CHAPTER -I

INTORDUCTION

1.1 General Background of the Study

Health is not only the absence of disease but a complete physical, mental and social well being (WHO 1994). By these words, we can understand the importance of health which plays vital role in our whole life. Disease which affects to the health and to the progressive life, the notion of health is entirely depend on society's dominant culture; its characteristics, technology and social structure. The idea of health linked with society's cultural pattern reflects on the strong tied to norms and values that varied from culture to culture. The linkage of cultural definition of health is based on a society's level of technological development and the social resources available to meet the need of its population.

The behavioral pattern of human beings may varied with person, time and place or the distinction may committed in accordance with differentiation on variables i.e. person, time and place. The increasing influence and intervention of electronic multimedia and information technology play the vital role to introduce the new lifestyle, different knowledge and attitude that brought the significant change in existing value system as well as sexual values and practices.

In society there is ambivalent view of sex as a source of pleasure and a means of procreation i.e. way of solvency on the one hand and as a sinful act on the other. HIV/AIDS is the major disease that is directly linked to the sexual behavior of human beings.

Diseases are mainly categorized into two types: Communicable and Non- communicable. Communicable diseases are transmitted from one person to another by different ways in the different parts of human body and diseases

which are not transmitted from one to another are called non- communicable diseases.

The diseases that are transmitted mainly through sexual contact during unsafe intercourse are known as sexually transmitted disease. Sometimes these diseases are also transmissible through transfusion of unscreened blood, contaminated needles, and form infected women to her child during pregnancy, childbirth, or breast-feeding. Sexually Transmitted Infections (STIs) have greater impact on human sexuality and morbidity. They largely affect external and internal sexual organs and causes various complication such as pelvic inflammatory disease (PID), ectopic, pregnancy, infertility, cervical cancer, miscarriage, stillbirth, congenital syphilis, ophthalmic, neonatorum etc. (Acharya,1999)

AIDS as emerged one of the most burning issues at present and has a challenge for human beings. It as been spreading at an alarming rate, even thousands of efforts for its prevention and control have been made continuously far and wide by government, I/NGOs to arrest the spread of HIV/AIDS infection. It is beyond the capacity of the medical world and categorized incurable disease. If proper action is not taken immediately, it will vanish the existence of human being one day. (Aryal, 2000)

The causative organism of AIDS is Human Immune Deficiency Virus in short HIV. It was first diagnosed in 1981 in the USA. Experts believed that it has been prevailing in human society before 1959 and they also viewed that the green monkey (found in Africa) has been carrying its virus. The AIDS virus was transmitted to man by its biting or eating its meat of uncooked brain (Rayamajhi, 2000). The virus was detected in 1983 in a patient with AIDS by Dr. Lue Montagnier (France) and later (1984) confirmed by Dr. Robert Gallo (USA). Initially the name given for the virus was Lymphadenopathy Associated Virus (LAV), Human T. Cell Lymphotrophic Virus Type- Three

(HTLV- III) and AIDS Related Virus (ARV). However, scientists later in 1986 agreed to give the virus a globally acceptable name HIV (Chhetri, 2005).

The acronym of the AIDS is Acquired Immune Deficiency Syndrome evokes a response of familiarity today. It is a condition resulting from infection by Human Immune Deficiency Virus. This disease called syndrome because it consists several signs and symptoms affecting different parts of human body.

In the development of AIDS from its initial infection, there are three stage i.e. window period, carrier stage and full blown AIDS. Window period is an initial infection, when flues like symptoms (fever, fatigue, rash etc.) appear in few persons but a majority remains symptom free. In this stage, the AIDS virus is not found when HIV antibody test is carried out, but the person can transmit the infection to others. This period took two months for the initial period. In the carrier stage the AIDS virus is seen when the HIV antibody test is carried out. This period might take 5-12 years form initial infection. It is also called HIV positive stage. AIDS is characterized by the presence of opportunistic infection, which would not, causes diseases in a healthy person.

HIV virus lives inside the human cell to reproduce itself. It is extremely fragile and doesn't survive long time outside the body. AIDS is transmitted mainly by sexual contact, contaminated with blood and from an infected mother to her new born baby. And it is not transmitted by social contact like shaking hands, sitting together, playing together and working together. Similarly HIV is not transmitted through food, water, utensil, toilet, towel, bathroom and insects.

World had witnessed many contagious deadly disease such as small pox, tuberculosis, malaria in the past century which claimed millions of lives in the world especially in the developing countries. Smallpox has been eradicated from the world and the remedies of these diseases have been developed and it can be cure now if diagnosed and get treatment in its early stage. But most people in the developing world are still suffering from these deadly diseases

due to lack of medical facilities and poverty. The mankind has not been fully released from these deadly diseases, the new communicable disease Human Immune-deficiency Virus/ Acquired Immune-deficiency Syndrome (HIV/AIDS) has compounded the sufferings and threatened the mankind, as so far now there is no permanent cure for this disease.

Migrant people are at a higher risk than the overall population for HIV infection for several reasons, some of which are related directly to the effects of their socio-cultural patterns. Others are related to economic transitions and changes in the availability and accessibility of health services, and the difficulty of the host country health care system in coping with the traditional practices and high level of mobility of the migrants. Interns of these factors HIV/AIDS is not different than other problems, but it is further complicated by the stigmatization attached to those infected with the virus (Haour-Knie,1993).

Male migrant workers are susceptible to HIV infection for several reasons. Although there are no reliable figures, it is believed that several hundred Nepali men migrate to India and other countries for employment every year. These migrant workers travel to all parts of India, particularly to the large cities like Delhi, Mumbai and other cities and towns in the hinterland. They usually travel alone, without their wives or regular sex partners. Though most male migrant over the age of 22 are married, their migration in search of work keeps them away from their families for 3-6 months or several years at a time, often living in predominantly male migrant housing situation while in India often contributes to a strong peer pressure force to engage in extramarital relationships, including patronization of sex workers and in same cases, male to male sex, Both increase a migrant's risk of contracting HIV. Their feelings of cultural alienation, combined with the dirty, dangerous and demeaning (3D) work that they often do contributes to increased alcohol and intravenous drug abuse, compounding the HIV risk. Due to language barriers, lack of social networks and cultural isolation, migrant workers are unlikely to have access to sexual health care and advice, including access to condoms. Lacking legal

protection, they are often unaware of their rights. Consequently, it is not surprising that UNAIDS found that 38000 people living with HIV Bangladesh in 2004, 48% were migrant workers (Gurung, 2004). While in their destination country, male migrant who patronize sex workers and contract HIV can spread the disease to other sex workers and local women. When thy return to their families to Nepal, if they are infected and unaware of their HIV status, they can pass the HIV virus to their wives and future children. It is believed that more than 50% of all HIV infection cases in Nepal actually originate in India.(Cite source) Thus, women having sexual contract with men who have been to India have a much higher risk of having risk of being infected by HIV of contracting SIDs than other women do. It is therefore imperative that any HIV prevention initiative in Nepal addresses the issue of cross border HIV/AIDS infection in migrant to and from India. (Chaudhary, Pulkit, 2006)

Factors that increase susceptibility and vulnerability to HIV in addition to migration are poverty, low level of awareness regarding the means of transmission and prevention of infection of HIV/AIDS, STIs, limited or inadequate reproductive health services delivery points for the rural population, wide gender, caste and ethnic disparities, a reportedly high incidence of STIs, social and cultural norms and taboos that prohibit the frank and open discussion of sex and sexuality. This also prevents that dissemination of knowledge and awareness about HIV/AIDS and STIs. (Cox, 1993)

It is for those very reasons that if, on the one hand, HIV/AIDS continues to spread its tentacles rapidly yet invisibly in almost all strata and section of the Nepalese society, then on the other hand the number of HIV/AIDS infected are increasing with the passing of each year. More unfortunate to know is that these same HIV infected people areas well as their family member are being forced to bear with the accompanying social repercussions like denial, blame, stigmatization, prejudice and discrimination that fear of AIDS brings out in individuals and society. (Jha, 1998)

Needless to point out, if such discriminations against HIV infected and their families continue to persist, than other PLHAs could be discourage from seeking necessary assistance, thereby pushing this dreaded disease and its silent yet deadly repercussions on individuals, families, communities and society underground. This, in turn, could greatly compromise the national, regional and international efforts to create an "enabling environment" to contain the further march of HIV/AIDS and at the same time minimize its adverse impacts on the PLHAs to make the new Nepal.

1.2 Problem Statement

Poverty is widespread in Nepal with 49% of the Nepalese living in absolute poverty. The World Bank estimate that over 50% of Nepalese live on the less than a dollar per day. The country remains agrarian, with agriculture contributing to 40 percent of the gross domestic product and consisting of 80% of employment opportunities. The GDP growth rate in 2000 was 6 percent, which is dramatic improvement from the average 3 percent in the 5 year prior, and this is mainly due to advances in subsistence farming. (Rayamajhi, 2000)

In Nepal, the economically active population aged 10 and above is estimated to be 10.3 million. This includes 5.3 million males and 5 million females. The bulk of the economically active population is between the ages of 25 and 44. Every year 300,000 new workers are added to the Nepalese labor market, but his economy has not been able to grow fast enough to absorb them. As the result, unemployment and underemployment rates are very high. It is estimated that 4.9 percent of total manpower in Nepal is unemployed and 47 percent underemployed. (NCASC, 2008)

HIV/AIDS represents a serious threat to Nepal. HIV is spreading rapidly in many parts of Nepal. It is estimated that in Nepal more than 70000 people in Nepal had HIV/AIDS in Dec 2007(UNAIDS 2007) and this figure is likely to rise rapidly in coming year unless efforts are made to prevent HIV transmission.

Although accurate national surveillance data is not available, HIV sero-prevalence in Nepal is still estimated to be below 1%. However there are some sub groups in particular areas where infection is above 5%. This may indicate that the country is in the process of transition from a “low prevalence epidemic” to that of a generalized one, through a stage of a “concentrated epidemic “. Most of infections in Nepal are though to be acquired in India by women/girls working in the sex industry, having worked in India and particularly in Mumbai was a statistically significant correlate with HIV infection and by male migrant workers engaging in unprotected multi partner sex (migration is common across in Nepal, but is particularly high in the mid western districts). Global experience has shown that migrant workers often become involved in risky sexual and behavior that increase their susceptibility to HIV and STIs, Which in turn places their spouses and sexual partners at risk of STIs and HIV. The increased susceptibility of parent makes children in communities from with male migration occurs extremely vulnerable to HIV/AIDS. It is expected that most families and children affected by the epidemic will come from these communities.

There is a need of information regarding the nature and extent of HIV/AIDS problem in the community, its impact, socio demographic features of the infected and affected, attitudes, beliefs and practices towards HIV/AIDS and STIs. Current interventions, treatment seeking behavior, care practices, services provisions, community structure and systems, stakeholders dynamics etc. Information in these areas in the district is either sketchy of inadequate or unavailable at all, particularly in relation to the extent of HIV/AIDS problem, care practices etc.

In this way, the central issue of this study is to analyze knowledge and attitude among migrant people and their spouse as well as evaluate gap between knowledge and behaviour towards HIV/AIDS. The problems that need to be investigated to explain their family background, their household level, their income and knowledge and attitude of ordinary people towards them.

1.3 Objectives of the Study

The main objective of this research is to find out the socio economic impact of AIDS on migrant people and their spouses, for this it is necessary to find out the socio economic condition, economic and occupational status of the infected people was studied. The specific objectives are as follows:

- To identify social and demographic characteristics of migrant people living with HIV/AIDS.
- To assess the knowledge and attitude of the general people towards HIV/AIDS.
- To find out gap between knowledge and practices towards HIV/AIDS and STIs.

1.4 Limitations of the Study

Like other individual student research works, this study has also its own limitations as well as delimitations which are as under:

1. The study is related only with socio and economic status of HIV among migrant labor and their spouses.
2. The study had limited only in the Hapur VDC of Dang district.
3. The sample size is small and concentrated only one ward of VDC.
4. This study is connected to fulfill the partial requirement of MA in Sociology and Anthropology therefore large are cannot be incorporated because of certain limitation such as time and resource.

1.5 Justification of the Study

The significance of this study has related with the social and economical impact of HIV on migrant population. The emphasis has been given upon situation of migration, HIV/AIDS vulnerability, and situation analysis of people living with HIV, Their socio economic condition, community attitude and belief towards PLHAs, stigma and discrimination. Thus the findings of this study may be useful and informative for policy maker, public health planners, academics, donor agencies and field workers who work on HIV/AIDS care, support and prevention.

- This study may be applicable to find out the situation of the people living with HIV/AIDS.
- The findings of the study will give the programmatic options to the planers to plan the community based care and support or impact mitigation program.
- The findings will give information about the socio and economic condition of migrant families.

1.6 Operational Definitions of the Terms Used in This Study

HIV : Human Immune deficiency Virus, is a virus that cause AIDS.

AIDS: Acquired Immune Deficiency Syndrome is stage of having two more diseases when the immune system gets so down.

Migrant People: People who had moved from one city to another or from one country to another in search of jobs or because of the conflict.

Attitude: It refers the way of feeling thinking and behaving.

Community: A community is a group of people living in a particular area who have organized to meet common goals, invest or problem.

Chronic: Something that last for a long time of that occurs of ten compare with acute.

Community health workers: Health worker who works in the community and way or may not have formal trainings.

STIs: Sexually transmitted Infections are the diseases transmitted due to unsafe sex. (Gonorohea, Syphilis)

Sex workers: Anyone who exchange sex for money or other favors.

Safer sex: Avoiding direct contract with a sexual partner genitals, blood, serum or vaginal fluid.

Targeted group: The Target group includes those people in ward no.8 of Hapur VDC who had migrated to various Indian cities for employment.

CHAPTER – II

LITERATURE REVIEW

This chapter leads about the available on STIs and HIV/AIDS, history of more vulnerable groups for acquiring HIV/AIDS etc were reviewed to generate the adequate relationship between the variables and to share the others opinion on the issued statement.

2.1 World Situation on STDs and HIV/AIDS

AIDS was first reported in 1981 in USA, the causative organism of HIV/AIDS was identified in 1983. The pandemic nature and the magnitude of the public health problem are associated by human immune deficiency Virus (HIV). Infections were recognized much later when the proportion of person infected with HIV rose very rapidly, however considerable efforts are being made to control the spread of HIV, as impact of HIV/ AIDS seems to be very serious in a long term aspects. The HIV virus does not resects geographical boundaries so no country of the globe is immune to HIV/AIDS. This is why this issue needs an issue of global thinking and intervention.

The majority of the world HIV infection has been acquired through sexual intercourse between men and women (heterosexual transmission). The proportion of HIV infection attributable to this mode of transmission continuous to grow HIV transmission through sexual intercourse between men and men (homosexual transmission) occurs in most part of the world. Although in the developed countries, it has become less common as the result of the adoption of safer sex practices by homosexual men (WHO, 1994).

Jha (1998), identifies four main modes of HIV spread namely sexual intercourse, infected blood and blood products, infected needle syringe, surgical instruments and infected pregnant women to her baby.

Bekalo (1994), pointed out the different modes of transmission as sexual intercourse including homosexual/heterosexual intercourse; oral/anal sex; artificial insemination blood transfusion; organ transplantation; use of contaminated syringes, needles, safety pins, blades, surgical instruments; tooth extraction, ear and nose piercing, pregnancy and delivery, drug abusers, wife inheritance, hospitality wives, shared use of blades and group circumcision (WHO, 2000).

Migrant groups often have poor living and working conditions, with no recreational facilities. Being in unfamiliar territory, they are also ignorant of the services available to them as well as often being unfamiliar with the social norms prevailing in their host country. Given their lack of awareness, these migrant workers have little access to HIV information, Health services, access to VCT center. Cultural and linguistic barriers heighten their lack of access to the services that exist. They might not even know where of how to obtain a condom, even if available (WHO, 1994).

The HIV/AIDS epidemic across the world has shown that the spread of HIV is clearly linked to rapid economic transition, such as being experienced by South Asian countries in the wake of globalization. Changes such as growing social inequality, rural unemployment, greater poverty, increased mobility, break up of communities, and erosion of traditional values are increasing the vulnerability of large segments of the population of the region to HIV/AIDS. In the last five years, South Asia has witnessed a 100 percent increase in the incidence of HIV prevalence, and according to UNAIDS, already over 5 million people are living with HIV/AIDS. HIV

is primarily affecting the socially and economically productive age group of 15-49, massive numbers of whom are on the move within the region and beyond. (Thapa, 2002)

It can be derived from the literature review that migrant workers and their families uniquely vulnerable to HIV/AIDs. If a migrant worker contracts STI or HIV, h/she can easily on the disease to their partner or spouse through sexual contract when they return back. Therefore, migrant and their family are at higher risk of infection than the general population. When HIV/AIDS strikes a household, the stress of illness, death and uncertainty about the future can be enormous. Household resources erode quickly, as adults become caregivers for sick family members, get sick themselves, or take in the orphaned children of relatives, neighbors, and friend. The slide from relative comfort to destitution can be frighteningly quick ordinarily, it is a women's duty to care for sick family members or relatives and for children. This obligation forces many women to neglect subsistence crop production or activities that generate income for the household. Labor diverted from these essential activities can lead to food insecurity. Redistribution of deceased husband/father, disenfranchises women and children, pushing them further toward poverty. (Cox, 1993)

The first AIDS day campaign took place in 1997 to emphasize that Acquired Immune Deficiency Syndrome (AIDS) is not just a campaign of concern of one day in every year. So the world AIDS campaign now starts each year celebrate worlds AIDS day in December 1.

The HIV/AIDS epidemic has already claimed more than 25 million lives and another 39 million people are currently estimated to be living with HIV / AIDS world-wide. Its cases have been reported in all regions of the world, but most people living with HIV/AIDS. 95% reside in low and middle-income

countries, where most new HIV infections and AIDS related death occur. The nations of sub Sahara Africa have been hardest hit; there is also increasing concern in parts of Eastern Europe and Asia. (UNAIDS, 2006). HIV is leading cause of death worldwide among those ages 15-59 years. The epidemic is considered a threat to the economic well being, Social and political stability of many nations (UN, 2007).

Current Global Snapshot

- It is estimated that 43.5 million people living with HIV/AIDS worldwide.
- 2 million people are recovering antiviral treatment.
- 62 million HIV counseling and testing session were conducted.
- 3.2 million orphans were provided medical services, education and community care
- About 18000 people become newly infected with HIV everyday in 2007.
- Worldwide, most people living with HIV are on unaware that they are infected.

The increasing ratio of infection and death rate could produce fatal scenario in the near future as the HIV/AIDS becoming the solely poor and developing nation. UNAIDS and WHO published situation about HIV/AIDS every year about world's Countries. Following table clears about more information about regional HIV/AIDS statistics and features at end of 2007.

The HIV/AIDS pandemic is one of the most serious health concerns in the world today because of the high case of Fatality rate and the lack of a curative treatment or vaccines. Epidemiological studies have identified sexual intercourse, intravenous injections, blood transfusions and fatal transmissions from infected mothers as the main routes of transmission of AIDS. Studies have also indicated that HIV

cannot be transmitted through food water, insect vectors or casual contact.

Table 1: Global scenario of HIV prevalence

Countries	**Adults and children living with HIV**	**Number of adult women living with HIV**	**Adults and children newly infected with HIV**	**Adults prevalence(%)**	**Adults and children deaths due to AIDS**
Sub Saharan Africa	25.4 million [23.4-28.4million]	13.3 million [12.4-14.9million]	3.1 million [2.7-3.8 million]	7.4 [6.9-8.3]	2.3 million [2.1-2.6 million]
Eastern Europe and Central Asia	1.4 million [920000-2.1million]	490000 [310000-710000]	210000 [110000-480000]	0.8 [0.5-1.2]	60000 [39000-87000]
Latin America	1.7 Million [1.3-2.2 million]	-	240000 [170000-430000]	0.6 [0.5-0.8]	95000 [73000-120000]
Caribbean	440000 [27000-140000]	210000 [270000-780000]	53000 [120000-380000]	2.3 [1.5-4.1]	36000 [24000-61000]
East Asia and Pacific	1.8 Million [1.1-2.4 million]	390000 [260000-560000]	360000 [160000-910000]	0.2 [0.1-0.2]	82000 [52000-120000]
South and south East Asia	6.4 million [3.7-9.9 million]	1.9 million [1.1-2.9million]	780000 [370000-1.9million]	0.7 [0.4-1.1]	450000 [260000-720000]
Middle East and North Africa	540000 [230000-1.5million]	250000 [80000-770000]	92000 [34000-350000]	0.3 [01.-0.7]	28000 [12000-72000]

(Source: UNAIDS global report 2004-2008, www.unaids.org)

The highest rate of adults and children living with HIV is in sub Saharan Africa (25.4 million), Number of adults women living with HIV(13.3 million, Adults and children newly infected with HIV (3.1 million) and death due to AIDS is2.3 million in 2008.

And the table shows that the adults and children living with HIV in East Asia and pacific and south and south East Asia is1.8 million and 6.4 million and the death by AIDS is 82,000 and 45000 people in 2008.

2.2 Situation of SAARC Countries

The first HIV infection on South region was reported in India in 1986. It is estimated that there are about 3 to 5 million people infected by HIV/AIDS. The pandemic was introduced in the regional some what later other part of the world. The infection rate in South Asia are lower than Africa but the spread of HIV is rapid in Maharastra and Tamilnadu States are main area to rapid increasing the HIV infection multiple sexual contacts have been the main routes of HIV transmission. In India 50 percent of commercial sex worker have been found to be infected in Mumbai (Aryal, 2000).

Girl Trafficking, Commercial Sex work, Seasonal Migration and mobility of youth in Search of job, Drug use are some factors they are very similar in the countries of south Asia and these factors are among others, responsible for contributing to spread HIV infection in the region (Chaudhary,2005).

Data on prevalence on STDs, including HIV/AIDS are not available for all SAARC countries are also limited in scope. However, the limited information that is available reveals a high level of prevalence of RTIs and STDS among both married and unmarried adolescent girls and boys. For example, in Bangladesh over 40 percent of Unmarried and married adolescent girls and 20 percent of unmarried adolescent boy are report to have had symptoms of RTIs and STDs respectively. In Sri Lanka, about 7 percent of adolescent are reported to have had STDs. The incidence of HIV/AIDS among adolescents is limited but increasing particularly among girls. For example, in Nepal, adolescent constitute about 16 percent of the HIV/AIDS case with adolescent girls representing 72 percent of the cases. Knowledge of HIV/ AIDS is limited among adolescents. For example only 19–24 percent of married adolescent girls are reported to have ever heard of HIV/AIDS in Bangladesh and Nepal (UNFPA, 1998).

Table: 1.1 Estimation number of people living with HIV in July 2008

SN	Country	Estiate	Low Estimate	High Estimate
1	China	700000	450000	1000000
2	Bangladesh	12000	7700	19000
3	Bhutan	<500	NA	<1000
4	India	2400000	1800000	3200000
5	Nepal	70000	50000	90000
6	Pakistan	96000	69000	150000
7	Sri Lanka	3800	2800	5100
8	Maldives	NA	NA	NA
9	Malaysia	80000	52000	120000

NA=Data Not Available

Source: UNAIDS, July 2008, Report on the Global HIV/AIDS Epidemic.

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

Table shows that the data are not available from Bhutan and Maldives. The deaths by AIDS are low in Bangladesh and Sri Lanka, however the data on deaths by AIDS in Nepal seems lower than India and Pakistan due to the high rate of infection the HIV/AIDS deaths would be high in the future.

2.3 Global Impact of HIV and AIDS in Human and Economic development

The HIV/AIDS pandemic has had a crippling impact on the development of many countries that were making significant progress in terms of health, life expectancy, and economic and social development, in some case reversing decades of development progress.

- Since 1999, average life expectancy has gone down in 38 countries, without a significant increase in the response to the disease, these countries will be 14% smaller than predicted in the absence of AIDS.
- Life expectancy in Zambia is now 34.
- The hardest hit countries in sub-Saharan Africa are losing 1-2% in economic growth annually.
- In some countries, up to 60% of today's 15 year olds will not reach their 60th birthday as a result of AIDS.

The effect on communities and families is devastating as parents, children, income earners and leaders become sick and die. These countries are losing large numbers of their present and future workforce and are struggling to increase budgets to meet the health and social services needs of those affected.

The impact of HIV/AIDS on households is catastrophic as primary breadwinners become ill and cannot work, or stop working to care for those who are sick. The results are new of further impoverishment for husbands who face increasing medical costs, and less money to spend on food, clothing or school fees. Children may be pulled out of school to look after sick family members or to work to support the household. Girls and women are biologically more vulnerable to becoming infected with HIV, and the they are also at greater risk due to economic and social inequities that limit their

choices, or that force them into transactional sex. Marriage or remaining faithful to a single partner do not protect women from HIV, as these women are becoming infected in growing numbers by their partners. (Acharya, 1999)

In addition to the greater vulnerability of women and girls to becoming infected with HIV, they also more often become the primary caregiver for those who are sick. Women who lose their husbands may also lose their property due to inequitable inheritance laws. Families are more likely to pull girls out of school to care for sick family members, and older women who often have no formal employment or source of income become caregivers to adult children who fall ill, and then surrogate partners to their orphaned grandchildren. (Aryal, 2000)

The orphan crisis is worst in sub Saharan Africa, where there is currently an estimated 12 million children who have lost one or both partners to AIDS. By 2010, the number of orphans in that region is expected to increase to more than 18 million. Orphaned children face a much greater risk of hunger, violence, exploitation and abuse as well as decreased access to education factors that also increase their likelihood of becoming infected with HIV. Family and community networks that would normally look after orphaned children have become overextended in many areas. Siblings may be spilt up as children are sent to different places to live, and many children end up on the street.

The impact of HIV/AIDS replicates itself in a cycle of illness, death and poverty, increasing the burden of the worst affected countries that are struggling to meet this large and growing challenge. (Khan, Tamar, 2005)

2.4 The Case of Nepal

HIV/ AIDS have become a major public health problem in Nepal. The first cases were reported in 1988. The potential for the spread of HIV in Nepal is large because of extensive use of commercial sex workers, high rates of sexually transmitted diseases, low levels of condom use and pockets on intravenous drug users. As of magh 2065, a total of 2229 AIDS cases and 13263cases of HIV infection are reported to the Ministry of health and Population, National Center for AIDS and STD Control (NCASC, 2009).

Table: 1.2 Cumulative HIV and AIDS situation of Nepal (As of 11 Feb, 2009)

Condition	Male	Female	Total	New cases in (17 Sept.09)
HIV positive (including AIDS)	8812	4451	13263	165
AIDS (out of total HIV)	1580	649	2229	35

Source: NCASC April 2010

Table: 1.3 Cumulative HIV infections by sub groups and sex

Sub-groups	Male	Female	Total	New cases in (11 Feb 09)
Sex Workers (SW)	3	792	795	6
Clients of SWs/STD	5832	104	5936	68
Housewives	-	3160	3160	46
Blood/Organ Recipients	27	11	38	0
Injecting Drug Use	2350	46	2396	19
Men having Sex with Men (MSM)	74	-	74	1
Children	473	314	787	25
Sub-group NOT Identified	53	24	77	0
Total	8812	4451	13263	165

**Mode of transmission – IDU or Sexual (Source: NCASC, September 2007)

Table: 1.4 Cumulative HIV infections by age group and sex

Age-group(Years)	Male	Female	Total	New cases in (17 Sept. 07)
0 – 4	190	112	302	10
5 – 9	216	155	371	12
10 – 14	78	51	129	3
15 – 19	246	252	498	6
20 – 24	1165	785	1950	11
25 – 29	2014	1050	3064	35
30 – 39	3604	1517	5121	62
40 – 49	1049	419	1468	17
50 – above	250	110	360	9
Total	8812	4451	13263	165

Source: NCASC, 11, Feb 09

Above tables confer the idea that most of the HIV infected people are clients of sex workers and intravenous drug users who are economically and sexually active age group of people (20-39), this clearly indicates that it will generate disequilibrium situation in the fourth coming days by destructing the socio-economic structure of the society.

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

An estimation shows approximately 34,000 cases of HIV/AIDS infection in Nepal (USAIDS, 2000), and another study at female sex workers with sexually transmitted diseases in Kathmandu shown a 17

percent rate, while it was 50 percent among intravenous drug users (FHI, 2002). Therefore the risk at AIDS spreading into the general population through the sexual partner of intravenous drug users and clients female sex workers is large (NDHS, 2002).

The datas are showing an increment of STIs in Nepal. The STI named syphilis was found 19% in Kathmandu, 18.8 in East-West highway of Terai and 13.6% in Pokhara valley among female sex workers. Who visit the skin and STI department of hospital, 3-4 % of them have found one of the STIs. It is recorded that 5.3% Truck Drivers have infected by syphilis, who are the clients of sex workers. Specially, this type of disease i.e. STI is high in developing countries. Its major causes are the human selling business, sex exploitation, the lack of proper treatment, changeable sex behaviour of human being, etc. (Chaudhary, 2006).

The transmission of HIV in Nepal follows a pattern quite common in other developing countries. A country based with malnutrition, diarrhea diseases a high death rates among children and women the AIDS epidemic will burden Nepal's already in adequate health system and tax is stretched resources to curtail HIV's further grip on least developed countries like Nepal. The development community feels strongly that the prevention of HIV/AIDS is the more than a public health concern (UNAIDS, 2007).

In response to the HIV/AIDS epidemic, the than His majesty government of Nepal (HMG/N) established the national AIDS control program (NACP) in 1987 with financial and technical support from the World Health Organization (WHO).

Cox and Subedi conducted a research survey in 1994 among Nepalese sex workers comparing some at their finding with those of other Asian countries. While relative to neighboring countries the AIDS pandemic

has been relatively effect to Nepal, but there is a tremendous potential for rapid spread of infection. Trafficking of Nepalese women and girls to serve the sex industry in India combined with migrant in India and Nepal are primary routes through which the virus threatens to take hold in the general population. High rates of illiteracy taboos regarding the open discussion of sex and limited health, infrastructure are common noted as factors, which the spread of infection (Cox and Subedi, 1995).

Study conducted by WHO, Shows level of Education, Place of Residence, and Mass media source of information exerts a strong effect on level of knowledge of HIV/AIDS. Education is the strongest and most consistent predictor of HIV/AIDS, awareness and level of knowledge. Women having more schooling are more likely to be aware of HIV/AIDS. There is positive relationship between education and knowledge about HIV/AIDS. Mass media and National awareness program have a positive association with the awareness and the level of knowledge of HIV/AIDS as well as maternal health service is positively and significantly related to the awareness of HIV/AIDS and the level of knowledge of HIV /AIDS among currently married women (Panta, 2004).

To sum up the analysis of HIV/AIDS that they have been done by various intellectuals and scholars in their text books and reports in varying periods' observe to have found spreading on expectedly from one area to another. The principle route of transmission of HIV/AIDS is heterosexual with FSWs and close relation among AIDS, prostitution and drug addicts.

On the basis of above description, it has been increasing as an alarming rate day by day in spite of preventive efforts to arrest the infection. It is beyond the capacity of the medical world. So far prevention is the only one remedy to protect from the infection from the infection of HIV/AIDS.

2.5 HIV/AIDS and STIs Control

The current situation of HIV in Nepal is different from when the first case was diagnosed in 1988. There are gaps and challenges to be addressed in the fight against HIV and AIDS. Nepal is low prevalence Country for HIV/AIDS (0.5%). However Some of The groups Show evidence of a concentrated HIV epidemic e.g. Sex workers 19.5 percent, migrant population 4-10 percent and Intravenous drug users (IDUs), Both in rural and urban areas, Since 1988 when the first case was diagnosed MOHP/DOHS and deterrent stakeholders came forward to address HIV and AIDS issues. The main Focus was given to preventive aspects. In 1995 MOHP in consultation with different stake holder developed a policy for the control of HIV/AIDS. However, the activities were implemented in sporadic and disorganized manner.

MOHP came to the conclusion that every Stakeholder working in the field of HIV and AIDS should come forward and world under one Umbrella within the framework of a single policy. As a result in 2002 a new strategy for HIV and AIDS was developed for 5 years (2002 to 2006) and consequently operational work plan was developed for 5 years (2003 to 2007). However, there are many gaps that were not identified during development of the new strategy guidelines that need to be addressed white revising it in 2006, (MOHP, 2006).

The new strategy shot-light the following main areas.

- Vulnerable groups
- Young people
- Treatment, care and support
- Epidemiology, research and surveillance
- Management and Implementation of an expanded response.

Broad political commitment a multi sectors approach, civil society involvement, public- private partnership, reduction of Stigma and discrimination against people infected and affected by HIV/AIDS and human right based approach have been outlined as some of the guiding principles in the development of strategy. To enable high level national AIDS council (NAC) Chaired by the Prime-minister was formed There is national AIDS Coordination committee (NACC) Chaired by the minister of Health which is responsible for reviewing and approving work plans and budgets, reviewing report and guiding implementation of the national strategy. The NCASC has the authority for technical review and advice on policy and funding issues and acts as the secretariat to the NACC. The NACC reports to the NAC. There is also a steering committee chaired by health secretary that meets on a regular basis to review program activities as well as to guide and direct program implementation. (DHS, 2004).

2.6 Vulnerability of mobile population in Nepal

- Approx 600,000 to 1.3 million Nepali men migrate to India each year.
- HIV provenance rated for migrant from western and mid far western districts are 1.1 and 2.8% respectively(Versus 0.05% the general population)
- Seasonal labor migrants constitute 46.03% of reported HIV case.
- Low risk rural female new constitute about 17.52% of reported HIV case, most of these are likely to be spouse of migrant workers.
- Migration has been increasing pulled by more than a decade of armed conflict, population pressure in the hills and poverty. Government Census has shown that 15% of males are absent from their district in a given period.
- 63% to 71% of migrant workers report the use of condoms at last six with female sex worker.

- A large number of labor migrant from Nepal to the areas where there is a higher risk of HIV infection. For example one study found that 9% of migrant returning from Mumbai to Achham district were HIV positive compared to 0.7% of migrant.

CHAPTER - III

RESEARCH METHODS

3.1 General Background of the Study area

Hapur VDC is a rural community of Midwestern Region of Nepal which is located in the western part of Ghorahi (District Headquarter). Hapur VDC is surrounded by Bijauri VDC and Ghorahi Municipality.

Due to unemployment, poverty, rising population pressure, food deficit problem and lack of other facilities have forced people to migrate from Dang district. Many people migrate to Indian cities and also to other countries from Hapur VDC in search of employment and other opportunities.

Ward no-8 of Hapur VDC consisted of people from various social – economic and cultural backgrounds. There were also significant number of people who had been migrated to various cities in India,and some them were HIV+.Ward no-8,a suitable area for research of Hapur VDC.

3.2 Population or Universe

The study was carried out in ward no 8 of Hapur VDC, which covers three village namely Awaldada, Bagia and Dahaltola. According to VDC statistics, there were 845 people in ward no 8. Of the total population of ward no 8, 195 had migrated to India. The research showed the rate of migration to India and other countries, was on the rise.19, respondents were taken for the study from total migrated population, by the method of purposive sampling. Among the sampled population, only 6 respondents were found to be HIV+.

3.3 Research Design

This research was both exploratory and descriptive in nature. Exploratory in the sense that this research explored and uncovered the trend of

awareness and attitude of HIV/AIDS among the study population. This also explored socio-economic factors, demographic characteristics and gap between knowledge and practices towards HIV/AIDS.

Descriptive research design has contributed to describe various aspects of HIV/AIDS affected people such as socio-economic status, their knowledge about HIV/AIDs.

3.4 Nature and Sources of Data

Both qualitative and quantitative data have been generated so as to explain research problems and analysis information for this research.

The primary and secondary data have been applied in order to obtain the required information for this research study. The primary data has been collected basically through field observation and filled up questionnaire focusing the objective of this study and has been attempted to explore knowledge, attitude and practices among respondents in consideration with HIV/AIDS/STIs. The secondary data has been collected from various educational materials published by various authors, research papers and reports, informative articles, public documents and various websites were reviewed for collecting information through internet.

3.5 Methods of Data Collection

To collect the required information the researcher has visited the selected households for household survey and fills up the questionnaire. For the further and supplementary information, interview and observation method have been carried out.

3.6 Data Collection techniques

3.6.1 Interview with PLHAs and Migrant People

The respondents consisting of 19 migrant people including PLHAs (people living with HIV/AIDS) were interviewed. Structured interview method

was used to obtain various information of the respondents: general information and their concern on HIV/AIDS.

3.6.2 Interview Schedule

The required data was obtained by using individual interview schedule and direct interview techniques. Questionnaires were prepared for the survey conducting interview. Questionnaires have been divided into two sections. The first section of the questionnaire is about the information on respondents' socio-economic characteristics such as: age, marriage, education, economic status etc. The second section of the questionnaire is with regard to Knowledge, Attitude and Practices (KAP) about HIV/AIDS/STIs, information on the availability of the health services in the study area, sexual behaviour attitude and practices and health consciousness among respondents. The questionnaire used in this survey is presented in Annex – 1.

It is obvious that the subject can't be introduced without preparing an adequate background. In some cases, the help of local volunteers were sought. In this way the required information were collected from the respondents. The interpersonal communication utility and participant field observation was carried out to collect first hand information.

3.6.3 Questionnaire

Structured questionnaire has been prepared to generate the realistic and accurate data from household survey of the respondent, to make favorable situation, I have tried to stimulate the people to share information without any hesitation and heredity requesting to fill up the questionnaires by themselves.

3.6.4 Focus Group Discussion (FGD) with Mother's Group and Local leaders

In order to know the various aspect of PLHAs, reasons for migration, social and economical status of migrant people and how to minimize the impact

of HIV/AIDS in society, FGD were held with Mother's group, Local leaders, Teachers, Users group, Local officials. Due to the nature of the study, most of the informations were derived from FGD. Due to unavailability of quantifiable data, qualitative information are given.

Also, instead of a different report, the findings of the FGD are incorporated in the chapters wherever appropriate.

3.6.5 Checklist

Check list is also one of the important tools of the data collection. This tool has been focused on the various aspect of participation of PLHAs in decision making level, level of awareness, participation condition, sustainable condition, skill development training and problem facing and more issues.

3.7 Data Processing and Analysis

All the information mentioned in the questionnaire have been edited first for consistency and with the help of computer software (MS Word and MS Excel), these have been entered in the computer and desired tables have been taken out. The variables such as: education level, age group, economic status, possession of communication, marital status etc. have been considered for the presentation and analysis of data. Both singular and cross table have been used to analyze the result. For this purpose, simple statistical tools such as; frequency and mean average are used in tabulation process. All interested in this subject can interpret the results in description manner to make understand the findings.

CHAPTER - IV

SOCIAL, ECONOMIC AND DEMOGRAPHIC CHARACTERISTICS OF MIGRANTS AND THEIR FAMILIES

Basically, it depends up on the PLHAs to declare his/her HIV status. Also, this declaration should be left completely to the wish of any individual. As such, the researcher, in respect to this value, neither encouraged nor discouraged to know the HIV status of the people in the study area. However, Researcher found few self declared PLHAs in the study area to whom we have called here self indentified PLHAs. It was found that these self identified PLHAs had voluntarily revealed their HIV status to the researcher in the hope of receiving assistance from this project. However, these self identified PLHAs could not be confirmed as to whether they were genuine PLHAs or not. Rather, they were included as HIV+ on the basis of their self identification.

Therefore, what should be made very clear is that all PLHAs are self identified. Also, the researcher neither conducted any blood test nor verified their prescription. It was entirely upon their own declaration. Furthermore, validation of the PLHAs self identification did not fall within the work scope of the researcher.

Nevertheless, the saying of the self identified PLHAs may be true due to their background, being India returnees, and the prevailing symptoms of their sickness.

Even though they are self identified PLHAs and not authentically validated PLHAs, it would still be helpful to provide some characteristics which would be helpful to understand PLHAs and design the program.

4.1 Sex and Caste/Ethnic Composition of Migrant People

There are altogether 19 migrants and their spouse have been selected in the study area. Out of19, 15 are male and 4 are female ,in the study, generally male frequently visit to India for employment and female do not go to India for employment. Female manage the householdworks.

Table 1.5: Sex and caste of Migrant people and their spouses

S.N.	Caste/Ethnic Group	Male	Female	Total	Percentage
1	Sunwar	3	-	3	15.78
3	Chhetri	6	2	8	42.10
4	Brahamin	2	-	2	10.53
5	Tharu	2	2	4	21.05
5	Gurung	2	-	2	10.52
	Total	15	4	19	100

(Source: Field survey 2009)

The table show that caste belonging to Chhetri massively go for migration. According to figure, 6 numbers of Chhetri have gone for work in different place of India. That is happening because most of the respondents belonged to Chhetri Caste. On the other hand, the table highlights that Brahmins.

As the shows less number of female visit to India for looking for employmet.

4.2 Education Level of migrant people

Most of the Migrant people and their spouses are found to be unable to read and write. So, they are mostly illiterate. It is well understood fact that because of illiteracy and lack of information, people have high risk of being infected from HIV+. Some of migrants men with primary and secondary level

education are also working in this profession in the study area. It may due to lack of other economic opportunity in this area.

Table: 1.6: Education level of migrant people and their spouse

Education Level	No	Percentage
Secondary level (6-10 class)	1	5
Primary level (3 – 5 class)	5	23
Unable read and write	13	72
Total	19	100

(Source: Field survey, 2009.)

Regarding Migrant people more than 72 percent of them had never been to school and are not been able to read and write, 23 percent had attained up to primary level, and about 5 percent had attained up to secondary level education. Lack of awareness about education and poor economic condition people could not get proper education.

4.3 Marital Status of migrant people

The marital status of migrant people reveals both married and unmarried.

Table: 1.7 marital status of migrant people

Marital Status	No	Percentage %
Unmarried	7	35
Married	12	65
Total	19	100

(Source: Field survey, 2009)

Out of total respondents 35 percent are unmarried and the remaining 65 percent are married.

4.4 Family Occupation

Occupation is the main indicator of the economic status so it plays vital role in the status of any person. After returning home many migrant people's occupation is labor for daily wages in the urban area. In addition, other are involved in agriculture, small self business, services in the private sectors and farming too.

Table: 1.8 Family occupations

Occupation	No	Percentage %
Wage labour	10	55
Government Service	4	20
Business	2	10
Farming	3	15
Total	19	100

(Source: Field survey,2009)

Above table shows that the higher percentage of containing 55 percent of the respondents are engaged as laborers in the urban area, followed by service in government sectors 20 percent, farming 15 percent and small business 10 percent. Lack of business knowledge to people often do not use money in productive sectors rater then in farming sectors.

4.5 Level of Land Holding Size and Production Unit

All migrant people have their own houses even though they are small. Similarly except of some migrant, all other have small fields to produce food for their own consumption. Although such farm lands are controversial in legal term. Some of them have occupied government land and start farming.

Table 1.9: Land holing size

SN	Landless	1-3 Kattha	4-6 Kattha	7-10 Kattha	Above 10 Kattha	Total Kattha
1	-	3	-	-	-	3
2	5	-	-	-	-	5
3	-	-	-	4	-	4
4	-	-	-	-	3	3
5	-	-	4	-	-	4

(Source: field survey2009)

In terms of physical facilities, it is observed that there is very poor hygiene and sanitation in the home and their surroundings. Few migrants have toilets and well drinking water facilities in house. Majority of people have no well facilities of like toilet and drinking water. it creates hygiene and sanitation problem that not only affects home of PLHAs but also the surroundings.

4.6 Family Income sufficient or not

Table: 1.10 Status of income source

Income sufficient to meet their household expencess	Male	Female	Total	percentage
No	13	3	16	68
Yes	2	1	3	32
Total	15	4	19	100

(Source: Field Survey, 2009)

The table shows that the 68 percent respondents' family income is insufficient to meet their household expenses. Of the 32 percent respondents are reported that they have sufficient income to meet the household expenses of their families throughout the year.

4.7 Working Cities in India and Other Countries of Migrant People

Even though the study area is in the border of India, there are several small cities nearly. However, migrants do not have attraction to go and work in the nearby cities, from where migrant can visit their family frequently. The most favorable city for migration are Delhi, Mumbai and near by cities of India. Mumbai has been a hub for Nepali migrant workers. If employment is not available in Mumbai, migrants go to nearby cities of Mumbai for temporary work. However, they prefer to return Mumbai later when employment is available.

Table 2 working cities

SN	Delhi	Mumbai	Punjab	Madras	Other countries	Total
1	5	-	-	-	-	5
2	-	6		-	-	6
3	-	-	4	-	-	4
4	-	-	-	-	3	3
5	-	-	-	1	-	1

(Source: field survey 2009)

Most of migrants work as Chaukidar (Watchman), besides that some people work as Driver, Cook, Caregiver, Recipients and many more. While working in India they earn NRs 3000 to 8,000. Some migrants who are working for a long time in India they earn up to Nrs 20,000 and more than that per month.

Table No 2.1 Reason for choosing the particular place

Description	No	Percentage
Neighbour	11	58
Good opportunity to find work	2	11
Heard about the place	3	16
Closer to birth place	1	5
Relative working in India	1	5
Other	1	5
Total	19	100

(source: Field survey, 2009)

The main causes of going to India are India as a neighboring country where people get good opportunity of job. And, another cause is that people think place of getting and some people 90 there in terms of propaganda about the places of India.

The percent of going to India respectively is 58 percent, 16 percent, 11 percent and 5 percent.

Table No. 2.2 Reason for migration

Description	No	Percentage
Absolute poverty	16	85
Due to relative	2	10
Skill development/ carrier maintain	1	5
Total	19	100

(Source: Field survey, 2009)

Almost the reasons the main and mentionable reason are obviously poverty. About 85% of people go to India due to poverty,10% people visit India because of their relatives, and 5% of people leave to acquire the education of skill development.

People of age group especially 15-25(58%),26-40(32%),10-14(10%) migrated to Indian Metropolitan cities in search of good job and earning. And, its mean age is 18. So this shows that active population and reproductive age of grow of migrate to India.

4.8 Detail of PLHAs in Hapur VDC Ward No 8

Among 195 people migrated to India and other countries in this year 06, 07 people have been found HIV+. Most of them are spouse of migrant returned from India. The cast and sex of the PLHAs of this ward is as follows:

Table 2.3: Sex and caste of PLHAs of Ward No 8

S.N.	Caste	Male	Female	Total
1	Sunwar	1	-	1
3	Chhetri	1	2	3
4	Brahamin		-	
5	Tharu		1	1
5	Gurung	-	1	1
	Total	2	4	6

(Source: Field survey 2009)

The table shows that HIV has been found more in female than male. According to respondents, male HIV infected have already died before they got checked.

4.9 Need of the PLHAs

To know and learn the specific needs of PLHAs, the researcher carried out FGD and interviews with PLHAs by visiting in their houses. More than this, their conditions are observed at close quarter. In the course of study, all are found to have become bed ridden. Given below are some of the specific needs of these PLHAs.

First of all PLHAs, for fear of being shunned or ostracized by neighbor and relatives, have not confided their HIV status to them. As the reason they revealed their HIV status to Researcher, It would be due to their hope of receiving some assistance from the project. Only some of the PLHAs have well established toilet and drinking water source at house. It is felt that the foremost need of the PLHAs is good hygiene and sanitation practice. In this regard the Mother group can play a meaningful and active role by encouraging the PLHAs and their caretakers to construct pit latrines, and dispose of the fluid waste of PLHAs in a practical manner and imparting the caretaker and the PLHAs with health education.

The second important need of the PLHAs is counseling services. It is unfortunate that till now there is no counseling service in HP. Nepal Women Community Service Center and Nepal Family Planning Association are providing VCT service in Dang district so counseling service is must to the PLHAs about OI management (Opportunistic Infections) and healthy life style. Similarly, though counseling, the rest of the family members could be made aware of AIDS so that they would provide better support to the PLHAs. Presently, due to the confusion within the family members concerning AIDS, PLHAs are not receiving full support in their care.

The third need of the PLHAs is palliative service. Currently, there is nobody in the Health post trained to provide palliative services to the PLHAs. As such, it has become necessary to provide such a training to the staff of the

Health Post has been discussed with the Mother's group and user's group, they pointed out that since the Health post staff can be transferred anytime, it would be better to give simple and practical palliative service training to local FCHVs(Female community health volunteers). By doing so, the PLHAs would be provided with reliable and sustainable palliative service.

On the other hand, due to the limited learning capacity of the FCHVs, it would not be practical to train spouse of PLHAs for community home based care and support(CHBC) activities.

The fourth and important need of the PLHAs is economic opportunities for their members such as micro credit program, small business and revolving fund or seed money for the economic activities.

4.10 Impact of HIV/AIDS at Household level

There are various impacts at the household level due to HIV/AIDS. When the migrant got infected from HIV+, the main source of income comes into the stage of stoppage which directly affects the economic status of family. Since PLHAs households have less land for cultivation, the agricultural production can not provide sufficient need and necessity for the family members when they got infection from HIV/AIDS in their working place, gradually they are unable to activate daily routine work so they have compulsion to resign from the post.

After being infected anyway, they have to search for medical assistance on the one hand, and on the other hand they have no source of income. If they hardly get source of income that goes off in medical assistance. So, they can not send money for family support which creates crisis in the economic status. This is the big negative impact on economic condition from HIV/AIDS.

PLHAs get salary ranging from NRs 1200 to Nrs 8000 per month. Some migrant were also earning more than Nrs 15000 per month. They do hard labour to make their needs meet. Furthermore, one person has to take care of his/her and the caretaker can not work for long hours outside the home, s/he is forced to go any where for earning. It is also reported that because of the nature of job, most of them get accommodation facility at the working sites.

4.11 Level of Income

In this area, most of the migrant families have lower income level because this area is also known as the socio-economically backward community.

Table: 2.4 level of income (in annual)

Level of Income (in Rs.)	No	Percentage
Less than 20,000	9	47
20,000-40,000	7	37
Above 40,000	3	16
Total	19	100

Source: Field Survey, 2009.

Above table reveals that most of the families 47% had income level lower than Rs. 20,000; 37% had between Rs. 20,000 to Rs. 40,000 and 16% had income above Rs. 40,000 because some members of these families are involved in services of private sector.

4.12 Cost of PLHAs on Treatment

After returning home being HIV+, most of the income is spent on the treatment of the PLHAs. Due to loss of regular income, treatment cost for OI management is managed either selling their crops or even their property.

Table 2.5: Cost in medical treatment

SN	Rang of amount	No	Percentage
1	< 5000	2	33
2	5000 to 8000	1	17
3	8000 to 12000	-	-
4	12000 to 20000	2	33
5	20000 an above	1	17
	Total	6	100

(Source: Field Survey, 2009)

PLHAs have spent more than 12000 and one PLHAs has spent more than 20,000 for medical treatment, As Government of Nepal is providing ARV(Anti retro Viral Therapy) without any cost from Rapti Sub- Regional Hospital Ghorahi, Dang and Nabakiran Plus is managing for the providing ARV but very few PLHAs are informed about this facility. So large amount of money has been spent on the OI management and medical treatment of PLHAs.

During FGD we found that the cycle of economic impact does not end with death of the PLHAs, Funerals are expensive depending on cast and type of funerals and rituals. During FGD it was reported that after the death of husband, due to ignorance of legal terms and lengthy process of legal procedures, many women loss the property or get less in comparison to real valuation of the propriety. Even many of funerals are forced to go back to their father's home.

It is also noted that money holders do not prefer to provide loans to the families of the PLHAs because they think that nobody will survive to repay back their loans. Thus the main impact on the family is economic impact.

Beside that the social impact of HIV/AIDS has been found as follows:

During FDG it is told that when the main respondent of the family became HIV+, the work load has been replaced to the children of the family, due to lack of regular income they are forced to discontinue the education. If the children are also HIV+, their status is also fund more complex. They do not get regular treatment or care for sanitation, hygienic food and OI treatment.

CHAPTER – V

KNOWLEDGE ON HIV/AIDS AMONG MIGRANT PEOPLE

This chapter presents the analysis of knowledge, sources of knowledge, modes of transmission, modes of non-transmission and preventive measures of HIV/AIDS and STIs.

5.1 Knowledge on HIV/AIDS/STIs among Migrant family and their spouses

This perception of human being is entirely dependent upon proper knowledge. With vacant knowledge, it is impossible to know the significance of anything. Only the knowledge can lead the person to the actual direction.

Table: 2.6: Knowledge on HIV/AIDS

Ever Heard About HIV/AIDS	No	Percentage
Heard	13	68
Not Heard	6	32
Total	19	100

(Source: Field survey, 2009)

The survey reveals that among the respondents 68 percent were found having heard about HIV/AIDS, 32 percent were found not having heard about HIV/AIDS. This data clearly indicates that most of the respondents were found having sound knowledge regarding HIV/AIDS. Many research and studies have shown that the knowledge is not affecting toward the reducing rate of HIV/AIDS, they have emphasized upon practical aspect.

5.2 Sources of Knowledge on HIV/AIDS among migrant people and spouses

Access to information concerning HIV/AIDS varies widely. This is determined by a number of factors like exposure to different channel contacts with health workers and health service institutions, meeting/ discussion with peers etc.

Table 2.7: Source of Knowledge on HIV/AIDS among Respondents.

SN	Source of information	No	Percentage
1	Peer educators	11	58
2	Health volunteer	15	78
3	Media(T.V/ Radio/ publication)	17	89

(Source: Field Survey, 2009)

The study shows, the majority of the respondents got knowledge about HIV/AIDS through Media (T.V./ Radio, Publication). Similarly, Health volunteer is another source from which 78 percent knowledge is gained and Publication/TV is another source from which 58 percent knowledge is received Peer educator.

Hence, what the data summarizes that the intervention program launched by different organization seems effective, because majority of the respondents are reported that they have got the information from various media.

5.3 Knowledge about Modes of Transmission on HIV/AIDS

As on date reported cases (by NCASC) disclose that unsafe sexual intercourse is the major cause through which HIV has spread into the Nepalese population, reported only the high-risk behavior sexual intercourse with infected person. The research discloses that all the respondents are found with

no proper knowledge about the various modes of HIV transmission. Of the total 19 respondent had reported that the only one modes of HIV transmission is sexual intercourse.

Table 2.8: Knowledge about Modes of Transmission on HIV/AIDS

SN	Mode of transmission	No	Percentage
1	Sexual intercourse	19	100
2	Blood transfusion	16	84
3	Infected mother to child	10	52
4	Sharing same Needles	15	78

(Source: Field Survey, 2009)

The table shows that the modes of transmission are sexual intercourse with infected person 19, followed by blood transfusion and Infected mother child are 16 and 10 respectively. Finally no. of respondents using same needles are 15 persons.

5.4 Knowledge about Modes of Non-Transmission on HIV/AIDS

Psycho-social factors such as social stigmatization, social discriminations, misperception, level of awareness of the community and community leaders plays a great role to develop the attitude of society towards people living with HIV/AIDS (PLWH/A). These factors are misinterpreting the real facts without being consciousness. Such traditions have produced doubt, fear and anxiety in the mind of majority of the people.

Table 2.9: Knowledge about Modes of Non-Transmission on HIV/AIDS

SN	Mode of Non- transmission	No	Percentage
1	Living together	19	100
2	Sleeping together	10	52

3	Mosquito bites	15	78
4	Kissing	9	17
5	Hand shaking	15	78
6	Using same toilet	12	63

(Source: Field Survey, 2009)

The study found out that majority of the respondents have significant level of knowledge about modes of non-transmission of HIV/AIDS. Almost all have more information that HIV/AIDS do not transmit by living together, 52 percent of respondents think HIV/AIDS do not transmit by sleeping together. The no. of respondents who think HIV/AIDS do not transmit by hand shaking and using the same toilet where 78 and 63 percent respectively. 78 percent of respondents think mosquito bites and 47 percent of respondents think kissing are also non-transmission medium.

Although an overwhelming majority of respondents reported positive answers on modes of non-transmission of HIV/AIDS, but some of them have been seemed confusion about whether it transmits or not by eating together, living together, sleeping together, mosquito bites, kissing and hugging, hand shaking and using same toilet.

5.5 Knowledge of Prevention on HIV/AIDS

It is well known that AIDS is incurable but preventive measures should be taken to control its spread. It is said that prevention is always better than cure and since there is no cure, then the only way to keep oneself safe is to take preventive measures. Every individual should be made aware of this fatal disease. All should be properly educated and warned of its consequences. The survey reveals that the majority of Migrant and their spouse respondents are found with some knowledge of prevention of HIV/AIDS.

Table 2.10: Knowledge of Prevention on HIV/AIDS

SN	Prevention methods	No	Percentage%
1	Using condom	17	90
2	Use screened blood	14	75
3	Disposable sharp equipment	12	62

(Source: Field Survey, 2009)

The survey shows that out of 19 respondents, 9o% respondents using condom can prevent the HIV/AIDS, followed by 75% using screened blood and 62% disposal of sharp equipments.

The level of knowledge of Migrant and spouses towards the means of different method of prevention is significantly high. Different intervention program launched by various governmental and non-governmental organizations are seemed to be effective and successful to impart the knowledge about prevention method.

5.6 Knowledge on STIs among Migrant and their spouse

It is estimated that 165 million new cases curable sexually transmitted diseases occur worldwide each year among women aged 15-49 years (WHO). Attempts are made only in two most common STIs, Syphilis and gonorrhea generally appeared in STI infected person. In addition to syphilis (genital ulcer) and gonorrhea (genital discharge), there are various kinds of STIs i.e. Chlamydia, Cancroids, Candidacies, Trichomoniasis etc. but respondents are found very poor knowledge concerning other kinds of STIs.

Sexually Transmitted Infections (STIs) are major global cause of acute illness, infertility, long term disability and death, with severe medical and psychological consequence for millions of men, women and infants. WHO

estimated that 340 million cases of syphilis, gonorrhea, Chlamydia and trichomoniasis occur through out the world in men and women aged 15-49 years and so percent cases occur in Asia developing countries in every year.

Table 3: Knowledge on STIs among Respondents

SN	Knowledge on STIs	No	Percentage
1	Knowledge on STIs	16	84
2	Knowledge on Gonorohea	10	52
3	Knowledge on Syphilis	12	63

(Source: Field Survey, 2009)

The study indicates that 84 percent spouse were found having knowledge on STIs, among of them 52 percent had the knowledge about gonorrhea and 63 percent had knowledge of syphilis.

The above data shows that most of the migrants have known the STIs is a product of unprotected sex, and they also have known the terms of STIs gonorrhea and syphilis that is generally appeared as the major symptom. So, it can be concluded that they are compelled to involve in this profession for their survival.

5.7 Knowledge, Attitude and Sources of Information about Condom among Respondents

Condom is a most effective contraceptive and it has no side effect. Several studies have demonstrated that the use of condom during sexual intercourse reduces the risk of transmitting or acquiring infection with HIV as well as the STIs and that proper and consistent use of condom can play vital role in AIDS prevention.

All the respondents are found with knowledge of condom. Of the total, 2 respondents reported that they have knowledge about condom from health workers/volunteers, 12 got from radio advertisement and 5 from IEC materials/ publications.

Table 3.1: Knowledge, Attitude and Sources of Information on Condom among Respondents.

Knowledge	Response		
About condom	19 (100%)		
Sources	Health Workers/Volunteers	Radio	IEC Materials/ Publications
Total	2 (10.52%)	12 (63.15%)	5 (26.31%)
If husband wouldn't agree to use condom	Accept what he says	Remind about HIV/AIDS	Refuse to have sex
Total	15 (78.94%)	1 (5%)	3 (15.78%)
Sources to get Condoms	Husband bring it	Buy own self from shop	Health Workers/Volunteer
Total	10 (52.63%)	4 (21%)	5 (26.31%)

(Source: Field Survey, 2009)

Of the total, 15 respondents reported that they accept sexual relation with their husband even if they are not ready to use condom; 1 respondents reported that they try to remind their husband about possible STIs in condition that the husbands are not ready to have sex with condom. And 3 respondents reported that they refuse to have sex with those husbands who are not ready to use condom. With reference to the sources of condom, 10 respondent said that

the husband bring it, 4 respondent said that they buy from the local shops and 55 percent said that they get condom by health workers.

The finding reveals majorities of Migrant and spouses get access to condom through health workers/volunteers. Similarly, 10 respondents reported that they get it through their husband and 1 respondent buy from local shops.

Different sources of information are prevailed in this study area but the source of mass media like radio are more effective because it is affordable for all respondents. Illiteracy makes least effective to the publication as a source of information.

Most of the respondents have different level of confidence toward the use of condom despite the refuse of husband. Some of them showed the confidence to avoid the sex with that husbands who are not ready to use condom and some want to remind their husband about HIV/AIDS through unprotected sex. Some numbers of respondents are ready to accept the husband's wants though they are fully informed about unprotected sex at its consequences. The change in level of confidence may be depending on availability of resources for their survival.

Different sources of condom are accessible to the Migrant and spouses out of which health workers and volunteers are effective and easily accessible up to them. Because of familiarity between them and they do not hesitate to receive condom from them.

5.8 Gap between Knowledge and Practices on Condom use among Respondents

The entire knowledge system possess by human being does not reflect on the practices. There may be vast difference between knowledge and practice because practices are always conditional and affected by the external situation.

Table 3.2: Gap between Knowledge and Practices on Condom use among Respondents

Knowledge about Condom	Number/ Percentage	Trends & Attitude Towards use of Condom	Number/ Percentage
known about condom	19 (100%)	Bothering to use	3 (15%)
Condom as Tools of Avoiding AIDS	17 (89.47%)	Do not Like by Husband	6 (31.57%)
Using Skill of Condom	12 (63.15%)	For avoiding Pregnancies	8 (42.10%)
Condom Keeping	6 (31.57%)	For avoiding STIs	13 (68.42%)

(Source: Field Survey, 2009)

Above table reveals all the respondents are known about condom, 89 percent respondents reported that they are known about condom as a tools at avoiding AIDS, 63 percent have using skill of condom and 31 percent have habit of condom keeping. Similarly, 15 percent reported that the condom is bothering to use, 31 percent said that the condom is not liked by Husband , 42 percent said condom is useful for avoiding pregnancy and 68 percent replied condom is useful for avoiding STIs.

Most of the Migrant and spouses have the knowledge that condom is an effective tool for avoiding HIV/AIDS and they have the skill of using condom also. But in practical aspects 3 respondents realize bothering to use condom during he sexual intercourse. 8 Migrant and spouses have used condom for avoiding pregnancies and 13 respondents have used condom for the purpose of avoiding STIs.

It can be concluded that there is not any problem of knowledge about HIV/AIDS and its prevention but the existing knowledge is conditioned to reflect on the practices by the attitude of partner’s nature of occupation, way of life etc.

5.9 Treatment seeking Behavior

The beliefs of sex and sexuality are absolutely confined within the framework of our poverty-stricken, superstitious, illiteracy, ignorance and backwardness society. In general, people do not tend to know their health status. If STI happens to someone he/she does not like to expose to other people. For the time being people are gradually becoming serious about their health status, it might be the reason of modernization and urbanization.

After I/NGOs and Government of Nepal have implemented the AIDS/STIs awareness campaign through different media channels broadcaster, messages, billboard, exhibiting street dramas, mobilizing peer educator, disseminating the message among the people; majority of the Nepalese people are found with some knowledge about AIDS/STIs.

Since almost all PLHAs got sick while working in India, they sought their first medical treatment while they were there. The PLHAs, during the interview, said the first symptoms of diarrheas loss of appetite. After seeing the doctor they are given the medicines to cure of diarrhea or revive their lost appetite. Majority of the respondents reported that they usually visited the private clinics(78%) and governmental hospital(5%) for treatment. Only 17 percent visited private medical store.

Table 3.3 Usual source of Health service facilities

SN	Places	No	Percentage%
1	Private clinic	15	78
2	Govt Hospital	1	5
3	Private Medical Store	3	17
	Total	19	100

(source: Field survey 2009)

In the study area there was no specific treatment seeking behavior. Rather, it all depends on the prevailing situation, condition of the disease, the truth and belief on the health care providers, availability of alternatives and the economic status of the family.

Similarly, it was found that there are a lot of difference in the treatment seeking behavior between PLHAs who, while undergoing a blood test and being diagnosed as HIV+ and a PLHAs who, even while in India, they are told of HIV+ status or they do know about it.

Those PLHAs who knew about HIV status were found to be reluctant to seek medical treatment in Nepal. Rather, they preferred to go to India. Similarly, PLHAs who don't know that they afflicted with HIV sought medical treatment in Nepal by going to private medical store, Health post and finally to Rapti Sub-Regional governmental hospital.

CHAPTER – VI

SUMMARY, MAIN FINDINGS, CONCLUSION AND DIRECTION FOR THE FUTURE RESEARCH

6. Summary

Migration to India and other countries from rural areas of Nepal is common phenomenon. Poverty, lack of education and employment, growing population are pushing factors for migration. Such migration brings separation from family or sex partner and other risk behavior which put them in high risk of HIV transmission.

HIV/AIDS is a major disease which directly affects the economic and social status of a family and in other sector of community. More than 70,000 people are living with HIV in Nepal and it being a growing challenge for economic and social empowerment of rural community.

To find out the social and economic status of migrant people living with HIV, to determine the explore the vulnerability of HIV/AIDS are the specific objectives of this study. Knowledge and attitude of the general people towards PLHAs and to explore the vulnerability of HIV/AIDS are the specific objectives of this study.

The study based on field survey, all the information and data were collected from the migrant people and their spouse and PLHAs, who are currently living in Hapur VDC-8 of Dang district, By the FGD, interview, networking tracking method and purposive sampling technique. The participant observation, unstructured interview, structured questionnaire are presented through the data and information. For the purpose of study, a sample of 19 migrants from each ward and 6 PLHAs were taken. All the data were mentioned both descriptively and statistically.

To explore and describe the relationship, the specific objective was made that is socio-economic impact of HIV/AIDS with reference to the people living with HIV/AIDS and their living environment.

A substantial review of related literature was made during the study period. The search is carried out within the migrant people and PLHAs returned from India and other countries and their living standard.

This research study of socio economic impact of HIV/AIDS among Migrant and their spouse in Hapur VDC-8 of Dang district have been analyzed social and economic status among them. This also showed HIV risk behaviors, routes of transmission and ways to prevent HIV/AIDS/STIs with consideration to the objectives, analyses were conducted and the objectives are as following:

- To identify the social and economic impact of HIV/AIDS .
- To assess knowledge, attitude and practices on HIV/AIDS and STIs.
- To find out the gap between knowledge and practices towards HIV/AIDS and STIs.

Basically the primary data has been utilized to fulfill the objectives of this study. The data was collected from the field survey, completed in the month of April 2009. Regarding this research study a total 19 respondents were chosen from of Hapur VDC-8 as the key respondents. These respondents have been selected in accordance with the project's outreach points, social mapping and social mobility. In this case the respondents were already contacted and involved in various awareness raising activities organized by NGO. The pre-structured questionnaires were constructed so as to meet the objectives of the study. After getting the information, the data was processed with the help of computer programming Microsoft Windows and Microsoft Excel.

On the basis of these procedures, the following section highlights the most important data findings, conclusions and recommendations of the study.

Various ethnic groups are affected by HIV/AIDS in Hapur VDC-8 of Dang district with the majority 2 person are chettari, 1person Sunuwar , 1 person Brahamin and other is 1 person living with HIV virus. The study reveals

that slightly more than half of the PLHAs 60 percent belong to the age group of 21-30 years. This group is big in this disease.

Most of respondents are returned from Delhi and Mumbai and the study reveals that overwhelming majority of the respondents 72 percent is illiterate and 28 percent educated and 25 percent from joint family and 10 percent are living single.

The economic condition is the most important components of the society. 32 percent respondents have sufficient means to meet the food and 68 percent have not. Food insufficiency is more female respondents. Most of the respondents families are in agriculture 47 percent followed by job, 25 percent and 20 percent are in business. Half of the respondent families have household saving but female respondents household saving is less than male respondents household. 85 percent respondent's families have their own land.

70 percent respondent said their physical condition is normal, 15 percent said sick and 15 percent said critical and only 65 percent respondents have access to health care and medicine and 35 percent have not access to proper health care and medicine.

Most of people living with HIV/AIDS have experience of discrimination (63%). In such 5 percent respondent had such experience by society, 21 percent by community, 12 percent by family, 20 percent by doctor, 5 percent by government and 5 percent by all institutions.

6.1 Main Findings

- People go migrate to mainly in India. But recent years people have started to go in various golf countries.
- People go to a particular city on the basis of network available their or their relatives/neighbours working there.
- It is found that due to absolute poverty people go for jobs as migrants.

- Among the various caste and sex, chhetri castes males and females migrate than other sex and caste.
- Most of migrants have not completed their basic education.
- It is found that more married people go for work than unmarried.
- After returning home from migration many migrants people's occupation is labour for daily wages in the urban area.
- Most of migrant people have only small land to produce food consumption. The product food could not be sufficient to fulfill even three months.
- The most favourable city for migration are Mumbai and Delhi.
- 68% respondet's family income is insufficient to meet their household expenses.
- Among migrants family, more migrants have knowledge about HIV/AIDS and main source of knowledge are peer educators and Media.
- People, who have been affected by AIDS, have no proper idea of treatment seeking behaviour however it is increasing.
- It is found that HIV/AIDS is transmitted to famous by their husband.
- All the respondets had known about condom, but 15% of think it is bothering to use.
- Despite 89.47% of respondents knowing condom as a tool for avoiding HIV/AIDS, 31.57% of husbands were against using condom.
- Even if one has the knowledge and access to condom, only few of them make use of it, when required.

- There data suggest that there is a gap between knowledge and practices on condom use among the respondents.

6.2 Conclusions

The alarming figures on the number of HIV infected person and AIDS patient is believed to be accelerated by frequent drug abuse, commercial sex workers. The PLHAs are living in very poor social and economical condition. As Dang district is one of the hilly districts of Nepal, there is to do more for PLHAs in district.

Due to extreme poverty, less opportunity of education and employment in district, people are forced to be migrants in Indian cities and other neighbor countries. Research reveals, that major factor influencing the formation of its concept and representation is the publicity given to AIDS by the mass media.

Research shows that the PLHAs are living with inadequate health access, social stigma, and discrimination with alienation. According to study, other most affected units are families of PLHAs and women. Families affected by HIV/AIDS are confronted with many potential problems. They are facing less economic support because of the loss of in the work force. Also, women afflicted with the competent people disease are struggling to care for themselves and their children.

On the legal aspects regarding HIV/AIDS nothing is active till now. The government also has formed high level and district level committee, but in practical there is no sufficient plan and program. Study finds that infected peoples participation in HIV/AIDS related programs are rare. And such programs are not gender sensitive; either governments program or other HIV/AIDS related programs.

Women PLHAs are in very initial stage of networking, they are not getting legal support. Designing and implementing programs for women PLHAs, prevention and research programs must also examine how to

incorporate gender analysis into programs. Health programs and policies must be informed by greater gender sensitivity. It is not a problem that can be solved by a simple mathematical formula. On the contrary, it requires the dedication, attention and commitment of the society. This is not unlike other socio economic problems that increase with the urbanization of the country. Therefore one should think about this problem before it takes and even more serious turn.

The above problems are increasing daily rather than decreasing. This rise the crucial questions as to how long the PLHAs and their families can continue to exist in the context of rapidly changing modernizing and westernizing country. Above all what will be the future of PLHAs and who will take care of them? Still remains a answered question.

The impact of HIV/AIDS has increased poverty and vulnerability. This increased vulnerability resulted in more HIV infections, higher impact on socio economic development and loss of productive life; the burden of disease would change dramatically over the next coming years and would put further stress on the health sector and local communities.

6.3 Direction to the Further Research

The following points should be considered for further researcher in concerned with the preceding research.

1. This research could not cover all the migrant people and their spouses of Dang district. Therefore in further research one should try to study all the migrants people of Dang district.

2. A detail comparative study is needed between HIV affects migrant people and non-affected migrant people.

3. There are no exact figures of migrant people. Therefore academic institution must involve in periodic research about migrant people and their socio-economic impact.

4. Case history must be involved in further research.

5. Not only the socio-economic but other aspects such as physical, exploitation, mental, psycho-social etc. must be the part of further research.

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ANNEX 1

QUESTIONNAIRE

I. Respondent Information

1) Name:
2) Age:
3) Caste:
4) Sex:
5) Religion:
6) Education:
7) Occupation: Main: Subsidiary:
8) Income:

   Monthly:

   Yearly:
9) Marital status

   Unmarried

   Married

   Divorce

   Widow/Separated
10) If married how many children do you have and their sex and age
11) Place of birth
12) Village :
13) House: Own or Rental
14) Composition of family member
15) Number of family member
16) How much your family earn

Monthly

Yearly

17) Income source of family

1) Job
2) Agriculture
3) Business
4) Rent
5) Pension
6) Inheritance property
7) Others

18) Is this income sufficient to meet the annual food and other expenses in your family?

a) How much land do you have

b) Do you have you own house, land or other property

19) Do you have job? If yes type of Job

Monthly income

Yearly income

20) How much land do you have

21) How much do you expend on food and other expenses.

22) What was your occupation before infection

23) After being HIV+ is your family income increased or decreased?

II) Concern on HIV/AIDS:

1) How do you hear about HIV/AIDS.
2) How do you know about it

Radio

TV

Newspaper

Friends

Others

3) How did you get it

Drug

Blood transfusion

Prostitute

Extramarital affairs

Wife

Husband

Clients

Workers

Other

4) When you know about the disease what did you feel?

Surprise

Fear

Depress

Frustrate

Stigma

Nothing

5) Do your family know about your HIV status?

If yes what was their reaction?

If no why did you not tell them?

6) Your friend know your HIV status

If yes what was their reaction

7) After being HIV+ did you feel sick

8) What type of behave and support you except from society and family?

9) If you are living in rehabilitation center, how do they behave with you?

10) Do they really care and support you?

11) Do you get necessary good and care?

12) What is your present physical condition?

13) What is your present medical condition?

14) What is your present financial condition?

15) How other people behave you? What is your reaction?

16) Have you getting equal opportunity as other people?

Yes No

17) If No, what is reason?

18) Do you know any or your children have positive?

Yes No

19) If Yes

20) Age Sex

21) How many programmers are implemented by various sectors for PLHAs do you know about them?

Yes No

22) Programmer Name:

23) Are you participating in any program?

Yes No

24) If Yes, what type of participation?

In decision making

In program implementation

In benefit shaving do you feel discrimination towards you?

Yes No

25) If yes from where?

By society

By community

By family

26)Do you know any orphans children by AIDS?

Yes No

27) Do you feel any discrimination compare to male patient?(for women)

Yes No

28) If yes, what kind of discrimination

29) What is your suggestion to other people?