Socio-Economic Impact of HIV/AIDS among migrant people and their spouses

(A Case Study of the Migrant People and Their Spouse of Laxmipur VDC of Dang District, Nepal)

A Thesis Report
Submitted to:
The Central Department of Rural Development
In the Partial Fulfillment of Requirement for
the Master Degree of Arts in
Rural Development

Prepared by:
Pawan Yogi
Campus Roll No: 388
Phone No. 9857830106
April 2009

Recommendation Letter

The Dissertation work entitled Socio-economic impact of HIV/AIDS among Migrant labors of Laxmipur VDC of Dang district by Pawan Yogi is papered under my supervision for the partial fulfillment of the requirement of the master of Art in Rural development. To the best of my knowledge, the study is original, primary data based and investigate useful information about HIV/AIDS and it's impact.

I forward this thesis (Document) to dissertation committee for evaluation.

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Mr. Umesh Acharya
Supervisor
Central Department of Rural Development

T.U. Kiritupur

Date: 29 April 2009

Approval Letter

The Evaluation committee has approved this Dissertation entitled **"Socio-economic Impact of HIV and AIDS, A case study of Laxmipur VDC of Dang District"** Submitted by Pawan Yogi for the partial fulfillment of the requirement of the master of Humanities in Rural Development.

Evaluation Committee		Signature
1. Dissertation Supervisor	Mr. Umesh Acharya	……
2. External Examiner	Mr. Suman Bashkota	……
3. Head of the Department	Mr. Pradeep Khadka	……

Date: 29 April 2009

ACKNOWLEDGEMENT

It is my great pleasure to extend my gratitude to lecture **Mr. Umesh Acharya**, under whose supervision, guidance, Coordination and Scholarly assistance this work would not have come into this form

I am grateful to Central Department of Rural Development of Tribhuvan University and specially to **Mr. Pradeep kumar Khadka,** head of the department, under whose permission I got chance to write this dissertation on this topic.

I would like to express my appreciation to Nava Kiran Plus Family, Dang plus family specially Mr. Tilak Khadka and staffs of NWCSC(Ms Kalpana Neupane, Mr Bhesh Bahadur BC, Mr Krishna Prasad Tiwari, Mr Lokmani regmi and NWCSC family. I am also indebted to those participants who responded my research questionnaires besides their feelings to discrimination and stigma.

My sincere thanks to Ms. Bimala Yogi, Chairperson, NWCSC for her inspiration and suggestions scholarly to bring this project in reality.

I have no words to express my dedication to my wife and children Sarmila giri, Govinda Nath yogi and Prasan Nath yogi, whose single endeavor, affection, love, inspiration and supports have made me able to bring this valuable document.

I express my heartfelt thanks to all my friends and relatives for their helpful hands and shoulders were always with me to complete this task.

All of my family members support was Instrumental behind this work to complete, Specially, I am indebted to UNDP, HIV and AIDS PMU, Mr. Loknath Kandel and Sujan Raj Onta for inspiration and guidance is always with me in my career and valuable suggestions to complete this work.

At last, I would like to express my heartily thanks to all whose direct and indirect contribute have helped me to accomplish this task in time.

Pawan Yogi
Chaughera-4, Dang
29 April 09

ABSTRACT

Migration to Indian and other countries from rural areas of Nepal is common phenomenon. Poverty, Lack of education and employment, growing population is pushing factors for migration. Separation from family or sex partner and other risk behavior 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 empowerment of rural community.

To find out the socio-economic status of migrant people living with HIV and to determine the knowledge and attitude of the general people towards PLHAs and to explore the vulnerability of HIV/AIDS was the objective of this report.

Interview with PLHAs and key formants of the VDS, focal group discussion with mother's group, user's group and local leaders and case study were the main methodology of the report.

The views and thinking towards PLHA and their families of the society and their economic status will be significantly changed via socioeconomic package, compared to current situation. The package is thus clearly more efficient in achieving its goal than by other means. Collaborating and coordinating with governmental and other existing skill, healthcare and economic agencies, the system will be more powerful and effective.

The HIV/AIDS epidemic has brought about challenges that are too diverse and complex to be tackled by government or by NGOs alone. It raises socio-economic, legal, ethical and human rights issues that all need to be addressed if the fight against the epidemic is to be successful. That is what it is most important to develop and must hold strong political commitment, clear national policy and strategy for the prevention of HIV/AIDS.

The awareness raising program should be conducted in collaboration and coordination with existing governmental, nongovernmental, skill development, healthcare and economic agencies is more practical and sustainable.

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LIST OF ACRONYMS/ABBREVIATIONS

AIDS	-	Acquired Immune Deficiency Syndrome
FHI	-	Family Health International
FSW	-	Female Sex worker
HIV	-	Human Immune Deficiency Virus
HMG	-	His Majesty of Government
IDU	-	Injecting Drug Users
INGO	-	International Non Governmental Organization
MOH	-	Ministry of Health
MSM	-	Men who have sex with Men
NCASC	-	National center for AIDS and STD Control
NGO	-	Non Governmental Organization
VCT	-	Voluntary counseling and testing
PLWHA	-	People living with HIV
STI	-	Sexually Transmitted Infection
STD	-	Sexually Transmitted Dieses
UNAIDS	-	Joint United Nations Program on HIV and AIDS
UNDP	-	United Nation Development Program
PMU	-	Program management Unit
UNICEF	-	United Nations Children Fund
USA	-	United State of America
WHO	-	World Health Organization
NWCSC	-	Nepal Women community service center, Dang

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. 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 infections (STIs). 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.

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.

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.

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.

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.

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 Statement of the Problem

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.

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 he 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.

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 annual report 07) 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.

1.3 Objective 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 determine socio economic status of migrant people living with HIV.
- To determine the knowledge and attitude of the general people towards HIV/AIDS.
- To know about social stigmatization and discrimination of people living with HIV/AIDS.
- To explore the vulnerability of HIV/AIDS.

1.4 Limitation 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 Laxmipur VDC of Dang district.
3. The sample size is small and concentrated only one VDC.
4. This study is connected to fulfill the partial requirement of MA in Rural Development 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 Definition of the terms used

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.

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.

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: A group of section of population for special and priority attention on the basis of having special link of character.

DACC- District AIDS coordination committee

PLHAs- People living with HIV virus.

NCASC- National center for AIDS and STD control

NGO- Non governmental organization.

UNAIDS – Joint United Nations Program on HIV/AIDS.

USAID- United States Agency For International Development.

VCT center- Voluntary Counseling And Testing Center.

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.

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.

The HIV/AIDS epidemic across the world has shown that the spread of HIV is clearly linked to rapid economic transition, such as mat 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.

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.

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 2.1: 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 2002-2004, 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 2004.

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 2004.

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: 2.2 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	-	<1000
4	India	2400000	1800000	3200000
5	Nepal	70000	50000	90000
6	Pakistan	96000	69000	150000
7	Sri Lanka	3800	2800	5100
8	Maldives	-	-	-
9	Malaysia	80000	52000	120000

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 60^{th} 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.

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.

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.

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

Condition	Male	Female	Total	New cases in (17 Sept. 07)
HIV positive (including AIDS)	8812	4451	13263	165
AIDS (out of total HIV)	1580	649	2229	35

Source: NCASC, Feb 2009

Table: 2.4.2 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: 2.4.3 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, 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

METHODOLOGY

3.1 General Background of the Study area

Laxmipur VDC is a rural community of Midwestern Region of Nepal which is located in the Eastern part of Ghorahi (District Headquarter). Laxmipur VDC is surrounded by Rampur VDC and Ghorahi municipality. Sishnea Khola flows along the western border of the VDC and holds the role of border line separating from the Ghorahi municipality and Balame Khola flows along the eastern border of Rampur VDC.

Due to unemployment, poverty, rising population pressure, food deficit program and lack of other facilities forced people to migrant from Dang district. Being a hilly and remote area many people migrants to Indian cities and in to other countries from Laxmipur VDC in search of employment and other opportunities.

3.2 Population:

This study included of 10 migrant people and their spouse from each ward of Laxmipur VDC. 1025 people had migrated to India and other countries during this year. The total number of sample was ten sample were selected from each ward, by using random sampling. The data was collected from the migrant people and their spouses and people living with HIV+ who were available at the time and interested.

3.3 Sample size and techniques

Household from the each settlement included in the sample on the weight basis of the respective settlement. The researcher had made a preliminary visit to the study site order to identify the representative settlements for study.

The household was the sampling unit of the study. A total 19 migrant people and 6 PLHAs was the sample. Size in the preliminary visit to the study site, Simple random was applied while choosing the respondents.

3.4 Research design

Exploratory was well as descriptive research design was performed for this research. However, mode of methodology dominates over the later. Besides, the study also explained the trend of awareness and attitude of HIV/AIDS among general people, knowledge of correct use of condom, economic status, experience, existing condition and the investigation of explored findings was described.

3.5 Nature and Sources of Data

The primary and secondary data has been applied in order to obtain the necessary 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 gathered 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.

3.6 methods of data collection:

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

3.7 Data collection techniques

3.7.1 Interview with PLHAs and migrant people

During the data collection period, Researcher interviewed about socio economic status, Knowledge about HIV/AIDS, Status of PLHAs and their suggestions to improve the situation of PLHAs with 10 migrant people and their spouse and 6 PLHAs of the VDC.

3.7.2 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 information 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.

3.7.3 Interview Schedule

The required data was obtained by using individual interview schedule and direct interview techniques. Questionnaire was prepared for the survey conducting interview. This questionnaire was divided into two sections. The first section of the questionnaire was about the information on respondents' socio-economic characteristics such as: age, marriage, education, economic status etc. The second section of the questionnaire was 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.

3.8 Data collection tools

Within above maintained techniques, following tools have been implemented for the collection of data

a) **Questionnaire**

Structured questionnaire was prepared to generates the realistic accurate data from household survey of the respondent, to make favorable situation, I had tried to stimulate the people to share information without any hesitation and heredity requested to fill the questionnaire by them

b) **Checklist**

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

3.9 Reconnaissance Visit

Considering the sensitive and complex nature of the study, the researcher made a short visit to Laxmipur VDC as reconnaissance visit in order to know the situation and finalize the study. During the visit, the researcher discussed with Mr. Prakash kumar Himali (focal person) DACC Dang, Mr Tilak Khadka, Chariperson Dang plus, Ms Bimala Yogi, Chairperson, and Mr Dipak Shrestha, Program coordinator, NWCSC, Dang. The researcher also visited with Mr Sudeshran Sharma , VDC secretary, Mr. Ishwori Prasad Chaliche HP incharge Laxmipur VDC. Discussions were held with members of Local club, Teachers, Peer educators, mothers group, users group, PLHAs and other community people. This exercise helped to refining the design of the study.

3.10 Data Processing and Analysis

All the information mentioned in the questionnaire has 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. ha been considered for the presentation and analysis of data. Both singular and cross tables has used to analyze the

results. For this purpose, simple statistical tools such as; frequency and mean average are used in tabulation process. All interested in this subject could interpret the results in description manner to make understood the findings

3.11 Detail of Laxmipur VDC

Migration pattern form mid western Nepal to Indian cities is very unique. There are specific towns and cities of India where people of specific VDCs and district of Nepal go to. For instance, generally people of Bajhang prefer to go to Banglore(Hatnna Paff 1990). Similarly people from Achham Doti districts generally prefer to go to Mumbai(Gurung 1999), But the people and Dang district do not have such particular preference and destination. Ppeople had gone to New Delhi as their first destination in their life. After that Mumbai, Panjab, Hariyana, Luknow, Uetter Pardesh and other countries like Malasiya, Quarter are also the attractive destination for migration.

Table No 3.11: Detail of migrant people from Laxmipur VDC

Ward No	Female	Male	Total population	Migrant people	Total households of migrant family
1	616	580	1184	146	115
2	782	791	1571	155	99
3	457	409	866	47	25
4	571	624	1188	69	63
5	403	390	793	86	54
6	686	707	1392	67	42
7	848	824	1672	195	112
8	614	644	1258	52	37
9	772	797	1561	206	188
Total					

(Source: Annual report Dec 08, HIV/AIDS program, NWCSC, Dang)

It was observed that higher rate of migration is 206 from ward no 9, after than 195 from ward No 7 and 155 from ward no 2 are the largest number to be migrant Indian and other countries. Reason for going to a particular city were, network available there or their relatives/neighbors were working there 68%, followed by good opportunity to find the job 38% and heard about the place before 12%.

Table No 3.12 : Reason for choosing the particular place

Description	**Percentage**
Neighbors/ Friends are also working there	68%
Good opportunity to find work	38%
Heard about the place there	12%
Closer to birth place	8.3%
Relatives working in India	6.5%
Other	2.5 %

(Source: Field survey, 2009)

Almost the reasons for going to India, the main reason was obviously poverty 89%, Interestingly 0.8 percent expressed their intention to learn some skill and 0.2 percent went to India due to their relatives were working there.

Table No 3:13 Reason for migration

Description	**Percentage**
Absolute poverty	89%
Skill development/ Carrier maintain	0.8%
Due to relatives	0.2%

(Source: Field survey, 2009)

It was very interesting to note that age of the majority of migrants at first migration was 15- 25(58%), 10-14(22%), 23-40(32%) and the mean age was 18 year. Thus, most of the migrants are economically active and in reproductive age.

CHAPTER – IV

SOCIO-ECONOMIC AND DEMOGRAPHIC CHARACTERISTICS OF MIGRANTS AND THIR FAMILIES

Basically, it depended 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.

Herein, 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 cast of migrant people

There are altogether 19 migrant and their spouse has been selected in the study area. Out of19, 15 are male and 4 are female. In the study are, generally male migrate to India for employment and female do not go to India for employment. Females manage the households.

Table 4.1 : Sex and cast of Migrant people and their spouses

S.N.	Caste	Male	Female	Total
1	Sunwar/Damai	3	-	3
3	Chhetri	6	2	8
4	Brahamin	2	-	2
5	Chaudhary/janajati	2	2	4
5	Other	2	-	2
	Total	15	4	19

(Source: Field report 09)

4.2 Education Level of migrant people

Most of the Migrant people and their spouses are found to be illiterate. It is well understood that illiterate people are in high risk of having HIV. Some of migrant 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: 4.2: Education level of migrant people and their spouse

Education Level	Percentage
Secondary level (6-10 class)	5
Primary level (3 – 5 class)	23
Illiterate	72
Total	100

Source: Field Survey, 2009.

Regarding Migrant people more than 70 percent of them had never been to school and are not been able to read or write, 23 percent had attained up to primary level, and about 5 percent had attained up to secondary level education.

4.3 Marital Status of migrant people

The marital status of migrant people reveals that both married and unmarried. The marital status is given in table 4.5

Table: 4.3 marital status of migrant people

Marital Status	Percentage
Unmarried	35
Married	65
Total	100

Source: Field Survey, 2009

Out of total respondents 35 percent were unmarried and the remaining 65 percent were 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: 4.4 Family occupation

Occupation	Percentage
Labor/Farming	55
Service	20
Business	10
Other	15
Total	100

Source: Field Survey, 2009

Above table shows that the higher percentage 55 of the family members of the respondents were engaged as laborer in the urban area, followed by service in private sectors 20%, farming 15% and small business 10%.

4.5 Level of Land holding size and production rate

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 started farming.

Table 4.5: Land holing size

Ward no	Landless	1-2 Kathha	3-5 Kathha	6-9 Kathha	Above 10 Kathha	Total
1	-	3	12	4	2	21
2	2	8	2	-	-	10
3	-	6	3	-	-	9
4	1	3	1	1	1	6
5	1	11	-	-	-	11
6	-	4	8		-	12
7	-	7	6	-	4	17
8	1	8	4	-	5	17
9	-	14	3	3	-	20

(Source: field report 09)

In terms of physical facilities, it was observed that there was very poor hygiene and sanitation in the home and their surroundings. Few migrant have toilets and well for source of water facilities in house, 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: 4.6 Status of income source

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

Source: Field Survey, 2009

Above table shows that the 68% respondent's family income is insufficient to meet household expenses. Of the 32% percent respondents reported that income is not sufficient to meet the household expenses of their families throughout the year, Table 5.6 shows the income status of the family of PLHAs.

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 could visit their family frequently. The most favorable city for migration are Delhi, Mumbai and many more. 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 4.7 working cities

Ward No	Delhi	Mumbai	Other cities	Other countries
1	3	3	2	2
2	4	8	4	-
3	5	4	2	-
4	2	6	1	1
5	4	4	2	-
6	5	3	1	1
7	2	8	-	-
8	1	9	-	-
9	3	-	4	3

(Source: field report 09)

Most of migrant works as Chaukidar (Watchman), besides that some works as Driver, Cook, Caregiver, Recipients and many more. While

working in India their earn NRs 3000 to 8,000. Some migrant who are working from many year in India they used to earn up to Nrs 20,000 and above per month.

4.8 Detail of PLHAs in Laxmipur VDC

Among 0099999 people migrated to India and other countries in this year 07, 6 people has been found HIV+. Most of them are spouse of migrant returned from India. The cast and sex of the PLHAs of Laxmipur VDC is as follows:

Table 4.8 : sex and cast of PLHAs of Laxmipur VDC

S.N.	Caste	Male	Female	Total
1	Sunwar/Damai	1	-	1
3	Chhetri	1	2	3
4	Brahamin		-	
5	Chaudhary/janajati		1	1
5	Other	-	1	1
	Total	2	4	6

(Source: Field report 09)

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 were observed at close quarter. In the course of study, all were 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, had not confided their HIV status to them. As the reason they revealed their HIV status to Researcher. It could be due to their hope of receiving some assistance from the project. Only some of the PLHAs

have toilet and drinking water source at house. It was felt that the foremost need of the PLHAs was good hygiene and sanitation practice. In this regard the Mother group can play a meaningful 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 until 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 are most necessary 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 give such a training to the staff of the Health Post was 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 in Household level

There are various impacts at the household level due to HIV/AIDS. When the migrant man became HIV+, the main source of income has been cut off which directly affects the economic status of family. The most important and service is economic impact. First of all, all the PLHAs were working in India and earning monthly salaries in India and sending back home money for their family members. The remittance was the main income source of the household, which the PLHAs households do not have at present. Since the land holding size is very small, thus agriculture production is not enough for the subsistence of the family.

After being HIV+, He/she got sick in India and could not continue the job and they are forced to resign from the job. Furthermore, one still had to go for medical treatment. Similarly, if, on the one hand, there was no monthly income, then one the other hand, one had to use the savings for treatment. Thus, money was not sent home right after being sick in India. This is how the economic impact on the household level begins.

PLHAs were having salary ranging from NRs 1200 to Nrs 8000 per month. Some migrant were also earning more than Nrs 15000 per month. They are having a hard time to make ends meet. On the other hand, the family still has to invest money for medical treatment. Furthermore, one person has to take care of he/her and the caretaker could not work full time outside the home, s/he is forced to let go any earning opportunity. It was also reported that because of the nature of job, most of them were getting 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 5.5 presents the level of income of the family.

Table: 4.11 level of income

Level of Income (in Rs.)	Percentage
Less than 20,000	45
20,000-40,000	35
Above 40,000	20
Total	100

Source: Field Survey, 2009.

Above table reveals that most of the families 45% had income level lower than Rs. 20,000; 35% had between Rs. 20,000 to Rs. 40,000 and 20% had income above Rs. 40,000 because some members of these families were 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 sell of crop or even their property.

Table 4.12: Cost in medical treatment

SN	Rang of amount	Spent	Remarks
1	< 5000	2	
2	5000 to 8000	1	
3	8000 to 12000	-	
4	12000 to 20000	2	
5	20000 an above	1	
	Total	6	

(Source: Field Survey, 2009)

PLHAs have spent more than 12000 and one PLHAs has spent more than 20,000 for medical treatment, As HMG is providing ARV(Anti retro Viral Therapy) without any cost from District hospital Ghorahi, Dang and Nabakiran Plus is managing for the providing ARV but very few PLHAs are informed about this facilities. So a lot 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 were 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 of their father's house.

It was 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 was 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 has 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

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. Unless and until proper knowledge, it is impossible to know the significance of anything. Only the knowledge could lead the person to the actual direction.

Table: 5.1: knowledge on HIV/AIDS

Ever Heard About HIV/AIDS	Yes
Yes	13 (93%)
No	6 (100%)
Total	19 (95%)

Source: Field survey, 2009 (Note: Percentages are mentioned in Parenthesis).

The survey reveals that among the static respondents 93 percent were found having heard about HIV/AIDS, 6 percent were found not having heard about HIV/AIDS. But 100 percent mobile respondents were found having heard about HIV/AIDS. Out of total respondents 95% were found having heard about HIV/AIDS and 5% were found having unknown.

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 5.2: Source of Knowledge on HIV/AIDS among Respondents.

SN	Source of information	Percentage	Remarks
1	Peer educators	11 (58%)	
2	Health volunteer	3 (15%)	
3	Media(T.V/ Radio/ publication)	5 (27%)	
	Total	19(100%)	

Source: Field Survey, 2009

The study shows, the majority of the respondents got knowledge about HIV/AIDS through Peer educators. Similarly, Health volunteers are another source from which is 15% and Publication/TV is another source from which 27 % Migrant received knowledge on HIV/AIDS. Many respondents stated that they have got information from Health/Volunteer workers about HIV/AIDS compared to other sources of information.

Hence, what the data summarizes that the intervention program launched by different organization seems effective, because majority of the respondents were reported that they have got the information from Health/Volunteers workers.

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 was sexual intercourse.

Table 5.3: Knowledge about Modes of Transmission on HIV/AIDS

SN	Mode of transmission	Percentage	Remarks
1	Sexual intercourse	18 (95%)	
2	Blood transfusion	13 (68%)	
3	Sharing same Needles	8 (42%)	
4	Infected mother to child	3 (23%)	
	Total	19(100%)	

Source: Field Survey, 2009 (Note: Percentages are mentioned in Parenthesis).

The table shows that the modes of transmissions are sexual intercourse with infected person (49%), followed by blood transfusion (36%), using same needles (13%) and infected mother to child (2%).

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

SN	Mode of Non- transmission	Percentage	Remarks
1	Living together	7 (37%)	
2	Sleeping together	4 (21%)	
3	Mosquito bites	8 (42%)	
4	Kissing	5 (38%)	
5	Hand shaking	3(15%)	
6	Using same toilet	12(63%)	
	Total	19(100%)	

Source: Field Survey, 2009 (Note: Percentages are mentioned in Parenthesis)

The study found out that majority of the respondents has 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 (37%), sleeping together (21%), mosquito bites (42%), kissing and hugging (38%), sharing same toilet (63%) and hand shaking (15%).

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 is transmit 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 5.5: Knowledge of Prevention on HIV/AIDS

SN	Prevention methods	Percentage	Remarks
1	Using condom	90	
2	Use screened blood	75	
3	Disposable sharp equipment	62	

Source: Field Survey, 2009 (Note: Percentages are mentioned in Parenthesis)

The survey shows that out of 19 respondents, 9o% respondents using condom could 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 too effective and successful to inject 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 were 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 were 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 5.6: Knowledge on STIs among Respondents

SN	Knowledge on STIs	Percentage	Remarks
1	Knowledge on STIs	14 (74)%	
2	Knowledge on Gonorrhea	12(63)%	
3	Knowledge on Syphilis	8(42)%	
	Total	19(100%)	

Source: Field Survey, 2009. (Note: Percentages are mentioned in Parenthesis.)

The study indicates that 14 (74%) spouse were found having knowledge on STIs, among of them 12 (63%) had the knowledge about gonorrhea and 8(42%) had knowledge of syphilis.

The above data shows that most of the migrant 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, 15 (75%) respondents reported that they have knowledge about condom from health workers/volunteers, 12 (60%) got from radio advertisement and 4 (20%) from IEC materials/ publications.

Table 5.7: 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	15 (75%)	12 (60%)	4 (20%)
If husband wouldn't agree to use condom	Accept what he says	Remind about HIV/AIDS	Refuse to have sex
Total	6 (30%)	8 (40%)	7 (35%)
Sources to get Condoms	Husband bring it	Buy own self from shop	Health Workers/Volunteer
Total	7 (35%)	6 (30%)	11 (55%)

Source: Field Survey, 2009; (Note: Percentages are mentioned in Parenthesis.)

Of the total, 6 (30%) respondents reported that they accept sexual relation with their clients even if they are not ready to use condom; 8 (40%) respondents reported that they try to remind their clients about possible STIs in condition that the clients are not ready to have sex with condom. And 7 (35%) 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, 35 percent

said that the clients bring it, 30 percent 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, 7 respondents reported that they get it through their husband and 6 respondents buy from local shops.

Different sources of information are prevailed in this study area but the source of mass media like radio are little effective because of their poverty, it is not 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 clients. Some of them showed the confidence to avoid the sex with that client who is not ready to use condom and some want to remind their clients about HIV/AIDS through unprotected sex. Some numbers of respondents are ready to accept the customer'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 form 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 5.8: 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 (95%)	Do not Like by Husband	6 (30%)
Using Skill of Condom	12 (60%)	For avoiding Pregnancies	8 (40%)
Condom Keeping	6 (30%)	For avoiding STIs	13 (65%)

Source: Field Survey, 2009; (Note: Percentages are mentioned in Parenthesis.)

Above table reveals all the respondents are known about condom, 95 percent respondents reported that they are known about condom as a tools at avoiding AIDS, 60 percent have using skill of condom and 30 percent have habit of condom keeping similarly, 15 percent reported that the condom is bothering to use, 30 percent said that the condom do not like by Husband , 40 percent said condom is useful for avoiding pregnancies and 65 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 HMG 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 diarrhea of loss of appetite. After visit of doctor they were 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(45%) for treatment. Only 12 percent visited private medical store.

Table 5.9 Usual source of Health service facilities

SN	Places	%
1	Private clinic	78
2	Govt Hospital	45
3	Pharmacy	12
4	NGO clinic	3
5	Other	1

(source: Field survey 2009)

In the study area there was no specific treatment seeking behavior. Rather, it all depended 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 was a lot of difference in the treatment seeking behavior between PLHAs who, while undergoing a blood test and had been diagnosed as HIV+ and a PLHAs who, even while in India, was not told of his HIV+ status or did not know about it.

Those PLHAs who knew about HIV status were found to be reluctant to seek medical treatment within Nepal. Rather, they preferred to go to India. Similarly, PLHAs who did no know that they afflicted with HIV sought medical treatment within Nepal by going to private medical store, Health post and finally to District governmental hospital.

CHAPTER – VI

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

6.1 Summary

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 Laxmipur VDC 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 20 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 on within the migrant people and PLHAs returned of 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 Laxmipur VDC 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 explore 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 10 respondents were chosen from every ward of Laxmipur VDC 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 Laxmipur VDC 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. 57 percent respondents have sufficient means to meet the food and 42 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 (70%). In such5 percent respondent had such experience by society, 15 percent by community, 12 percent by family, 20 percent by doctor, 5 percent by government and 5 percent by all institutions.

6.2 Conclusions

According to study, 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 able body's adults in the work force and women afflicted or not with 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 of governments program or of other HIV/AIDS related program.

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 have been increasing more HIV infections and 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 Agenda for Action

- Specific population group must be targeted for education. Mass awareness campaign need to be complemented by interventions tailored for specific groups.
- Health professional must be trained and aware of HIV/AIDS. Refresh training and knowledge must be done in hospital and health post for health worker and doctors.

- Specific population groups must be targeted for drug education, sexuality and mass anti drug awareness campaign need to be complemented in participation with concerned people.
- Access to VCT service should be increased in hilly and remote areas.
- Poverty should be given to the fieldwork rather than seminar, conferences table work or paper work.
- Economic options for PLHAs, CSW and drug abuser are crucial factor. Government should reserve such options for them.
- Women and children should have equal access to educational and economic opportunities that may reduce their risk of HIV infections.
- Intervention strategies for those already affected by HIV/AIDS should be broadly defined and address families need. These needs may be emotional physical, social, financial, religious and spiritual.
- Peer education and one by one communication can be effective parts of AIDS prevention and knowledge.
- Women should have control over their body, that is sexuality discourse should brought into discuss.
- PLHAs concern must be integrated into major programs such as STIs control, to effect policies and appropriate behavioral change as well participation of PLHAs can lead such program to successful.
- HIV/AIDS prevention requires long term strategies and ultimately require political, economic and social restructuring of relationship through legal reforms. Issues such as unequal access to resource, stereotypical roles and responsibilities that are disadvantageous to women and differential legal rights, properly and in heritance rights all constrains women's ability to prevent HIV/AIDS.

- Governmental and international organizations must treat HIV/AIDS as a medical, social, economic and political priority and seek comprehensive integrative approaches for addressing this issue.

6.4 Recommendations

The true devastation caused by HIV/AIDS is yet to be fully recognized. The impact of HIV/AIDS is unique because it kills adults in the prime of their lives, thus depriving families, communities, and entire nations of their young and most productive people. Adding to an already heavy disease burden in poor countries, the HIV/AIDS epidemic is deepening poverty, reversing human development achievements, worsening gender inequalities, eroding the capacity of governments to provide essential services, reducing labor productivity and supply, and putting brake on economic growth. These worsening conditions in turn make people even more vulnerable to infection and undermine the ability of governments to respond to the epidemic. From the findings of the study and conclusion derived follows recommendation has been provided:

- It is said, “Education is the main defense of the nation.” Education is the chief significant weapon of the mankind, which could provide us energy to follow the right direction. It enables us to comprehend, compare, analyze, communicate and act accordingly. The lack of proper education on HIV/AIDS can cause maximize the infection. That is why the distribution of IEC (Information, Education and Communication) can play greater role to minimize the risk of infection among people.
- HIV/AIDS is more than a public health priority. It is a complex, multifaceted problem affecting all aspects of society, multi-spectral and interdisciplinary involvement is essential for building and adequate response to the HIV epidemic. The prevention awareness program must be enhance is the strategy of primary focus.

- Since the STIs increase the risk of HIV transmission and AIDS itself is a kind of STIs, good STI treatment and control system is the best way to control HIV spreading, including partner tracing and partner treatment. STIs can be controlled by educating people to change their behavior, encouraging the use of condom, promoting appropriate health seeking behavior, providing acceptable, accessible and effective clinical services, encouraging sexual partners, and particularly asymptomatic or poorly symptomatic women, to attend clinical services.
- Major challenges remain in the promotion of use of condoms are social, cultural and religious sensitivities, lack of access to condoms and inability to talk frankly about condom or sex. To make the condom easily available the social marketing of condom program will be the best possible way for the promotion and distribution of the condom.
- To fulfill the gap between knowledge and practices BCI (Behaviour Change Intervention) is crucial and essential for the prevention and control of the epidemic of HIV/AIDS. This program is having long process and time consuming and essential because to reduce the risky sexual behavior into safety sexual behavior. In terms of BCI program, it is one of the major tasks to be implemented and which could change the mentality of the people towards safety sexual behavior. In addition to the BCI program, there must be created enabling environment for the people upon which they could land off safely and all the program related with HIV/AIDS should be launched taking into consideration to the skill and capacity building of the people.
- The HIV/AIDS epidemic has brought about challenges that are too diverse and complex to be tackled by government or by NGOs alone. It raises socio-economic, legal, ethical and human rights issues that all need to be addressed if the fight against the epidemic is to be successful. That is what it is most important to develop and must hold strong political commitment, clear national policy and strategy for the prevention of HIV/AIDS/STIs.

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CASE STUDY

Ms Gita Pun (30) in habitant of Laxmipur VDC -8, Sunpur, her life style was simple and ongoing with one son and three and with her husband Mr. Motilal Pun (65).

Mr. Motilal Pun has been to Delhi (India) for work and returned to Nepal being HIV+. Later on being unsafe sex they have one child Ms Urmila Pun(6) HIV+.

After the dead of her husband the community begin to avoid her and she begin to work as servant in Ghorahi Bazar of Dang district. During the regular visit, Ms Sharmila Giri Outreach worker of Nepal women community service center, she gave her the information and education about HIV/AIDS and STIs in the meeting of women's group in VDC.

As she was getting seek due to STIs from long time, She was referred to Information and counseling center at Ghorahi and she was found HIV+ during VCT test.

NWCSC staffs discuss with her family and with community people, Leaders, mother group of VDC and she has been selected to work as Peer educator in the Laxmipur VDC.

Now Ms Gita Pun and her daughter Urmila pun is taking ARV in district hospital Ghorhai and Gita is actively working as PE in Nepal women community service center and she used to share these information with friend and neighbor in community.

Her life is being simple, she thanked to NWCSC and for their kind support.

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?