viruses. The newly formed viruses break free from the host, destroying the cell in the process. The new viruses get on to infected and destroy other C4 Lymphocyte (WHO, 2003).

The disease that spread from one person to another person mainly through sexual contact during unprotected intercourse is known as sexually transmitted diseases. HIV/AIDS can be transmitted by other routes also. In fact, multiple sexual contacts may lead serious health problem and causes viruses vulnerable diseases. Some time, these diseases are also transmissible though transfusion of infected blood, contaminated needles and from infected mother to her baby during pregnancy childbirths or breastfeeding. HIV/AIDS have greater impact on human sexuality and morbidity. The largely affect external and internal sexual

organs and cause various complications such as infertility, cervical cancer, miscarriage, still birth entopic pregnancy etc. (UNAIDS, 2003)

During the three months to six months "window period" a HIV/AIDS injected person's tests would report a false negative and could give the HIV infected person a false sense of security which would result in his/her continuing to injected others. The only way to prevent HIV is to prevent behavior which would make a person vulnerable and which would expose him/her to the risk of HIV/AIDS infection. The practices of "safe sex" though the use of condoms could reduce the risk of HIV/AIDS infection considerably. Use of disposable needles and syringes and ensuring the supply of infection free blood and blood products are other measures needed for reducing the risk of HIV/AIDS infection. A woman infected with needs to seriously consider the risk of infecting her before deciding to go for a pregnancy. (Bhende and kantikar, 2004)

Brown (2004) wrote about HIV in Asia in this article HIV epidemics in Asia. He uncovered great diversity, both in severity and timing. Several factors affect the rate and magnitude of growth of HIV prevalence, but two of the most important are the size of the sex worker population and the frequency with which commercial sex occurs. In view of the present state of knowledge, even countries with low prevalence of infection might still have epidemics affecting a small percentage of the population.

According to Hindu religion, one has to purify with gold treated water if s/he touches a Shudra. Similarly a utensil has to be purified with a burning charcoal if it is used by an untouchable. House of the so called upper caste person has to be purified by chanting mantras of Rudri (a religious practice often performed to free the people of higher caste from evil spirits, which clearly indicates that untouchable enters the house (Hemchuri, 1995).

Dalit is defined as the different cast group which are economically exploited, socially disadvantaged, politically marginalized away from education and kept back in religious and untouchable ethnic community (INSEC 2053 B.S. in NDS, 2003). The INSEC further reported major four types of Dalits viz: Kami, Damai,Sarki and Gaine, and Badi.

According to Human Development Report 2006, due to the poor socio-economic conditions, Dalits are often subjected to exploitative labor practices like the Haliya system. Such duress from poverty made them migrate in search of work. Such relocation for work isolates them from home for long duration increased risk to HIV/AIDS due to high risk behavior.

2.2 Empirical Literature Review

Half of the world population are under the age of 25. This includes the largest ever generation of adolescents who are approaching adulthood in a rapidly changing world. A common threat, runs through all of their lives: the aspiration for a better future. This aspiration is bolstered by a Millennium Development Goals (MDGs) agreed to by world leaders in 2000. Investment in young people is fundamental to achieving those goals (UNFPA, 2003)

In Nepal, the main government agency responsible for HIV/AIDS and STD control is the National Centre for AIDS and STD control (NCASC) under the Ministry of Health and Population. The NCASC launched a HIV/AIDS/ control strategic plan (1997-2001) in 1997. However, these short and medium term plans and strategic plans had no clear-cut objectives and programs for HIV/AIDS control and national level. The HIV/AIDS prevention and control programs were loosely nitrated with the PH package. To make up for the shortfalls of past plans and strategies, the government formulated a Comprehensive National HIV/AIDS strategy in 2002, trusted the National AIDS Council chaired by the prime minister, to political commitment (National HIV/AIDS Action Plan 2005-2006).

The National Strategic Plan, 1997 clearly indicates government Commitment to mobilize and involve various ministries during December 1997, the ministry of health, ministry of education and ministry of women and social welfare signed a tripartite joint statement for HIV/AIDS education for school age children, both in and out of school (National HIV/AIDS Action plan 2005-2006)

2.2.1 Global Situation of HIV/AIDS

The development of the problem of HIV/AIDS is new phenomenon, which emerged into the last decade and within short span of time it become a serious global problem. It is reported that at the first phase HIV spread especially among gays, male bi-sexual and narcotic addicts and at the second phase most of it spread through heterosexual intercourse and the number of infected men and women were equal, at third phase the spreading expanded to Asia pacific's East and Middle East. The prevention of HIV infection is one of the goals for Healthy People

2010, but access to culturally appropriate intervention approaches could limit progress toward this goal (USDHHS, 2000).

In developing countries, HIV/AIDS threatens decades of development because it attacks people in their most productive years, destroys communities, disrupts food production, and places heavy burden on the already weak health services. AIDS is the leading cause of death among women ages 15 to 44, claiming 27,000 lives in 2005 (UNAIDS/WHO, 2006). As in most places in the world, in the Nepal, young people are engaging in sexual behaviors at earlier ages and with minimal knowledge and much misconception about HIV/AIDS and other sexually transmitted diseases. Sexual activity during adolescence, especially when it is initiated at a young age, raises concerns about the acquisition of sexually transmitted disease including HIV/AIDS and greater exposure to pregnancy and associated morbidity (Blum et al., 2003)

HIV transmission through sexual intercourse accounts for about three quarters of all HIV infections world-wide. More than 80 percent of HIV infections transmitted through sexual intercourse. In other words HIV infection is sexually transmitted disease (UNAIDS, 2001).

According to the UNAIDS in 2003, as estimated 4.8 million people (range 4.2 to 6.3 million) became newly infected with HIV. This is more than in any one year before. Some 37.8 million people (range 34.6 to 43.3 million) are living with HIV, which killed in 2003, and over 20 million since the first case of AIDS were identified in 1981 (UNAIDS 2004).

UNAIDS and the WHO have estimated that approximate 40 million people living with HIV/AIDS infection is far more common in the world than previously. Among them 2.5 million are children under 15 and 37 million are adults. About 5 million were infected with HIV in 2003 alone of this 700,000 are children under the age of 15 years. In 2003 total 3 million people died of HIV/AIDS. Among them 2.5 million were adults and 500,000 were children. (UNAIDS/WHO, 2004).

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 (range: from 15.1 to 20 million) women 2.3 million (range: from 1.7 to 3.5 million) children, were living with HIV/AIDS. More ever, 4.3 million (range: 3.6 to 6.6 million) people were newly infected by HIV/AIDS. Out of this figure 3.8 million (range 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 6, 000 people are in immediate need of life saving AIDS drug: of these, only 1.65 million are receiving the drugs (UNAIDS/WHO, 2006).

The AIDS epidemic update of 2007 has shown a decrease in global HIV prevalence and it is reported that the seroprevalence of HIV has been leveling off in many countries and is decreasing in Sub- Saharan Africa. After 25 years later since its discovery in 1981, 40.3 million people worldwide are living with HIV and 3.1 million people died by AIDS and is capable of “hollowing out” the very core of a society, destroying the often most economically productive age group (25 - 45 years). High risk groups within South Asian countries are showing evidence of dangerously high prevalence rates of HIV in the ranges of 60-70 percent. South-East Asia region has the second largest no of people living with HIV/AIDS, next only to Sub-Sahara Africa (JNHRC, 2008).

According to the UNAIDS/WHO the latest statistics of the global HIV/AIDS epidemic estimates that 33.3 million (range from 31.4 to 35.3 million) people living with HIV/AIDS infection is far more common in the world than previously. Among 33.3 million HIV/AIDS infected persons 2.5 million (range from 1.6 to 3.4 million) are children under 15 and 30.8 million (range from 29.2 to 32.6 million) adults are living with HIV/AIDS in 2009, and 15.9 million (range from 14. 8 to 17.2 million) women living with HIV/AIDS. In 2009 among infected 33.3 million people, 1.8 million (range from 1.6 to 2.1 million) people were died of AIDS. Moreover, 2.6 million (range from 2.3 to 2.8 million) people newly infected with HIV in 2009 Similarly 2.2 million (range from 2.0 to 2-4 million) adults newly infected with HIV in 2009.

Orphan children due to AIDS in 2009 (under 18 years old) 16.6 million (range) from 14.4 to 18.8 million). Worldwide at the end of 2009, women accounts for just over half of all adults living with HIV.

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 that 22.5 million people were living with HIV/AIDS at the end of 2009 (UNAIDS, 2009) with around 68 percent of all people living with HIV/AIDS. Asia has remained relatively stable and is still largely concentrated among high-risk groups. The number of people living with HIV in Eastern Europe and Central Asia has almost tripled since 2000.

2.2.1. HIV/AIDS Situation in SAARC Countries:

The HIV/AIDS epidemic is relatively recent in South Asia. The first case was identified in India in 1986. This means that the endemic was introduced in the region later than other parts of the world. The infection rates in south Asia are lower than Africa but the spread of HIV is rapid (Aryal, 2000).

South Asia has one of the fastest growing epidemics in the world. Since its entry into region every country has been new infection. In South Asia almost 7400000 people are living with HIV where 990000 people were newly infected in 2005. HIV prevalence is also raising rapid in many parts of the South Asia. People living with HIV/AIDS in Pakistan, Bangladesh and Srilanka was estimated to be 56000, 7500 and 4700 respectively. People living with HIV/AIDS in 2003 increased to 85000, 11000 and 5000 in 2005 respectively (UNAIDS, 2003 & 2005).

As previously mentioned, the SAARC region has the highest number of PLWHIV after Sub-Saharan Africa. At first glance, the Scenario appears to be that of a low infection epidemic. However, there are wide ranging variations from country to country in terms of magnitude of the epidemic and mode of transmission. There is solid evidence of concentrated epidemics among vulnerable population and localized epidemics on general population.

One of the most devastating consequences of the HIV/AIDS epidemic is the growing number of orphaned children and those left vulnerable by disease and death of caregivers and family members. It is already estimated that over 1.3 million children have lost one or both parents from AIDS-related deaths in SAARC countries. With HIV prevalence still rising in south Asian countries and the stage of high rates of AIDS related deaths yet to come, the real impact on children will only be felt deeply in the coming years.

Families and communities in south Asia are already doing their best to cope with relatively large numbers of orphans, due not only to AIDS related infections but through other factors including high levels of maternal mortality. The future increase in numbers of maternal, paternal and double orphans due to AIDS related deaths will continue to place enormous stress on already weak and overburdened family and community safety nets, unless systems to strengthen capacities over the long term are rapidly developed. It is essential that countries start to develop strategies action plans to address this growing concern.

Bangladesh is a country with a low HIV prevalence but high vulnerability. The estimated number of HIV positive cases was approximately 7500. Bangladesh has documented the lowest condom use, very high number of clients of sex workers, low knowledge of HIV/AIDS. In Bhutan the total reported cases at the end of 2004 were 72 and heterosexual behavior was found to be the primary mode of transmission. Bhutan has still a low epidemic country.

India with 1.027 billion people, 28 percent of who live in urban areas has an HIV/AIDS infection rate estimated to be 0.8 percent of the adult population. Although the prevalence rate can be interpreted to mean that India is not a high prevalence country. In 2003, it was estimated that 5.1 million adults were infected with HIV. In Maldives the estimated number of PLWHIV is less than 100 and the prevalence among the adult population is <0.1 percent. The reported HIV and AIDS cases as of December 2003 were 1.2.

In Nepal the estimated number of PLWHIV (people living with HIV) at the end of 2003 was 61,000 with an estimated prevalence of 0.5 percent. The cumulative number of reported HIV positive (including AIDS) cases as of August 2004 was 4,164. In Pakistan at the end of 2004, the estimated number of PLWHIV was 74,000 with an estimated prevalence of 0.1 percent. The reported number of HIV positive (including AIDS) cases as of June 2004 was 2,462. Srilanka is considered as a low prevalence but highly vulnerable country. At the end of 2003, the estimated number of PLWHIV was 3,500. As June 2004, the number of reported HIV positive (including AIDS) cases was 552.

2.2.2. HIV/AIDS Situation in Nepal:

The first case of AIDS in Nepal was reported in 1988. AS of December 2007, National Centre for AIDS and STD control (NCASC) has officially confirmed 10546 HIV positive cases and 1610 confirmed cases of AIDS in Nepal.

The issues related to HIV and AIDS in Nepal are still in the stage of denial because of socio-cultural norms, stigma, discrimination and the lack of a strong commitment from the Government. Similarly the Government has to deal with other challenges such as the Maoist conflict and political instability, which has sidelined the issues of HIV and AIDS. Many development activities including efforts to control the HIV and AIDS epidemic have been sidelined with security taking up the Government's priority.

Other challenge faced by the Government in this area is the lack of committed leadership and capacity to coordinate on a sector-wide level. As we have learnt from the experiences of countries such as Uganda, a strong and committed leadership in the Government sector is essential to fight against HIV and AIDS epidemic. Despite regular denial and ignorance from authorities and the general public about its seriousness, it has become an open fact that HIV and AIDS is rapidly emerging as a major public health and social problem and is likely to be a leading cause of death in Nepal in the coming years. Factors like poverty, low levels of education, denial, gender inequality, stigma, and discrimination have intensified Nepal's vulnerability to HIV and AIDS. The ongoing conflict due to Maoist insurgency, political instability and the lack of education and awareness about HIV and AIDS are all factors that have fuelled the spread of the HIV and AIDS epidemic in Nepal.

The lack of existing economic opportunities and the risk of being forced to enlist into Maoist army have caused mass migration into Indian border towns and internal migration into urban cities. Due to the lack of awareness and separation from the family for an extended period, the migratory population is at great risk of being infected with HIV and AIDS by being involved in different risk behavior. Recent data suggests a generalized epidemic among the large numbers migratory workers that cross the border with India and high prevalence rates of HIV infection in the wife's of infected migratory workers.

The latest Government data at August 2004 shows that 4164 people are HIV positive and out of that 808 people have reached on the stage of AIDS (NCASC Report, June 2004). Contrary to this Government report, UNAIDS reports shows that more than 60,000 people are currently living with HIV and AIDS in Nepal (UNAIDS report 2004).

AIDS entered in Nepal through the prostitutes either women or girls who were involved in prostitution in Mumbai and other cities of India. They are generally supposed to come back to home, which help HIV/AIDS to spread in Nepal (Acharya 1998). It is argued that India is turned into the epicenter of HIV/AIDS and this is creating a threat to Nepal because of open boarder with India.

NCASC (2010) reported that proportion of women 15-49 living with HIV was 28.6 percent and average number of AIDS deaths per year was around 4,701, while the average number of new infections per year was 4,760 and per day 13. Heterosexual transmission is the key route of spreading HIV in Nepal. About 90 percent infections are transmitted through sexual

transmission. Injecting drug users, female sex workers and their clients are the key drivers of the epidemic.

The HIV epidemic in Nepal has evolved from a “low prevalence” to a “Concentrated epidemic”. As of 2008, national estimates indicate that 69,790 adults and children are infected with HIV/AIDS in Nepal, with an estimated prevalence of about 0.49% in adult population (15-49 years old). As of December 2009, only 14,320 cases of HIV and 1,755 AIDS cases had been reported to the national center for AIDS and STD control (NCASC). The male to female sex ratio is 2.9:1. Despite rapid increase of voluntary counseling and training and other service outlets, of the national estimate only 20 % were identified as HIV positive (USGASS, 2010). Table 1 shows the cumulative HIV/AIDS reported cases. Further, figure 1 shows the same by age group and sex.

Table No.2. 1:- Reported HIV/AIDS Cases

	Male	Female	Total
Cumulative total HIV infections reported	10,569	5,693	16,262

Source: NCASC, 2010.

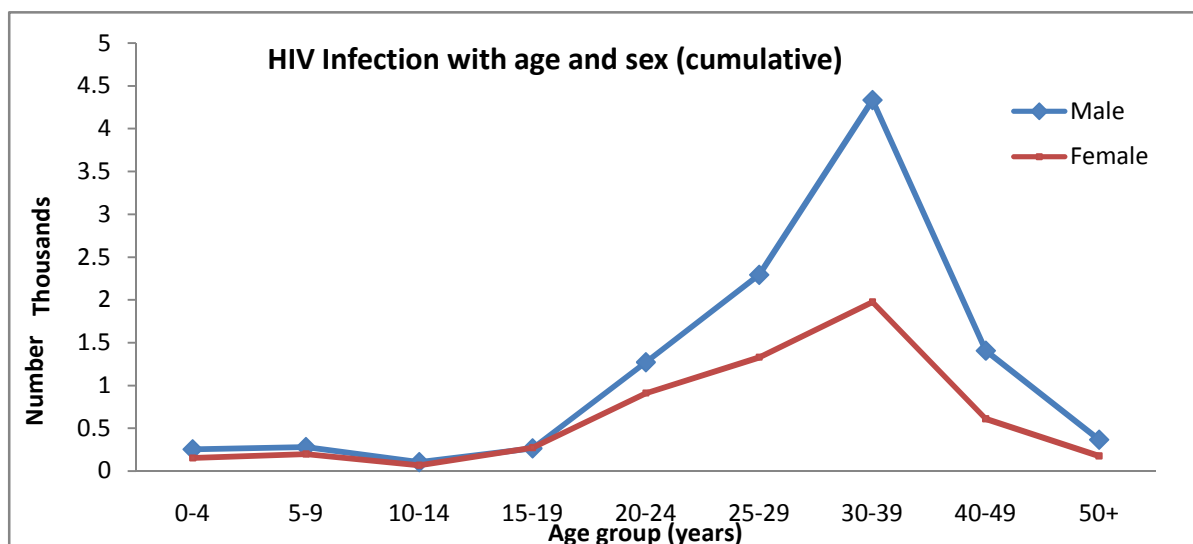


Figure 1: Cumulative HIV infection with age and sex

Table 2 depicted that clients of sex workers are seriously infected constituting total of 7215 number which is about 44 % of total reported infection. This is followed by house wives (26%) and drug users (16%). However, very few numbers (only 84) did not revealed any sub-group causing HIV infection. In short, males are more vulnerable to infections compared to females.

Table No.2. 2: Cumulative HIV infection by sub group and sex

Sub group	Male	Female	Total
Sex workers (SWs)	7	866	873
Injecting drug users	2,559	58	2,617*
Men who have sex with men (MSM)	151	NA	151
Blood or organ recipients	35	14	49
Clients of SWs/STDs	7,111	104	7,215
House wives	NA	4,209	4,209
Male Partners	27	NA	27**
Children	624	413	1,037
sub group not identified	55	29	84
Total	10,569	5693	16,262

Source: NCASC, 2010.* Mode of Transmission- IDUs or sexual ** Male partners of FSW/Female IDU/Female migration NA= Not Applicable

2.2.4 National policy HIV/AIDS of Nepal:

The history of Nepal's response against HIV/AIDS begins with the launching of first national AIDS prevention and control programme in 1988. Several organizations including government NGOs and INGOs are currently working for the prevention and control of HIV/AIDS in Nepal. The activities among others include outreach communication and advocacy programmes to people in general and the vulnerable groups in particular, cross border initiatives targeted at the migrant workers making condoms accessible through retail outlets and others outlets promoting their use. Providing rehabilitation and counseling to the sex workers, capacity building of health for STD and HIV/AIDS care, conducting regular sentinel surveillance, providing clinical services and programmes aimed at raising the quality of and increasing accessibility of STDs treatment and HIV care services (New era, 2003 and MOH, 2002).

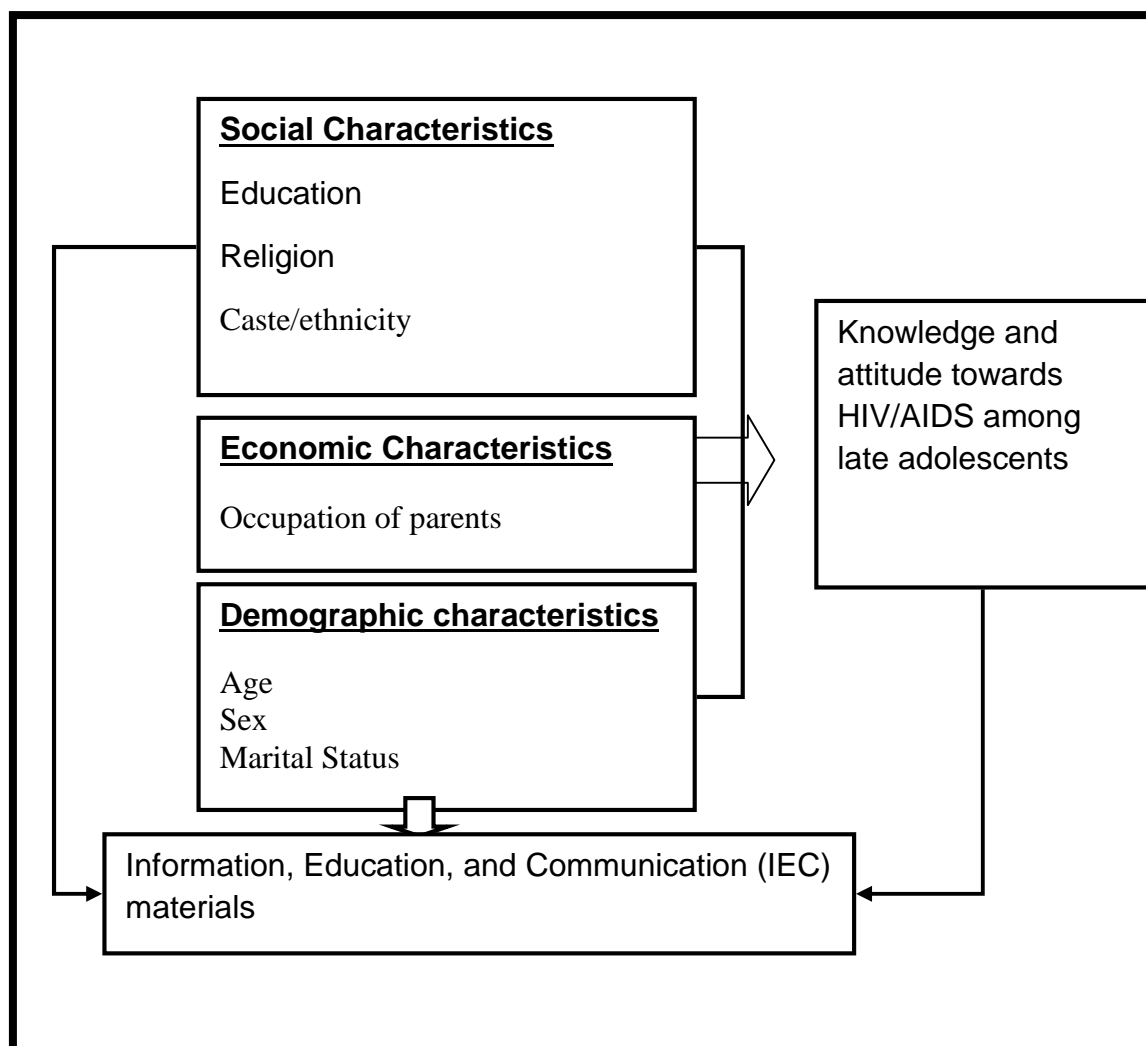
2.2.5 HIV Surveillance Activities in Nepal 2010

- Nepal's priority in HIV/AIDS surveillance is strengthening of the second generation surveillance system.
- National centre for AIDS and STD control (NCASC) receives HIV/AIDS and STI case report from HIV testing and counseling site.
- Regular integrated biological and behavioral survey (IBBS) among high risk groups.
- Routine programme data special studies such as Nepal demographic health surveys.
- Researchers (including operational researcher) size estimation of most at risk population (MARPs)
- HIV infections estimations and projections are being done in every two year.
- Producing impact data from modeling (spectrum).
- NCASC is leading the HIV surveillance activities in Nepal, in technical collaboration with family health international (FHI) and World Health Organization (WHO).

2.3 Conceptual Framework of the Study

In this research, the conceptual framework to explain the socio-economic as well as demographic variables with knowledge and attitude of late adolescents towards HIV/AIDS. So as to make a concept whether there exist any impact in relation to adolescent's prevalent knowledge and attitude on HIV/AIDS.

Figure Schematic flow diagram of conceptual framework of research



It is conceptualized that the respondents' age, sex, and education may affect the knowledge and attitude towards HIV/AIDS. It is further made an attempt to Show that parental

background characteristics such as education caste/ ethnicity, occupation income, determine the knowledge and attitudes towards HIV/AIDS of adolescents children. Government policy adolescents to bring changes on them regarding their sexually and alerting them on HIV/AIDS through IEC Material and orientation also plays a vital role in determining knowledge and attitude on HIV/AIDS of the adolescent.

CHAPTER-III

RESEARCH METHODOLOGY

Methodology is the main parts of the study following methods were used to conduct this study. This study mainly focus on the HIV/AIDS among Dalit community in the settlement Nagtole, Kamitole and Hanuman chowk of Hemja VDC of Kaski district.

3.1 Nature and sources of Data

Mainly primary data was used in this study. Primary data was collected conducting field study through structured interviews and schedule questionnaire and reference secondary data from various sources such as Journals, periodicals, profile reports of Village Development Committee and related books were used.

3.2 Selection of the study area

This research is the case study of Dalit community in Hemja VDC which was situated in Kaski District of Gandaki Zone of Nepal. It lies in North West part of the District. Various Dalit people live in Hemja VDC such as Bishwakarma, Napali, Gandarva etc. In this community Dalit child leave their school education at the primary level because they had been engaged in different activities for their livelihood sustenance. Hence course of primary education doesn't include about AIDS and other related to STDs. Therefore, within the broad framework of Information, Education and Communication model this research aims at whether IEC criteria differ in knowledge and attitude towards in the area where early marriage practice is common being important reason of rapid spread of HIV/AIDS, in generic terms STDs.

The study area was selected based on the discussion with district based HIV/AIDS related stakeholders like, District public health, kaski, Nepal CRS, Pairabi, Paluwa, Hemja public health office. Whatsoever, academic discussion with research advisors and research investigator was duly considered for easy execution of work and probable implication of research work.

3.3 Introduction to the study Area

The local key- informant persons have reported that 'Hanhjha' was named after the term 'Yahimaja'. According to Janardan Sharan Tripathi (Master in Sanskrit, culture and History), the great Nepali poet and linguist, and historian says that, people from Bhot (Mustang/Dolpa) used came and settle for the business purpose. They enjoyed living here so they settle in this place. After that it was known as Yahimaja, later in the course of time it turned to "Hemja". Whereas Adhikari (2006), reported that, "Hangjha was named after the Tibetan word, where

Hang' means flatland due to river and Jha' means settlement. He further reported that king of Kaskikot, Kulmandal Shah had come to perform his customary rules in the Seti Gandaki River of Hangjha, during that time he enjoyed a lot of bath in the river, then named was changed as Hemja by him.

Later on the name Hangja was renamed as Hemja. According to Mukunda Sharan Upadhaya, the great Nepali poet, in Sanskrit Hem' means jewels and Ja' means land. So the etymological meaning of Hemja is very fertile land which can produce gems and gold.

1.1.7 3.3.1 Geographical Location

This study covers the different settlement of Hemja VDC Hemja is taken as an advanced village in terms of physical facilities, population and agriculture production. It is situated to the north west of the zonal headquarter Pokhara a sub-metropolis, in Kaski district of Gandaki zone.

Hemja VDC is located within 28°24'-28°30' north latitude and 83°58'-84°00' east longitudes. The study site is plain which is known as Hemja Bensi. It has fertile agriculture land which is surrounded by the rivers in its three sides. To its southeast there is Yamdi River and to northeast it is border by Seti River, they meet at Yamdi to the border of Pokhara. It is border by Lamachaur and Simpani; part of Pokhara sub-metropolitan city in east, Dhital, Dhampus and Dhikurpokhari VDC in the west, Puranchaur and Lahhachowk VDCs in the north and Sarangkot and Kaskikot VDC in the south.

Pokhara-Baglung highway passes from the middle of the VDC which is a major infrastructure of the study area. The highway links almost all wards of the village. It has promoted the access of the study area to the urban area (especially Pokhara) and enhanced opportunities to extend business within and outside the village for the local people.

1.1.8 3.3.2 Social Organization

This VDC consist of 15 education institute out of this one is a private campus, one government higher secondary school, two government secondary schools and two private secondary schools and nine primary schools (VDC Profile, 2003). The developing social organization working in the village include VDC office, health post, Micro-credit and co-operatives, NGOs (e.g. MSDO, YIC etc) and different youth clubs and a drug rehabilitation

and consultancy center; this is established by INF Pokhara. Beside these government and non-governmental organizations there are lots of mothers groups, forest user groups and other community based organizations.

3.3.3 Economic condition

Generally, the main source of economy in the study area is agricultural activities. Most of the people of this study site are small or large farmer. Rice, Maize, Millet, Wheat, Barley, Potato etc are the main crops of this area. Similarly, fruits (i.e. orange, guava, banana, lemon etc) and vegetables are produce in the massive scale. Vegetables and fruits are normally sold to Pokhara and some time outside Pokhara as well such as Kathmandu and Narayangardh. Here is lack of industrial development. Farmers are producing agricultural products based on the traditional/indigenous knowledge and skills. They also have access to get new technology and information from the government and non-government extension workers.

3.4 Sample Design

This study was based on both explanatory and descriptive research design. The questionnaire was designed to obtain information about household and knowledge and attitude about HIV/AIDS of late adolescent in Dalit community. The descriptive design was made to describe the socio-economic condition and the major problem associated with them.

3.5 Sample size

Altogether 68 households were selected. Among them 140 respondents were chosen of age group 14-19 years from Dalit community. This is because even in 1 household more than two respondent's .Among those 73 were males and 67 females.

3.6 Method of sample selection

The research study was adopted purposive sampling technique to collect data from the study site. Districts and the study site was selected which is familiar for me. Similarly Dalit community of Hemja VDC was also selected and the eligible respondents i.e. adolescents of age group 14-19 was interviewed.

3.7 Questionnaire design

Structured questionnaire is the main tools of the study. Language and structured questionnaire was checked thoroughly so as to make simple and clear. Questionnaire was developed in English but will be asked in Nepali. The questionnaire was divided into following:

-) Household questionnaire,
-) Individual questionnaire,
-) Respondent's Knowledge about HIV/AIDS questionnaire.
-) Respondent's attitude about HIV/AIDS

For this thesis the researcher developed the questionnaire. The questionnaire includes household questionnaire, individual questionnaire, and respondent's knowledge about HIV/AIDS questionnaire and respondent's attitude about HIV/AIDS. For the household questionnaire, it includes Name of locality, Household no, Name of the household head, Name of the respondents; etc. Individual questionnaire includes their religion, age, household income, total numbers of family, marital status etc. Respondent's knowledge about HIV/AIDS questionnaire and attitude about HIV/AIDS questionnaire includes their opinion about HIV/AIDS (Annex -I).

3.8 Method of Data collection

The study was based on primary data; therefore required information for this study was taken by conceptualizing the pretested questions prepared by United Nations Kosovo Team, 2008 (Knowledge, Attitude, Practices and Behavior Study on HIV/AIDS with Young People in Kosovo) in which the questions related to HIV/AIDS knowledge and attitude.

3.9 Data analysis Techniques

The collected data were edited and analyzed with the help of computer using programs such as SPSS; Cross tables were used for presenting the data about knowledge and attitude on HIV/AIDS. The data had been analyzed by clear language for the further clarification.

3.10 Problem of Fieldwork

During the fieldwork, the researcher faced few problems. It was a time of Dashain and Tihar, so it became difficult to meet the respondents in their house as they were busy preparing for

the festivals. So it took long time to visit and revisit them. They were not ready to answer the questions as they told they get nothing from that they were quite busy.

CHAPTER- IV

BACKGROUND CHARACTERISTICS OF THE RESPONDENTS

This chapter reflects the socio-economic and demographic characteristics of the respondents. Socio economic background provide information about caste/ethnicity, religion, education, occupation, income and demographic characteristics provide information about sex and age, family type and size, marital status of the respondents.

4.1 Socio-economic and demographic characteristics of the population

4.1.1 Distribution of the population by age and sex:

The collected data shows that majority of the study population 79.9 percentages range between 15-59 years out of 81.2 percent were of males and 78.9 percent were females and the second is of the age group between 0-4 years 15.4 percent that include the 13.2 percent male and 15.4 percent females. Similarly, the lowest percent of the study population 4.5 percent were from the age group between 60 and above.

Table No. 4.1 Distribution of population by age and sex

Age Group	Sex				Total		Sex Ratio (Male: Female)
	Male		Female				
	Number	Percent	Number	Percent	Number	Percent	
0-14	23	13.1	31	17.7	54	15.4	1:1.35
15-59	142	81.1	138	78.9	280	80.0	1:0.98
60 & +	10	5.8	6	3.4	16	4.6	1:0.60
Total	175	100.0	175	100.0	350	100.0	1:1

Source: Field Survey, 2010.

The table 4.1 presents the general information about the percentage distribution of the study population by age and sex. The largest percent of the study population (80 percent) is from the age group of 15-59, which has been followed by the age group of 0-14 (15.4 percent) and the least from the age group of 60 and above (4.6 percent).

4.1.2 Population distribution by marital status

Marital status is another important variable which affects the knowledge and attitude towards HIV/AIDS. Table shows that more than half (52.8 percent) people are unmarried, out of which 54.5 percent are male and 51.1 percent are female. Similarly 41.0 percent people are married, whereas 41.3 percent are male and 40.8 are female. It shows that there is the prevalence of early marriage practice among females.

Table No.4.2 Distribution of Population five years and above by marital status

Marital Status	Sex				Total	
	Male		Female		Number	Percent
	Number	Percent	Number	Percent		
Married	69	41.3	71	40.8	140	41.0
Unmarried	91	54.5	89	51.1	180	52.8
Divorced	0	0.0	4	2.3	4	1.2
Separated	2	1.2	2	1.2	4	1.2
Widow/Widower	5	3.0	8	4.6	13	3.8
Total	167	100.0	174	100.0	341	100.0
Source: Field Survey, 2010						

4.1.3 Population distribution by education status

Educational attainment of the people (children and their parent's education) is one of the important socio-economic factors which can play vital role for the level of their children on HIV/AIDS.

Table No.4.3 Distribution of Population by educational status

	Sex	Total
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Educational Status	Male		Female		Number	Percent
	Number	Percent	Number	Percent		
Illiterate	23	24.7	78	60.0	101	45.3
Literate	70	40.70	52	40.0	122	54.7
Total	93	100.0	130	100.0	223	100.0
Educational attainment						
Primary pass	43	54.5	28	71.8	71	60.1
Secondary Pass	25	31.6	9	23.1	34	28.8
SLC and above	11	13.9	2	5.1	13	11.1
Total	79	100.0	39	100.0	118	100.0

Source: Field Survey, 2010.

Only 11.1 percent of the study population obtained SLC and above, out of which 13.9 are percent male and 5.1 percent are female. 45.3 percent of study population is illiterate and 54.7 percent were able to read and write. Similarly 60.1 percent of study population is primary pass and 28.8 percent people were secondary pass in study population. The analysis of above table shows that percent of the study population's education SLC and above SLC is very low. Maximum level of education to this group is limited to intermediate level. None of the people were found of studying in bachelor level. Due to free educational policy of government, people have been concentrating in primary level. But it was found that they could not continue their studies further to the higher level because of poor economic condition and social burdens. Thus, the percent of higher level is lower than primary level. Nowadays, Dalit people are aware and knew the value of education and send their children to school for education.

4.1.4 Distribution of population by caste/ethnicity

Demographically represent mixed caste/ethnic society. The study site has dominated by Brahmin (61 percent), followed by Chhetri (22 %) and then by the Dalits (17 %). Dalits are found to be the most deprived community group in the research site (Hemja Village Profile, 2003).

Ethnicity represents the difference of the population, which is a cultural factor. The cast and ethnicity of study population were shown in the table below. The selected community is Dalit community so that the selected populations are Damai, Kami, Sarki and Gandarva ethnicity.

Table No. 3.4 Distribution of population by caste/ethnicity

Caste/ethnicity	Number	Percent
Damai	76	21.7
Sarki	89	25.4
Kami	130	37.2
Gandarva	55	15.7
Total	350	100.0

Source: Field Survey, 2010.

Table 4 shows that majority of the study populations are from Sarki (37.2 percent) followed by Kami (25.4 percent), Damai (21.7 percent) and Gandarva (15.7 percent) respectively.

4.1.5 Distribution of population by occupational status

Occupation of people can also be taken as an important variable that determines the social economic status of the household and also affects the knowledge and attitude of their children on HIV/AIDS.

Table No.4.5 Distribution of Population by occupational status

Occupation	Sex				Total	
	Male		Female		Number	Percent
	Number	Percent	Number	Percent		
Agriculture	41	23.9	88	52.0	129	37.8
Services	4	2.3	1	0.6	5	1.5
Business	19	11.0	20	11.8	39	11.5
Foreign Employment	37	21.5	1	0.6	38	11.1
Students	71	41.3	59	35.0	130	38.1
Total	172	100.0	169	100.0	341	100.0

Source: Field Survey, 2010.

Table 5 clearly demonstrates that 38.12 percent people are in students. Whereas, only 41.3 percent male and 35.0 percent female were engaged in education sector in total. The percent is followed by agriculture (37.8 percent), business (11.5 percent) and foreign employment (11.1 percent). Only 1.5 percent people involved in services sector. The collected data clearly defines that agriculture is the main source of income of the Dalits (study population) and much of the Dalit people are involved in education sector.

4.2 Characteristics of the Adolescent

This section presents the demographic characteristics of the respondents. In the demographic characteristics, Age-sex composition family size /type and marital status have been included.

4.2.1 Distribution of the respondents by age and sex

Age and sex composition plays an important role in determining the population distribution of the study area. Thus, an attempt was made to obtain information on the age structure of late adolescents among Dalit community. During the interview the respondents were asked to state their completed age

The respondents of age group 14-19 were selected. In demographic analysis age and sex both are pillar of demographic study although sex is personal characteristics of person, information on sex can be normally be obtained without difficulty. The age sex composition of population has significant implication for the field of demographic analysis.

Table No.4.4 Distribution of Respondents by Age and sex

Age Group	Sex				Total	
	Male		Female		Number	Percent
	Number	Percent	Number	Percent		
14	11	15.1	11	16.4	22	15.7
15	11	15.1	8	11.9	19	13.5
16	9	12.3	12	17.9	21	15.0
17	13	17.8	12	17.9	25	17.9
18	9	12.3	4	6.0	13	9.3
19	20	27.4	20	29.9	40	28.6
Total	73	100.0	67	100.0	140	100.0

Source: Field Survey, 2010.

The collected data shows that majority of the respondents' 28.6 percent of 19 years among selected age group out of which 27.4 percent were of males and 29.9 percent were females and the second is of the age group 17 years i.e. 17.8 percent that include the 17.8 percent male and 17.9 percent females. Similarly, the lowest percent of the respondents 9.3 percent were from the age group of 18.

4.2.2 Distribution of the respondents by family type and size

Family size plays on vital role for determining the population change and has the impact on quality of life. Household size of the respondents ranged from 2 to maximum of 7+ members. It is generally believed that larger the family size, lower would be gain the knowledge about HIV/AIDS.

Table No 4. 5: Distribution of respondents by family type

Types of family	Number	Percent
Nuclear	96	68.6
Extended	44	31.4
Total	140	100.0

Source: Field Survey, 2010.

As the above table clearly states that 68.6 percent of the surveyed household had nuclear family pattern whereas, 31.4 percent of them had extended family.

The family size of Respondents is categorized into three types, viz. small family, middle family, and large family. In this study, the small family means the family having 1-4 members. Middle family indicates the family having 5-6 members and the large family means the family having more than 6 members. The percentage distribution for family size is given the table 8.

Table No .4. 6 Distribution of respondents by family size

Size of Family	Number	Percent
Less than 5 members	37	26.4
5 to 6 members	85	60.7
7 and above members	18	12.9
Total	140	100.0

Source: Field Survey, 2010.

The above table shows that, 60.7 percent of the household fall under middle size family (5 to 6 members) and the household of small family (less than 5)are 26.43 percent and large family (7 and above) is 12.9 percent. So the table shows that fewer households had larger family members and large number of families had small size.

4.2.3 Distribution of the respondents by caste/ethnicity

People from diversified background were found residing harmoniously. Hemja VDC is dominated by Brahmin, chhetry, followed by Newar respectively. In total respondents of 140,

highest number of population was observed for Kami (58.5 percent), followed by Sarki (24.2 percent), Gandarva (9.3 percent) and Damai, (7.8 percent) respectively. In total, the number of male was observed slightly higher than female population.

Table No. 4. 7 Distribution of respondents by caste/ethnicity

Caste/ethnicity	Sex				Total	
	Male		Female			
	Number	Percent	Number	Percent	Number	Percent
Damai	4	5.5	7	10.4	11	7.8
Kami	40	54.8	42	62.7	82	58.5
Sarki	22	30.1	12	18.0	34	24.2
Gandarva	7	9.6	6	8.9	13	9.3
Total	73	100.0	67	100.0	140	100.0

Source: Field Survey, 2010.

4.2.4 Distribution of the respondents by religion

Nepal is a multilingual, multicultural country. Religion of respondents is also one factor that may influence the knowledge about HIV/AIDS. In Hindu religion sex before marriage is not allowed and is seen as social taboo but values of every religion are not same. So it influences the human behavior. In this study all respondents of Dalit community followed Hindu religion.

4.2.5 Distribution of the respondents by marital status

Marital status represents one of the variables of the demographic status. Marital status of the respondents can be considered as of the key factors for knowledge and attitudes of HIV/AIDS.

Table No.4. 8 Distribution of Respondents by Marital Status

Marital status	Sex		Total
	Male	Female	

	Number	Percent	Number	Percent	Number	Percent
Married	3	4.1	8	11.9	11	7.9
Unmarried	70	95.9	59	88.1	129	92.1
Total	73	100.0	67	100.0	140	100.0

Source: Field Survey, 2010.

There were total 140 eligible respondents for this purpose. Out of them 11 were married and 129 were unmarried. This situation shows that the traditional concept of early marriage is still functioning to some extent in Dalit community. So that there was few number of married females than males because of females are already married and went their brome house.

4.2.6 Distribution of the respondents by living with

This variable has been categorized into different divisions, such as: Parents, on your own, Close family, something else in this study. And the majority of the respondents reported they living with their parents.

Table No. 4. 9 Distribution of respondents by living with

Respondents living with	Number	Percent
Parents	133	95.0
Relatives	6	4.3
Friends	1	0.7
Total	140	100.0

Source: Field Survey, 2010.

The table11 shows that out of 140 households almost of all (95.0 percent) respondents are living with their parents and 4.3 percent living with on their relatives. Similarly 0.7 percent respondents living with others.

4.2.7 Distribution of the respondents by monthly household income

In the context of Nepal most of the adolescent population are considered to be economically active but school going adolescents are economically inactive. Income is the variable which is the most important to find out the economic status of the respondents, and it is very different to determine their economic status during this period, because most of respondents do want to open their income status of their parents.

Traditionally, Dalits are occupational caste groups. They have their own occupation or income ways. For example: Kami are metal worker, Sarkis are shoe maker, Pariyars (Damai) are tailor and Gandarvas are singing folk song in other community such as Brahmin, Chhetry

etc. However the pattern is changed now. From the moment when the government had given special privileged to this community for the abroad employment the occupational or income ways structure has been changed since then.

Table No. 4. 10 Distribution of the respondents by monthly household income

Monthly income	Number	percent
500-2000	3	2.1
2001-5000	12	8.6
5001-8000	48	34.3
8001 and above	77	55.0
Total	140	100.0

Source: Field Survey, 2010.

The collected record states clearly that majority of the respondent's parent's incomes are from Rs. 8001 or more, i.e. 55.0 percent. Similarly, the second majority of the respondent's parent's income is from Rs. 5001-8000, i.e. 34.3 percent and Rs 500-2000 monthly income of respondent's family income. It shows that the economic status of the respondent's parent's is not sufficiency. Although the number of Dalits are low in Services, Business, Foreign employment etc. The respondent's parent's incomes are more than Rs 8001. Because their parents are mostly involved in buying others agricultural products in low costs and selling them having some margin.

CHAPTER-V

KNOWLEDGE AND ATTITUDE ABOUT HIV/AIDS

This chapter examines the extent of knowledge about HIV/AIDS among late adolescents among Dalit community and also discuss their attitude regarding HIV/AIDS. In this regard, some questions were made to know their level of knowledge and attitude about HIV/AIDS. The calculated index was cross tabulated with different variables and analyzed as follows.

5.1. Knowledge on HIV/AIDS

Hearing about anything is a basis for knowledge; however, only hearing about a topic would not change the behavior of a person on that issue. Respondents were asked whether they had heard about HIV/AIDS or not. Age was categorized into conventional three categories of three year age interval from 14-19. Here comprehensive knowledge includes knowledge on reduce the risk of getting HIV/AIDS by using a condom every sex, person get infected with the HIV by getting infections with a used needle, HIV/AIDS can be transmitted from mother to child, person can not gets HIV by sharing food with a person who has HIV/AIDS, person gets HIV from mosquito bites and healthy looking person has HIV.

Table No. 5.1 Comprehensive knowledge about HIV/AIDS by selected background characteristics

Background Characteristics	Comprehensive Knowledge about HIV/AIDS				Total	
	Yes		No			
Sex	Number	Percent	Number	Percent	Number	Percent
Male	22	27.5	58	72.5	80	100.0
Female	15	25.0	45	75.0	60	100.0
Age						
14-15	6	18.2	27	81.8	33	100.0
16-17	8	20.5	31	79.5	39	100.0
18-19	23	33.8	45	66.2	68	100.0
Monthly income						
500-2000			3	100.0	3	100.0
2001-5000	8	66.7	4	33.3	12	100.0
5001-8000	11	22.9	37	77.1	48	100.0
8001+	18	23.4	59	76.6	77	100.0
Exposure to newspaper						
Everyday	5	19.2	21	80.8	26	100.0
Every other day	5	45.5	6	54.5	11	100.0
Whenever you can	13	30.2	30	69.8	43	100.0
Seldom	11	26.2	31	73.8	42	100.0
Never	3	16.7	15	83.3	18	100.0
Exposure to Radio						
Everyday	24	26.4	67	73.6	91	100.0
Every other day	3	37.5	5	62.5	8	100.0
Whenever you can	5	26.3	14	73.7	19	100.0
Seldom	5	27.8	13	72.2	18	100.0
Never			4	100.0	4	100.0
Exposure to Television						
Everyday	12	19.4	50	80.6	62	100.0
Every other day	4	36.4	7	63.6	11	100.0
Whenever you can	11	29.7	26	70.3	37	100.0
Seldom	8	34.8	15	65.2	23	100.0
Never	2	28.6	5	71.4	7	100.0
Total	37	26.4	103	73.6	140	100.0

Source: Field Survey, 2010.

5.2 Heard of HIV/AIDS by sex

Hearing about any thing is a basis for knowledge; however, only hearing about topic would not change the behavior of a person on that issue. Respondents were asked have you heard HIV/AIDS or not only eight females are unknown about it.

Table No.5.2 Distribution of Respondents about the Knowledge of HIV/AIDS by Sex

Heard/Knowledge of HIV/AIDS	Male		Female		Total	
	Number	Percent	Number	Percent	Number	Percent
Yes	73	100.0	59	88.1	132	94.3
No	-	-	8	11.9	8	5.7
Total	73	100.0	67	100.0	140	100.0

Source: Field Survey, 2010.

Table 5.2 shows that almost of respondents (94.3 percent)) have heard about HIV/AIDS out of total 140 respondents. Only 8 (5.7 percent) respondents don't have knowledge about HIV/AIDS. According to the above table the male respondents were knowledgeable, than female respondents which was 100.0 percent and 88.1percentage respectively.

5.3 Knowledge on Difference between HIV/AIDS and AIDS

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

Table No.5.3 Distribution of Respondents by Knowledge on Difference between HIV/AIDS and AIDS.

Difference	Number	Percent
Yes	41	29.3
No	93	66.4
Don' know	6	4.3
Total	140	100.0

Source: Field Survey, 2010.

Above table 5.4 shows that out of 140 respondents 41(29.3 percent) said that HIV/AIDS and AIDS are different, which is very low. About 66.4 percent respondents said that both are same. That respondents falling in doesn't know category is 4.3 percent.

5.4 Knowledge on Transmission Modes of HIV/AIDS

Knowledge about the ways of transmission of HIV/AIDS shows the further clarity about the knowledge on HIV/AIDS. The late adolescents must have the knowledge about modes of transmission so they can prevent from HIV/AIDS.

Respondents having heard of HIV/AIDS were also asked about the knowledge on ways of transmission of HIV/AIDS. This is rather a good indicator of knowledge than only hearing about the disease. The respondents having knowledge on ways of transmission of HIV/AIDS are presented in below table:

Table No.5.4 Distribution of Respondents by Knowledge on Transmission modes of HIV/AIDS

Mode of Transmission	Number	Percent
Mother to child	106	75.7
Sharing a Toilet	21	15.0
Used infected needles	127	90.7
Sharing a food	30	21.4
From mosquito bites	33	23.5
Total	140	100.0

Source: Field Survey, 2010

Note: Total percent may exceed 100 due to multiple responses.

From the above table, out of 140 respondents, almost all of them (90.7 percent) reported to have knowledge on modes of transmission of HIV/AIDS, Used infected needles. But mother to child and from mosquito bites were responded as modes or HIV/AIDS transmission by 75.7 percent and 23.5 percent respondents respectively. Only 15.0 percent respondent reported HIV/AIDS are transmitted from sharing a food.

5.5 Sources of HIV Information and Hearing of HIV/AIDS

Sources of information many have important role to achieve knowledge about HIV/AIDS for the late adolescents. Various sources were used by the respondent's information.

It shows that the radio comes in first television second and third in school as a source of knowledge. As per as data it is found male adolescents are more conscious than female adolescents.

Table No.5.5 Distribution of Respondents by Source of Information

Source of Information	Number	percent
Radio	86	60.0
Television	84	61.4
Friend or Relative	24	17.1
Newspapers	42	30.0
In school	47	33.6
Doctor/Nurse	13	9.3
Work place	5	3.6

Source: Field Survey, 2010

Note: Total percent may exceed 100 due to multiple responses.

5.6 Knowledge on Preventive Measures of HIV/AIDS

Preventive measure is another important variable. In order to know the preventive measure of HIV/AIDS a question was asked to all the respondents how we can avoid getting HIV/AIDS and the result is shown in the following table.

Table No.5.6 Distribution of Respondents about Knowledge on Preventive Measures of HIV/AIDS by sex

Method of Prevention	Male		Female		Total	
	Number	Percent	Number	Percent	Number	percent
Abstain from sex	17	23.28	3	4.47	20	14.3
Both partners have to other partners	6	8.21	5	7.46	11	7.9
Use a condom at every sex	72	98.63	47	70.14	119	85.0
Have fewer partners	23	31.51	17	25.37	40	28.6
No casual sex	11	15.06	9	13.43	21	15.0
Avoid injections with use needles	36	49.31	31	46.26	67	47.9
Don't know	8	10.95	8	11.94	16	11.4

Source: Field Survey, 2010.

Note: Total percent may exceed 100 due to multiple responses

Table 5.5 shows that almost all of respondents who had heard of HIV/AIDS (98.63) male and 70.14 percent female had knowledge to use condom during sexual intercourse for the preventive measures of HIV/AIDS. Similarly, half (49.31 percent) male respondents and 46.26 percent of female respondents reported avoid injections with use needles is the true method of preventive HIV/AIDS. About one third (31.51 percent) of male and 25.37 percent female respondents reported have fewer partners is the true method of preventive HIV/AIDS. At last, 8.21 percent male and 7.46 percent female respondents reported both partners have to other partners is the true method of preventing HIV/AIDS.

In case of preventive measures males seemed to have more knowledge than females, which may be due to traditional male dominance in the society which allows male to lead in terms of knowledge and education.

5.7 Information sources and its influences on HIV/AIDS attitude

Communication media plays a vital role in dissemination of HIV/AIDS message to the people. The role of channels in different media of communication in providing message to the community people can not be neglected. Sources of information may have an important role to influence on HIV/AIDS attitude. That's way the respondents were asked volunteer work with AIDS patients, teacher with HIV/AIDS should continue teaching in school etc.

Table No.5.7 Distribution of Respondents attitude by source of Information

Items on Questionnaire	Radio		Television	
	Number	Percent	Number	Percent
I am willing to do volunteer work with AIDS patients	79	56.4	23	16.4
Teacher with HIV/AIDS should be allowed to continue teaching in school	65	46.4	34	24.4
I will not hesitate to buy food from the shopkeeper with AIDS	53	37.9	47	33.6
People with HIV should be kept out of school	45	32.1	33	23.6

Source: Field Survey, 2010.

Note: Total percent may exceed 100 due to multiple responses.

Major sources of information related to HIV (Table 5.6) for nearly one fourth were television and the radio, and few participants indicated that they would seek information from newspaper. The acquired knowledge varies according to social and demographic characteristics. Despite very few participants listen to radio and watch television. Significance of radio and TV proved that Audio and visual effective sources for people who have lower level education. In the village, this result may reflect traditional Nepali beliefs that open discussion about sex is taboo and obtaining HIV information from family members or health professionals would be inappropriate or unseemly. It should be noted that even with information from television and radio; there was still a serious HIV knowledge deficit among participants. . This implies that obtaining HIV-related information through television was problematic. It could be due to distortion of message, unclear. Moreover, TV and radio have

very few marked influence on HIV related facts, chances of transmission from mother to child and use of infected syringe, were vary considerably among the other facts.

5.8 Attitude on Curative Measures of HIV/AIDS

As we know that HIV/AIDS is fatal disease, so appropriate curative measures are rare. An additional question was put forward to know their attitude about the curative measures of HIV/AIDS .The attitude depends upon the knowledge of late adolescents on HIV/AIDS.

Table No.5.8 Distribution of Respondents about Curative Measures of HIV/AIDS

Response	Male		Female		Total	
	Number	Percent	Number	Percent	Number	Percent
Can be cure	46	63.0	34	50.8	80	57.2
Can't be cure	27	37.0	25	37.3	52	37.1
Don't know	-	-	8	11.9	8	5.7
Total	73	100.0	67	100.0	140	100.0

Source: Field Survey, 2010.

Table 5.8 shows that out of total respondent of 140, more than half(57.2 percent) believed that HIV/AIDS is curable however about one third 37.1 percent (37.0 percent male and 37.3 percent female) respondent believed that HIV/AIDS is not curable. At last only 5.7 percent females are unknown about it.

CHAPTER VI SUMMARY AND CONCLUSIONS

This is the study of knowledge and attitude on HIV/AIDS in Dalit community of Hemja VDC, Kaski. This study is based on primary data and quantitative type, 140 respondents were selected from selected area. Population interviewed for this research in the Nagetole, kamitole and Hanuman chowk of Hemja VDC, Kaski.

6.1. Summary of Findings

The objective of this study was to examine knowledge and attitude on HIV/AIDS among late adolescents in Dalit community of Hemja VDC of Kaski district. The study primarily concentrated on knowledge and attitude on HIV/AIDS in late adolescent age group of 14-19 years. Basically, indexes for knowledge and attitude on HIV/AIDS was constructed based on collected information and these indexes were cross and frequency tabulated. The following are the major findings of this study:

6.2. Summary of Household Characteristics

Out of 350 sample population, 0-14 consisted 15.4 percent, 15-59 consisted 80.0 percent and 60 and above 4.6 percent of population. Majority of the sex ratio is 0-14 years which was 1:135. Out of 350 sample population, 21.7 were Damai, 25.4 percent were kami, 37.2 percent were sarki and 15.7 percent were gandarva. Most of the sample populations are unmarried (52.8 percent) which is followed by married (41.0 percent). Dalit had more numbers (38.1) involved in students which is followed by Agriculture (37.8 percent), business (11.5 percent), foreign employment (11.1 percent) and services (1.47 percent). Most of the sample population were literate (54.7) percent) which is followed by illiterate (45.3 percent), primary (60.1 percent), secondary pass (28.8 percent) and SLC and above (11.1 percent).

6.3. Summary of Individual Characteristics

Almost all of respondents at 19 years respondents' age group are about 28.6 percent and fewer respondents at 18 years and about 9.3 percent. The highest numbers of respondents are males 52.1 percent and females are 47.9 percent. Most of the respondents reported that their family type is nuclear (68.6 percent). Majority of the respondents have only 5 to 6 members (60.7) in the family. Dalits refers Kami, Damai, Sarki and Gandarva in this study. The highest number of respondents is Sarki (58.5 percent), followed by Kami (24.2 percent), Damai (7.8 percent) and Gandarva (9.3 percent). All of the respondents 100 percent are Hindus. The proportion of married and unmarried was different that is 7.9 percent and 92.1 percent. Most of the respondents from Sarki community (58.5). Majority of the respondents living with their parents (95.0). Majority of the respondent's parent's monthly income were from Rs. 8001 and above (55.0 percent).

6.4 Summary of knowledge and Attitude of Respondents toward HIV/AIDS

In this study out of the total 140 respondents only 27.5 percent male and 25.0 percent female have comprehensive knowledge about HIV/AIDS. The percentage of respondents who have HIV/AIDS was higher among males (88.1 percent). Radio, Television, and newspaper are the main source of information about HIV/AIDS. Most of the respondents (94.3 percent) have heard about HIV/AIDS this can be the increasing access of information, education and communication materials. In this study 29.3 percent respondents have knowledge on difference between HIV/AIDS and AIDS. Almost all of (90.7 percent) of the respondent believes that HIV/AIDS is transmitted through used infected needles followed by 75.7 percent respondents that have knowledge about HIV/AIDS transmission through mother to child. Majority of 85.0 percent respondents reported that, use of condom at every sex is the method of prevention of HIV/AIDS. Most of the respondents (56.4 percent) reported that their knowledge about HIV/AIDS influences on HIV/AIDS from the source of radio. All respondents (140) get knowledge about HIV/AIDS from the source like radio, television, newspaper, friend, in school, doctor/nurse and work place. Majority of the respondents (61.4 percent) get knowledge about HIV/AIDS from the source of television. Majority of the respondents reported that the HIV/AIDS are curable 57.2 percent and followed by not curable 37.1 percent and only 5.7 percent said don't know.

6.5 Conclusion

This study is based on knowledge and attitude about HIV/AIDS among late adolescents in Dalit community of Hemja VDC, Kaski. It is based on primary data. This study summarizes the information of 140 late adolescents from Dalit community. HIV/AIDS is a burning issue of the world most of the adolescents are affected. So, they have need of knowledge about it.

After analyzing the data, it has found that most of the respondents at 19 years age group which was 28.6 percent. Most of the respondents are from kami community. All of the respondents (100 percent) are Hindus. Majority of the respondents have heard HIV/AIDS. But some respondents have misconception about HIV/AIDS. Knowledge on transmission and prevention measures were also higher. It may be the advertisement of HIV/AIDS through media.

The study shows that communication and education are the most important aspects which changes knowledge and attitude of late adolescents but also common people. Males' respondents are more aware about HIV/AIDS and mode of transmission than that of the female respondents. Thus, the study clearly indicates the importance role of communication and education increasing awareness about HIV/AIDS.

6.7 Further Research Issue

- This study is based on Dalit community, the comparative study can done Damai, Kami, Sarki and Gandarva caste.
- This is the study of knowledge and attitude about HIV/AIDS among late adolescent (14-19 years). A case study from Dalit community of Hemja VDC, Kaski. Further study can be carried out in other specific community and specific age groups as well
- This study is based on only few parameters with socio-economic and demographic variables. Using other variables 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.

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QUESTIONNAIRE

KNOWLEDGE AND ATTITUDE ABOUT HIV/AIDS AMONG LATE ADOLESCENT IN DALIT COMMUNITY

Informed consent

Namaste I am.....I am a thesis year student of Central Department of population Studies, T.U, Kirtipur.My thesis topic is Knowledge and Attitude about HIV/AIDS among Late Adolescent of Dalit Community.

The aim of this topic is to examine the knowledge and attitude among late dalit adolescent of Hemja VDC.It will help us to know their knowledge and attitude about the HIV/AIDS. And also it will be beneficial for policy maker, programmer and to the students to conduct the same research in different areas.

The information given by you is mainly used for academic purpose and will be kept quite confidential.

I will be thankful for your kindly co-operation and hope that this thesis will be equally beneficial for us.

SECTION-I: IDENTIFICATION

Ward no:

Name of locality;

Household no:

Name of household Head:

Religion:

Name of the Respondent:

Family type ;(Nucler-1, Extanded-2):

SECTION- II: HOUSEHOLD SCHEDULE

ID	Name of the household member	Relation with the HH Household Head-1 Husband\Wife-2 Sun\Daughter-3 Mother in law\Father-4 Father\Mother-5 Brother\Sister-6	Sex: Male-1 Female-2	Completed age	Education Illiterate-1 Literate-2 Primary pass-3 Secondary pass-4 Above SLC-5	Marital status: Married-1 Unmarried-2 Divorced-3 Seperated-4 Widow/widower-5	Main occupation: Agriculture-1 Services-2 Student-3 Business-4	Adolescents
201	202	203	204	205	206	207	208	209
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								

Total no of family:

SECTION – III: INDIVIDUAL QUESTIONNAIRE

Q1.Record sex of the respondent!

(Do not ask, mark only one response!)

1. Male **1**
2. Female **2**

Q2.what day, month and year were you born? **(Write down the date as mentioned by the respondent!)**

<u>D</u>	<u>D</u>	<u>M</u>	<u>M</u>	<u>Y</u>	<u>Y</u>	<u>Y</u>	<u>Y</u>
----------	----------	----------	----------	----------	----------	----------	----------

Q3.How old was you at your last birthday?

(Write down the number of years!)

Q4.what is your religion? **(Circle only one response!)**

1. Hindu **1**
2. Buddhist **2**
3. Muslim **3**
4. Others? **(Specify)**

--

Do not read!

9. Do not know/Do not wish to answer **9**

Q5.Are you married? **(Circle only one response!)**

1. Yes **1**
2. No **2**

Do not read!

9. Do not know/Do not wish to answer **9**

Q5a.If yes, of which age did you get married? **(Write down the number!)**

(Write down the number of years!)

--

Do not read!

9. Do not know/Do not wish to answer **9**

Q6. Who do you live with? **(Mark only one answer!)**

--

1. Parents **1**
2. on your own **2**
3. Close family (wife and/or children) **3**
4. Something else **(specify)** **4**

--

Q7.How much monthly income does your family has? **(Circle only one response!)**

1. Rs.500-2000 **1**
2. Rs.2001-5000 **2**

3. Rs.5001-8000 3
4. Rs.8001+above 4

Do not read!

9. Do not know/Do not wish to answer 9

Q8.How many members are there in your family?

(Write down the number!)

Do not read!

9. Do not know/Do not wish to answer 9

Q9.Do you read the newspaper? (**mark only one answer!**)

1. Everyday 1
2. Every other day 2
3. Whenever you can 3
4. Seldom 4
5. Never 5

Do not read!

9. Do not know/Do not wish to answer 9

Q10.Do you listen to the radio? (**Mark only one answer!**)

1. Everyday 1
2. Every other day 2
3. Whenever you can 3
4. Seldom 4
5. Never 5

Do not read!

9. Do not know/Do not wish to answer 9

Q11.Do you watch television? (**Mark only one answer!**)

1. Everyday 1
2. Every other day 2
3. Whenever you can 3
4. Seldom 4
5. Never 5

SECTION-IV: Respondent's Knowledge about HIV/AIDS

Q12.Have you ever heard of HIV/AIDS? (**Circle only one response!**)

1. Yes 1
2. No 2

Do not read!

9. Do not know/Do not wish to answer 9

Q13. Do you know the full form of HIV/AIDS? (**Circle only one response!**)

- 1. Yes 1
- 2. No 2

Do not read!

9. Do not know/Do not wish to answer 9

Q14. If yes, specify

Do not read!

9. Do not know/Do not wish to answer

Q15a. In the past month, have you heard or seen any information about the HIV/AIDS? (**Circle only one response!**)

- 1. Yes 1
- 2. No 2

Do not read!

9. Do not know/Do not wish to answer 9

Q15b. From what source did you receive this information about the HIV/AIDS? (**More than one answers possible!**)

- 1. Television 1
- 2. Radio 1
- 3. Friend or relative 1
- 4. Newspapers 1
- 5. In school 1
- 6. Doctor/Nurse 1
- 7. Work place 1
- 8. Others (**specify**) 1

Do not read!

9. Do not know/Do not wish to answer 9

Q16. Is there a difference between HIV/AIDS and AIDS? (**Circle only one response!**)

- 1. Yes 1
- 2. No 2

Q17. In the past month, have you discussed the HIV/AIDS with anyone? (**Circle only one response!**)

- 1. Yes 1
- 2. No 2

Do not read!

9. Do not know/Do not wish to answer 9

Q18. With whom has you discussed the HIV/AIDS during the past month? (**More than one answers possible!**)

- | | |
|-----------------------|---|
| 1. Partner | 1 |
| 2. Friends | 1 |
| 3. Family | 1 |
| 4. Health Care Worker | 1 |
| 5. Religious persons | 1 |
| 6. Others! (Specify!) | 1 |

--

Do not read!

9. Do not know/Do not wish to answer

Q 19. Do you think that AIDS is a serious problem, somewhat of a problem or not a problem in your community? (**Circle only one response!**)

- | | |
|--------------------------|---|
| 1. Serious problem | 1 |
| 2. Somewhat of a problem | 2 |
| 3. Not a problem | 3 |

Do not read!

9. Do not know/Do not wish to answer 9

Q 20. Do you personally know any one who has HIV or has died from AIDS? (**Circle only one response!**)

- | | |
|--------|---|
| 1. Yes | 1 |
| 2. No | 2 |

Do not read! 9. Do not know/Do not wish to answer 9

Q21. How likely do you think it is that you yourself could contract HIV/AIDS? Would you say there is no risk, a small risk, a moderate risk or a high risk of risk of getting HIV? (**Circle only one response!**)

- | | |
|------------------|---|
| 1. No risk | 1 |
| 2. Small risk | 2 |
| 3. Moderate risk | 3 |
| 4. High risk | 4 |

Do not read!

9. Do not know/Do not wish to answer 9

Q 22. Why do you think you are at risk of contracting HIV? (**More than one answer possible!**)

- | | |
|--|---|
| 1. Have many partners | 1 |
| 2. Do not always use of condoms | 1 |
| 3. Have used intravenous drugs | 1 |
| 4. Partner has other partners | 1 |
| 5. Blood transfusions/ Unsafe injections | 1 |

- 6. Have been with sex workers 1
- 7. Have been in contact with infected persons 1
- 8. Other? (Specify)

Q 23. Why do you think you are at little risk or no risk of contracting HIV?

(Do not read the answers, record what respondent claims! More than one answer possible!)

- 1. Not sexually active` 1
- 2. Have only one partner and he/she is faithful 1
- 3. Trust my partner 1
- 4. Always use condoms 1
- 5. Always use condoms with people, I don't know very well 1
- 6. Do not use intravenous drugs 1
- 7. Do not go to sex workers 1
- 8. Have not been in contact with any infected persons 1
- 9. No HIV/AIDS in Hemja 1
- 10. Other? (Specify!) 1

Do not read!

9. Do not know/Do not wish to answer 9

Q 24. How can we avoid getting HIV/AIDS? (**More than one possible answers!**)

- 1. Abstain from sex 1
- 2. Both partners have to other partners 1
- 3. Use a condom at every sex 1
- 4. Have fewer partners 1
- 5. No casual sex 1
- 6. Avoid injections with use needles 1
- 7. Other? (Specify!) 1

Q25.Can a person reduces the risk of getting HIV/AIDS by using a condom every time they have sex? (**Circle only one response!**)

- 1. Yes 1
- 2. No 2

Do not read!

9. Do not know/Do not wish to answer 9

Q26. Do you think the HIV/AIDS can be transmitted from a mother to child? (**Circle only one response!**)

- 1. Yes 1
- 2. No 2

Do not read!

9. Do not know/Do not wish to answer 9

Q27. Do you think a person can get infected with the HIV by sharing a toilet with a person who has HIV/AIDS? (**Circle only one response!**)

- 1. Yes 1
- 2. No 2

Do not read!

9. Do not know/Do not wish to answer 9

Q28. Can the risk of HIV transmission is reduced by having sex with only one uninfected partner who has no other partners? (**Circle only one response!**)

- 1. Yes 1
- 2. No 2

Do not read!

9. Do not know/Do not wish to answer 9

Q29. Can a person get infected with the HIV by getting infections with a used needle? (**Circle only one response!**)

- 1. Yes 1
- 2. No 2

Do not read!

9. Do not know/Do not wish to answer 9

Q30. Can a person gets HIV by sharing food with a person who has HIV/AIDS? (**Circle only one response!**)

- 1. Yes 1
- 2. No 2

Do not read!

9. Do not know/Do not wish to answer 9

Q31. Can a person gets HIV from mosquito bites? (**Circle only one response!**)

- 1. Yes 1
- 2. No 2

Do not read!

9. Do not know/Do not wish to answer 9

Q32. Can a healthy –looking person has HIV? (**Circle only one response!**)

- 1. Yes 1
- 2. No 2

Do not read!

9. Do not know/Do not wish to answer 9

Q33.How easy is it for a late adolescent person your age to find out about HIV/AIDS?

(Circle only one response!)

- | | |
|---------------|---|
| 1. Easy | 1 |
| 2. Difficult | 2 |
| 3. Impossible | 3 |

Q34.Is it possible in your community for someone to get a test to find out if they are infected with HIV? **(Circle only one response!)**

- | | |
|--------|---|
| 1. Yes | 1 |
| 2. No | 2 |

Do not read!

9. Do not know/Do not wish to answer 9

Q35.Where could they get this test? **(More than one possible answer!)**

- | | |
|---|---|
| 1. Government hospital/clinic | 1 |
| 2. Private hospital/clinic | 2 |
| 3. VCT center (center for Volunteer Counseling and Testing) | 3 |
| 4. Pharmacy | 4 |
| 5. Family planning centre | 5 |
| 6. Field worker | 6 |
| 7. Mobile clinic | 7 |
| 8. Other? (Specify) | 8 |

Do not read!

9. Do not know/Do not wish to answer 9

Q36.I don't want to know the results, but have you been tested for HIV in the last 12 months? **(Circle only one response!)**

- | | |
|--------|---|
| 1. Yes | 1 |
| 2. No | 2 |

Do not read!

9. Do not know/Do not wish to answer 9

Q37.I don't want to know the results, but did you get the results of that test? **(Circle only one response!)**

- | | |
|--------|---|
| 1. Yes | 1 |
| 2. No | 2 |

Do not read!

9. Do not know/Do not wish to answer 9

Q38.Did you tell anyone the results of the test? **(Circle only one response!)**

- | | |
|--------|---|
| 1. Yes | 1 |
| 2. No | 2 |

Do not read!

9. Do not know/Do not wish to answer 9

Q39.Whom did you tell? **(Circle only one response!)**

- 7. Stay away from people who are sick 1
- 8. Not drink alcohol 1
- 9. Not smoke 1
- 10. Keep a positive attitude 1
- 11. Medicine (pills) use 1
- 12. Visit doctor 1
- 13. Other? (Specify) 1

Do not read!

9. Do not know/Do not wish to answer 9

Q43. In which ways you can support person who has HIV/AIDS?

- 1. Yes
- 2. No

Do not read!

9. Do not know/Do not wish to answer 9

ASPECT	ANSWER
1. Not avoiding these friends/neighbors	
2. Helping care for children/old people in family	
3. Helping with farming or family business	
4. Helping support the family	
5. Sharing meals with the family	
6. Helping plan for the future to increase self confidence	
7. Other?(specify)	

Q44. If a relative of yours has the HIV/ AIDS, would you be willing to care for them in your household? **(Circle only one response!)**

- 1. Yes 1
- 2. No 2

Do not read!

9. Do not know/Do not wish to answer 9

Q45. If a teacher is infected with HIV but is not sick, should he or she be allowed to continue teaching in school? **(Circle only one response!)**

- 1. Yes 1
- 2. NO 2

Do not read!

9. Do not know/Do not wish to answer 9

Q46. If you knew that a shopkeeper or food seller is infected with the HIV, would you buy food from them? **(Circle only one response!)**

- 1. Yes 1
- 2. No 2

Do not read!

9. Do not know/Do not wish to answer 9

Q47.If a member of your family got infected with the HIV, would you want it to remain a secret? **(Circle only one response!)**

- 1. Yes 1
- 2. No 2

Do not read!

9. Do not know/Do not wish to answer 9

Q48.Would you accept to attend the same class/group in school with a person that you know is infected with HIV? **(Circle only one response!)**

- 1. Yes 1
- 2. No 2

Do not read! 9. Do not know/Do not wish to answer

Thank You for Your Valuable Time!