CHAPTER – I

INTRODUCTION

1.1 General background

The new "Killer disease," HIV/AIDS is stated as the latest and challenging health issues in the medical science which has become a major public health problem of each and every nation in the 21st century. It has challenged the discipline of medical science since more than two and a half decades which has no curable treatment invented in the world to date.

Acquired immune Deficiency Syndrome (AIDS) is not hereditary. It is characterized by the number of syndromes occurring together. Evidences indicate that HIV does not transmit easily but it transmits by the body fluids such as blood, semen, vaginal fluids and breast milk. It does not transmit by causal contact i.e. body contact, sneezing, coughing or by insect bites.

HIV is the human immune deficiency virus that finally leads to AIDS. Various evidences claimed that unprotected sexual intercourse; heterosexual or homosexual; either vaginal sex, oral sex or anal sex, infected blood transmission and production, sharing of contaminated syringes or needles, breastfeeding, from HIV infected mother to baby are the main routes of HIV transfusion from one person to another. The most common way of transmission is unprotected sexual intercourse with HIV positive partner (PRB, 2006).

HIV/AIDS at first was seen in an urban area- Los Angles of America in 1981. The HIV infection rate appears to decrease in some industrialized countries, however, the cases of new infection are increasing strikingly in developing countries; especially in the sub-Sahara Africa, Asia, Latin America and Caribbean (UN/WHO, 1991) where most of the people are suffering from several problems such as poverty,

malnutrition, tuberculosis, unequal distribution of available resources, unemployment, difficult livelihood, food insecurity, low access to health facility and so forth.

HIV/AIDS pandemic is affecting urban youth especially those who are involving in anti social work i.e. sex related activities (Aryal, 2004) which increase the prevalence rate of HIV/AIDS. Not only urban youth, but also the stream of HIV/AIDS pandemic is now spreading from urban to rural area and between rural areas (ICPD, 1994:71). By late 1991, over 400,000 cases of AIDS had been reported to WHO from 162 countries by taking into account under diagnosis, under reporting and delay in reporting (UN/WHO, 1991).Various attempts are being made in preventing the HIV/AIDS. Cairo conference (ICPD, 1994) considered HIV/AIDS issues as the major component of reproductive health and all the member states of UN actively took attention in following the preventive measures to control the HIV prevalence. In 1995, the Beijing conference was also held which emphasized the reproductive and sexual heath and reproductive and sexual right, mainly of female.

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

a) Window Period

In this period when HIV Virus enters into the human body, generally cold cough may appear and again disappear after sometime. In spite of being infected, human body seems to be healthy. Unconsciously the infected person may transmit HIV virus to another person through sexual intercourse and by other activities. In this period it is difficult to find out the presence of virus even if blood is checked.

b) Carrier Stage

After crossing the window period, patient inters into this period, however, patient still seems to be healthy but HIV virus increases inside the human body. It takes five to ten years to be matured for adults and child for one to two years in general. In this period, the signs and symptoms can be found if the blood is checked up.

c) AIDS

After six months to ten years period, symptoms of AIDS are appeared. When signs and symptoms are seen physically or if the test for HIV is positive, then the situation is known as AIDS. Because of poor immunity, person is affected by a series of diseases. AIDS is one of the health conditions where body's immune system gradually degrades caused by HIV belonging to the retroviral family. Over the period of time, the immune system weakens and body loses its natural ability to fight against diseases.

There are various curiosities regarding the issues of HIV/AIDS like as how the HIV is transmitted, various stages from HIV infection to AIDS, the principle manifestations of AIDS and the mortality risk associated with AIDS. These considerations involve biological, epidemiological and behavioral elements that combine to give the AIDS epidemic which is its unique characteristics.

When AIDS finally sets in the human body then the body may show several signs and symptoms, such as fever, lost of weight, diarrhea, persistent and severe fatigue. But such symptoms are common in other conditions as well. There is no any medical treatment to those who once are infected by this disease. However, preventive measures are possible like abstinence from unsafe sex, be faithful between husband and wife in sexual relationship, consistently use of condoms during sex, similarly not to use drugs and unsterilized syringe. Mainly the young people (15-49) are highly infected by HIV/AIDS found in the world epidemic history (WHO, 1991). Worldwide, the highest reported rates of STDs are found among young people ages

15 to 24. In developing countries the proportion of HIV infected young people is higher in comparison of developed countries. The STDs and HIV/AIDS infection occurs highly among girls and boys under 25 years of age (Rai, 2004). Adolescents and are the risk age in acquiring HIV and STDs because of often having multiple short-term sexual relationship, not to following the preventive way during sex, lack of sufficient information and understanding of HIV/AIDS (ibid). The HIV/AIDS infection rate is increasing because the pre-marital sex is not acceptable in society. The young boys and girls may have good knowledge about the way of prevention and treatment of this disease but they shy to seek health care when they come to STIs because they feel difficulty to communicate to heath workers about the reproductive health matters (UNFPA, 2006).

Nepal is highly heterogeneous country in terms of geography, ethnicity, language and culture. Demographically, it is characterized with high population growth rate, high fertility, high infant (64/1000) and child mortality. Nearly half of all children below five years of age are underweight, low socio-cultural parameters such as low literacy rate, traditionally lower status of female, gender inequality, girls trafficking, violence, and longer working hours of female and low access to heath service, education, political instability (World Bank, 2006), that leads to vulnerability by HIV/AIDS. Unemployment results migration. Migration for blue color job is the major cause of devastating of health. Nepal is recognized as one of the poorest country. More then 31 percent of people are under the absolute poverty line (CBS, 2004). Available heath services are not acceptable, affordable, and effective for all. Such mention worst conditions made the environment more favorable in getting HIV infection. Demand for prostitution of the Nepalese JANAJATI girls especially of remote district like Khotang is the major contributing factor for spreading HIV/AIDS and there is low coverage of media in making aware about HIV/AIDS.

There is the low prevalence of HIV among other Asian countries; however current epidemical data suggest that the inflection of HIV has been increasing rapidly. The major risk factors behind continuous increasing are flesh trade, drug abuse,

irresponsible behaviors (Bista,2002), continued spread among injecting drug users, trafficking of female sex workers, changing values among youth people, high rates of migration and mobility (http:/web.worldbank.org). HIV/AIDS was for the first time appeared in 1988 in Kathmandu. Since then, the number of people having HIV/AIDS has been rapidly increasing all over the country and thus became the emerging issues.

1.2 Statement of the problem

Nepal is a poor country. Low access to the availability of health facilities, open border with India where the sex markets are prevalent and Nepali female are also involved in such sex industries .The main reasons for this problem is poverty and unemployment. To reduce the unemployment and poverty, people involve in sex industry. Sex industry is illegal in Nepal consequently the practice are more unsafe resulting rising AIDS vulnerability. The STIs and HIV/AIDS prevalence is higher in female sex worker, clients of sex worker. The clients of sex worker are army, police, migrants, campus students and so on (Bista, 2002:23).The use of contraception properly is main preventive way of HIV/AIDS but only 58 percent of demand of family planning is met (Pathak, 2002) yet in the country. In Nepal, the age of puberty is decreasing mean age at marriage is increasing (CBS, 2003: 287). Due to the gap of entering in puberty age and marriage age cause pre-marital sex which is unsafe may cause different kind of STIs.

HIV/AIDS, a new but challengeable heath issues however, the social and behavioral research on STIs and HIV/AIDS is very limited number (UN, 2002).There are several causes related to economic, cultural, biological conditions that make people more vulnerable. More importantly, lack of access to education, personal income and equal property rights, deprivation, accusation are some of the phenomenon that promote to commercial sex that at most cases finally result to HIV infection. Moreover, knowledge of STIs and HIV/AIDS varies by gender, age, place of residence, the level of access to information and communication, and personal behaviors (UN, 2002).

In the Nepalese context, most of the people are the inhabitants of rural area (85%) and out of them 40% children suffer from malnutrition and various diseases (CBS, 2003). Lack of employment opportunities and income generating activities are also the causes of HIV spreading. Most of the people have no access to quality education as 46 percent people of Nepal are still illiterate (CBS, 2003). In this context, it is essential to know the situation of STIs and HIV/AIDS in rural areas to female and their extent of knowledge, attitude and behavior for taking appropriate policy options to combat against it.

Indian markets have greater role in Nepal as being the historical linkage particularly for the purpose of marketing, employment as low paid laborers. There is long history of labor flow from Eastern Hill of Nepal to Eastern and North Eastern part of India, especially in tea estate and infrastructure development. The area as a whole was commonly known as 'muglan', an unknown place (Subedi, 1993). More importantly, the commercial sex is common in many of these Indian towns. There is still high flow of poor people from Eastern Hill of Nepal to Jogabani and Siliguri like places for the purpose of searching to the labour job.

Sex before marriage in the low cast communities is the normal part of their lives and sign of modernization. Multiple sex among girls/women whose husband is in foreign labor market especially from low cast community is one of the major contributing factors for spreading STIs and HIV/AIDS. Thus, what is the extent of knowledge, attitude and behaviour of the reproductive age women on a Rai community is the main problem of this study. However, the following are the specific research questions of this study.

1. Do the knowledge, attitudes and behaviors of the reproductive age women about STIs and HIV/AIDS depend on the level of education, age composition, age at marriage and husband education level?

2. Do all the respondents by age, level of education and ethnicity have same attitude and behaviors towards the STIs and HIV/AIDS infected person in the society?
3. What is the role of media in acquiring the knowledge to STIs and HIV/AIDS?
4. Do they have information regarding modes of transmission and preventive measures of HIV/AIDS by age, marital status education and ethnicity?
5. How do respondents perceive multiple sexual relations?

1.3 Objectives of the study

The main goal of this research is to examine the knowledge, attitude and behaviours to STIs and HIV/AIDS among Rai communities reproductive age female of Badaka Diyale VDC in Khotang district. The specific objectives of this study are:

- To examines the socio-economic and demographic background of the female on Rai community.
- To examine the knowledge and attitudes on STIs and HIV/AIDS, modes of transmission and its preventive measures among respondents.
- To study the role of media in building the knowledge and attitude about STIs and HIV/AIDS.
- To identify their view and their attitudes towards STIs and HIV/AIDS.

1.4 Significance of the Study

This study has attempted to analyze the knowledge, attitude and behaviour on STIs and HIV/AIDS among reproductive age women of Badaka Diyale VDC Khotang District. Reproductive age women are increasing at high risk of contacting and transmitting sexually transmitted disease including HIV/AIDS and they are typically poorly informed about how to protect from them.

This study is supposed to be useful ever for planners, policy makers, NGO/INGs and other organizations in relations to the introduction and formulation of

plans and programs in national level and also helpful for those students, researchers, investigation and other people who are interested about reporduvte age women. it will be useful to improve the status of women especially on rural areas. Thus while formulating policies and programmes, it should be formulated by giving keen attention towards the current situation of women for these over all cases, this study will be helpful for those NGOs/INGOs and government sectors who are lunching their programs in the case of women and HIV/AIDS because this study attemptes to reflects the overall scenario of kanolwedge attitude and behaviour on STIs and HIV/AIDS among reproductive age woman. It will be also useful as a guide for further research in similar context and findings of the study will be useful for planners and policy markers.

1.5 Limitations of the Study

Any research work is hardly without any limitations. This study is based on the variables such as age, age at marriage, ethnicity, media attention, and level of education, occupation and educational status. The major limitations of this study are following.

This study is academic and limited to both, time and resources, limited on the sample data collected from the Rai Community of Badaka Diyale VDC in Khotang district.

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

The result of the study may not be generalized as a whole for the entire region as this study covers only the Rai community who are the permanent residents of Badaka Diyale VDC of Khotang district.

1.6 Organization of the study

This study is systematically organized into six chapters. The first chapter is about the introduction of the STIs and HIV/AIDS, research problem, objectives and limitations of the study.

The second chapter is about the literature in which the literatures concerning the global, regional and country wise situation of STIs and HIV/AIDS has been presented. It has specifically focused on the literatures from South Asian counties and further highlighted about the available literatures from Nepal. The research methodology is presented in chapter third in which methods, tools and techniques of data collection and analysis has been presented. The details discussion about demographic and socio-economic characteristics is presented in chapter four. The findings of the study about the extent of knowledge, attitude and behaviors on STIs and HIV/AIDS of the respondent of Badaka Diyale VDC are presented in chapter five. Finally, the summary, conclusion and recommendation of the study are presented in chapter six.

CHAPTER – II

THE LITERATURE REVIEW

2.1 The World situation on HIV/AIDS

Acquired Immunodeficiency Syndrome (AIDS) epidemic is the most destructive health disaster in the human history. It has now become a global crisis and is one of the worst challenges for development. HIV/AIDS is a major threat to the productive segment of the labor force by reducing earning and skills and experience. There is still neither a cure nor vaccine for AIDS. Though life-prolonging drugs have been made accessible and affordable, the treatment is out of access of especially those who are living in the developing countries (PRB, 2006). The first case of it was reported before two decades in Los Angeles in June 5, 1981. The causative factor of AIDS, i.e. HIV was identified in 1983. Irrespective of race, ethnicity, geographical boundaries, gender and socioeconomic condition, HIV/AIDS has been spreading. Now, there is no country without having HIV/AIDS. However, HIV prevalence rate in developing countries is higher compare to developed countries (PRB, 2006).

The pandemic nature and magnitude of the public health problems associated with HIV infection were taken as a global issue much later when HIV rose very rapidly. Observing the global epidemic, it is estimated that 38.6 million people worldwide were living with HIV by the end of 2005 and 4.1million became newly infected with HIV .Out of this figure, it is estimated that 2.8 million had died due to AIDS (UNAIDS, 2006). Out of total infected children, only 15 percent are living outside Africa region.

The behaviors of the people and HIV preventive programs determine the spread of HIV infection. The number of HIV infected people is increasing in continuous basis because of growing population and life prolonging efforts of antiretroviral therapy (UNAIDS 2006).

The global statistics published by UNAIDS/WHO in 2006 informed that nearly 39.5 million have been living with HIV/AIDS since 1981. Similarly, 37.2 million adults, 17.7 million women, 2.3 million children were living with HIV/AIDS.Moreover,4.3million people were newly infected by HIV/AIDS. Out of this figure 3.8 million were adult. Youth, less than 25 years old, accounts half of all the new HIV infected population. Worldwide, around 6,000 people infected with HIV every day. In developing countries, 6.8 million people are in immediate need of lifesaving AIDS drug; of these, only 1.65 million are receiving the drugs (UNAIDS/WHO, 2006).

Two decades ago when HIV/AIDS emerged as health problem in South African countries, a vast difference was observed in life expectancy. In 2003, the average life expectancy of eleven countries was 47 years down from 62 years. A more striking example is the situation in Botswana where the figure before AIDS was 74.4 years (PPD, 2003).

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

The rate of HIV prevalence is continuously rising over the years with the multiple impacts on human livelihood. There is close relationship between HIV/AIDS and economy.

The epidemic has negative effects on GDP growth in high prevalence countries. The impact of HIV/AIDS on human security is given as follows.

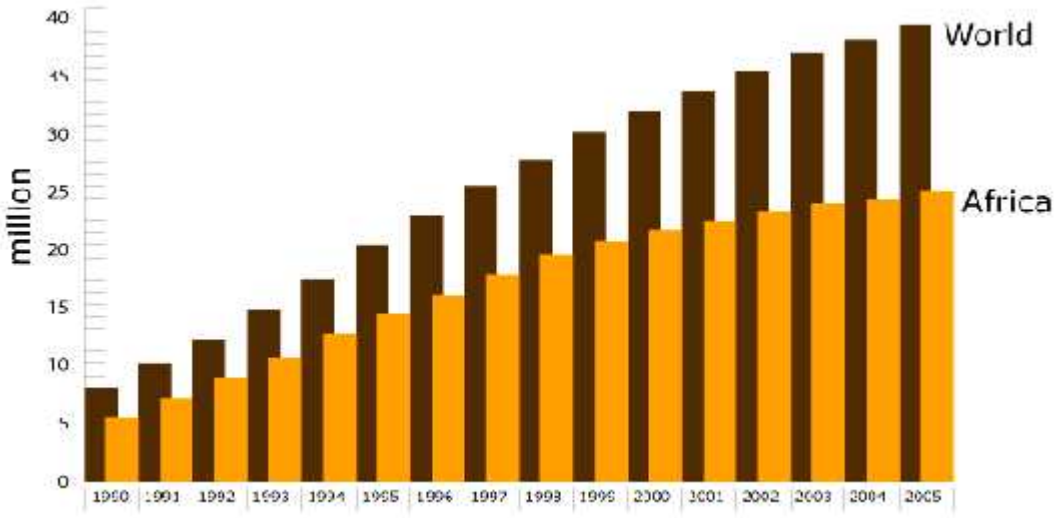
Table 2.1: Impact of HIV/AIDS on Human Security

Human security categories	**Economic**	**Food**	**Health**	**Environment**	**Personal**	**Community**	**Political**
Scale of impact of HIV/AIDS	positive high impact (++)	positive high impact (++)	positive very high impact (+++)	No impact (-)	positive high impact (++)	positive low impact (++)	positive low impact (++)

Source: AIDS in Asia, 2001

HIV/AIDS rested death has forced to sell all the properties to cover for economic burden of high treatment and other cost of HIV/AIDS. In a large perceptive, the reduced household income and shift in expenditure from consumption goods to medical care have resulted negative impact on private and health sector. Among these categories, i am trying here only about personal, community and less on economic impacts on HIV/AIDS and its prevalence rate on Rai community of Badaka Diyale VDC, Khotang over the reproductive age females.

Fig: The Global trends of HIV/AIDS



Source: www.unaids.org/en/HIV. data/epi2006

The number of people living with HIV/AIDS has risen from around 8 million in 1990 to nearly 40 million today, and has been growing. Around 63 percent of people living with HIV/AIDS are from sub-Saharan African (UNAIDS/WHO, 2006). In percent of population aged 15-49, the top 15 HIV/AIDS prevalence countries outside Africa are Haiti, Bahamas, Trinidad and Tobago, Belize, Guyana, Suriname, Papua New Guinea, Cambodia, Barbados, Honduras, Jamaica, Thailand, Ukraine, Estonia, and Myanmar (PRB, 2006).

2.2 Regional situation of HIV/AIDS

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

In this region, the cumulative death by HIV/AIDS is 24, 00,000 (PRB, 2006). Based on its extensive antenatal clinic surveillance system, as well as national surveys about HIV/AIDS testing and mortality data from its civil registration system, an estimated that 5.5 million were living with HIV/AIDS in 2005 (UNAIDS, 2005). Neither HIV/AIDS prevalence rate is not uniform nor is the number of people dying from HIV/AIDS uniform, even in the African countries. Somalia, Senegal, Botswana, Lesotho, Swaziland, Zimbabwe are the high HIV/AIDS infected countries. Somalia and Senegal the HIV prevalence is under 19 percent of the adult population where as South Africa and Zambia around 15–20%, Botswana (24.1%), Lesotho (23.2%), Swaziland (33.49%) (UNAIDS, 2006). The sub-saharan African region has the high prevalence rate of HIV/AIDS.

Lower educational status resulted rise in school dropout, conflict, failure to use condom, lack of awareness of preventive measures are responsible to increase the number of people, mainly youth living with HIV (World Bank, 2003) bearing largest burden (22% people's age15-49 year of age are living with HIV/AIDS) of HIV/AIDS.

The spread of HIV/AIDS between Eastern Europe and Central Asia is closely linked. Injecting drug use, prostitution, trafficking of women and girls across the regional broader, increasing migration and mobility to seek the work and tourist induced sexual risk behaviors have been resulting to HIV/AIDS. The mobile population, commercial sex worker, drug user, and unprotected homosexual intercourse act as the bridge population that is responsible to spread the HIV/AIDS in European countries (World Bank, 2003). In Latin America, some 1,40,000 [1,00,000-4,20,000] were newly infected with HIV/AIDS in 2005. Brazil, Chile, Costa Rica, Mexico, Panama, Uruguay and Venezuela have high prevalence rate of HIV/AIDS in this region (UNAIDS, 2006).

2.2: The regional statistics for HIV and AIDS, by the end of 2006

Region	Adult and children living with HIV/AIDS (in million)	Adult and children with nearly infected (in million)	Adults prevalence (%)	Death of adult and children

				(In million)
Sub-Saharan Africa	24.70	2.80	5.9	2.10
South and East Asia	7.80	0.86	0.6	0.59
East Asia	0.75	0.10	0.1	0.04
Latin America	1.70	0.14	0.5	0.06

Source: World Epidemic of AIDS & HIV published by UNAIDS/ WHO, 2006

The adult HIV/AIDS prevalence is higher in African countries followed by Caribbean, South and Eastern Asia. In this region, HIV is spreading because of open borders; flow of population to different countries is higher. Only in sub-Saharan region 2.1 million people had died by the late of 2006 which is largest figure of death as compared to other continents.

2.3 The HIV situation in Asia

National HIV infection level in Asia is low compared with some other continents, notably African countries. But the population of many Asian countries is so large. Low level of HIV prevalence in those large populated countries means large numbers of people are living with HIV/AIDS.

In Asian HIV infection profile shows that 8.3 million [ranges from 5.7 million-12.5 million] people living with HIV in 2005. In 2006, the figure of HIV infected people has increased to 8.6 million [ranges from 6 million to 13 million].The cumulative death of AIDS due to HIV infection including those who become newly infected is approximately 6,30,000 (UNAIDS, 2006) by the late of 2006 in Asia. Mainly poverty related factors such as separation of marital partners, sex for commercial gain, high prevalence of other sexually transmitted infections, unsafe sexual behaviors plays the chief role in increasing the HIV infection rate. Customs, beliefs and practices like sexual partnership, across age groups, use of intra vaginal desiccants, use of alcohol and drugs and so forth are the major risk factors in contributing to HIV transmission (Narayan et al., 2004).

China, the largest country of Asia where 6,50,000 [ranges from 0.39-1.1 million] people were living with HIV by the end of 2005[1]. The majorities of the clients of sex worker in China are female internal migrant worker and are involved in paid sex. Due to the conservative thinking, traditional attitudes and believes, they do not follow the preventive measures resulting in HIV/AIDS. Half of the new HIV infection is due the unprotected sexual practice in china in 2005 (UNAIDS 2006).

India, the first serological evidence of HIV infection appeared in northeast state among female sex workers in Tamilnadu in 1986. India, the second most populous country, has significant number of people living with HIV/AIDS. Approximately, 5.7 million [ranges from 3.4 million-9.5 million] people of which 5.2 million people of adult age 15-49 were living with HIV in 2005 (UNAIDS, 2005). The Indian government estimated that about 3.8 million people were infected with HIV and 5,50,000 were with AIDS in 2002 (World Bank, 2003). About two third of the reported HIV infections have been in seven states of India where HIV prevalence is 4-5 time higher then in other Indian states. The highest prevalence rate are found in Mumbai, Karnataka, Nagpur area of Maharashtra, some part of Tamilnadu, Andrapradesh, some part of Manipur, Nagaland and some part of West Bengal . Notably in the south part of the country, the infection levels in rural and urban tend to be similar (UNAIDS, 2005).Unprotected heterosexual intercourse has been the major cause of HIV spreading in rural area. Paid sex, drug users are also responsible for spreading HIV in India. Due to the social and cultural factors, more than half of the street based sex worker never or seldom used condoms but brothel based sex is safer as compare to counter part.

South –East Asian region has high number of HIV infected people. Vietnam is another host country in Asia. In 2005, 2,60,000 (ranges from 1,50,000-4,30,000) were living with HIV and 4000 people become infected with HIV each year (UNAIDS, 2005). Less than half of young people have comprehensive knowledge of HIV.

[1] www.unaids.org/en/HIV.data/epi2006.

Moreover, the heath policy of this country has given emphasis to strengthen the knowledge and awareness on HIV/AIDS (UNAIDS 2005).

In neighboring country Thailand, it is estimated that 580000 adults and child were living with HIV by the end of 2005 (UNAIDS, 2006). One third of the newly infected in 2005 were married women who probably were infected by their spouse. The government of Thailand is encouraging for regular HIV test and use of condom. Due to the social change, the pre-marital and homosexual practices have become common in Thailand which remains high risk of HIV infection. The homosexual practice has increased from 17 percent in 2003 to 28 percent in 2005 (UNAIDS, 2006). In Myanmar, it is estimated that 3,60,000 people are living with HIV infection. The government has lunched many programs to save the life of individuals. More then11000 injecting drug user are believed to have been benefited from the government effort (UNAIDS, 2006).

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

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

Table 2.3: HIV/AIDS infection in South Asian Region

Country	Reported AIDS case	% of prevalence among adult with HIV *	Estimated HIV infection
Bangladesh	17	<0.1	13,000
Bhutan	13	<0.1	< 100
India	48,933	0.8	39,70,000
Maldives	9	<0.1	< 100
Nepal	634	0.5	58,000
Pakistan	-	0.1	-
Sri-Lanka	405	0.1	4,800
Afghanistan	-		-

Source: HIV/AIDS in Asia 2005

J SAARCE Tuberculosis Center Thimi, Bhaktpur, Nepal 2003.

The first case of HIV positive was detected in 1980 in Bangladesh. Due to strengthening the awareness programs, information education and communication campaign about disease, the HIV infection is low in Bhutan. India is highest infected county. Within short period, it has emerged as one of the most serious health problems in India. The first case of HIV was reported in 1991 in Maldives. In this country the prevention and control programs are lunched from grass rout level to control the disease. Continuous spread among injecting drug users, trafficking of female for prostitution, changing values among youth people, high rates of migration open border and low awareness among female who have sex with male are the major risk factors of HIV/AIDS infection in south Asian region. (http:/web.worldbank.org).

2.4 The Knowledge of HIV/AIDS

UN (2002) claims that in 31 out of 34 countries, at least 95 percent of the most educated female respondents knew about AIDS. The knowledge of HIV/AIDS varies

by educational level. In Peru 99 percent of educated had heard about AIDS followed by 47 percent with no education. But in few countries such as Brazil, Malawi, Uganda, and Zambia, the knowledge of HIV/AIDS is high with no education. The 98 percent of those with no education said they knew about AIDS.

Radio, television, and newspapers and magazines are considered as the major sources of information. Every seven in ten male and almost half of female have heard about HIV/AIDS by radio. But in some countries television is serving as more effective source of HIV information. In highly HIV infected countries, the main sources of information were friends and relatives (UN, 2002).

A study on HIV/AIDS among college youth in Mumbai was conducted in 1996 which reveled that the basic concept about contraception was lower, to about one-fifth of both male and female respondents regarding STDs transmission 64 percent of male and 54 percent of female had accurate knowledge that STDs can be transmitted through blood transmission and direct skin to skin contact (UNFPA, 2006).

Most of the girls in India get marriage earlier and nearly half of all female are sexually active by 18 years of age. The knowledge of STIs and AIDS is particularly limited even among urban collage students; it ranged from 65 to 95 percent in boys and 25 percent in girls. The knowledge about mode of transmission, prevention and treatment, particularly of HIV/AIDS seems low. The main source of information is mass media (ICRC, 2004 cited in UNFPA, 2006:53).

Study report on reproductive health needs for adolescents held in Bangladesh; published the finding in 1999, revealed that most of the adolescents did not have clear idea about the reproduction, number of girls who know about condom (preventive measure) was low (35%), the knowledge on STIs was low in rural areas compare to urban. Pre-marital affairs is common among adolescent (UNFPA, 2006: 48) only three in four of youth had heard and HIV/AIDS, but did not know about its symptoms, transmission and prevention.

In Sri-Lanka, the gender discrimination is low. The awareness level of HIV and AIDS is high and STI prevalence is high. The awareness level on HIV and AIDS is higher among college level male student as compare to female. In Maldives, a report published in 2003 that provides demographic and socio-economic profile of youth people revels that youth know how STIs are transmitted but there is lack of qualitative and quantitative information on actual adolescent's sexual behaviors (UNFPA 2006:59-60).

The study on Nigeria revels about the knowledge on mode of HIV transmission. The students believed that major modes of transmission are sexual intercourse, unprotected blood exchange, mother to her newly born baby and sharing needle and razor. Majority of the respondents (78%) believed that HIV is transmitted through sexual intercourse followed by mother to her baby, sharing needle and blade with 74 percent and 75 percent respectively. Inaccessibility to adequate information and education on adolescent sexual and reproductive health, the problem of HIV/AIDS had become a major problem among youth in Nigeria (UNAIDS, 2005).

2.5 The HIV/AIDS Situation in Nepal

Nepal, the least developing country is also suffering from pandemic HIV/AIDS infection for last two and half decade. Nepal has the low prevalence rate of HIV and AIDS (0.5%), however, some of the groups like sex worker, Clients of sex worker, intravenous drug users, both rural and urban area, migrants workers, the prevalence rate is higher (NCASC, 2006). The current situation of HIV/AIDS is different from when the first case of HIV/AIDS was identified in Nepal. Since than the number of people having HIV positive is gradually increasing. The trend of detected HIV positive data shows that there were only 4 HIV positive in 1988. The increasing rate of HIV positive was low by late 1996. In 1996 this number reached to 135. After one year in 1995, this number rapidly rose to 489. In the year of 2004, 1282 people were infected with HIV positive. By the end of 2005, more then 950 cases of AIDS and over 5,800 cases of HIV infection were officially recorded. By the end of March

2007, this number of AIDS infection rose to 1293 out of 9043 number of people living with HIV around the country (NCASC, 2007). The new case of infection by HIV in March 2007 is 155 and 25 out of total HIV (NCASC, 2007). UNAIDS estimated that 75,000 people were living with HIV at the end of 2005. According to the official record, 384 had died by the end of 2nd March 2007. The HIV/AIDS infection varies by sex, working behaviours, personal attitudes towards sex and so forth. The infection by HIV/AIDS of male population is two times higher then female population in Nepal (NCASC, 2007) as given in the following table.

Table 2.4: The cumulative HIV infection by sub-group and sex in Nepal

Sub-group	Male	%	Female	%	Total	New Cases in March 2007
Sex Worker(SW)	-	-	669	100.00	669	4
Clients of SWs/STIs	4,191	96.60	103	3.40	4,294	58
Housewives	-	-	1,778	100.00	1,778	48
Blood or organ recipients	17	77.30	5	22.70	22	0
Injecting Drug Use	1,844	98.20	33	1.80	1,877	31
Men having Sex with Men (MSM)	13	100.00	-	-	13	0
Children	245	62.80	145	37.20	390	14
Total	6,310	69.80	2,733	30.20	9,043	155

Source: (NCASC, 2007)

The variation in prevalence of HIV/AIDS can also seen by age and sex. Male are highly infected by HIV/AIDS as compared to female in Nepal. High mobility, comparatively less strong society for male in sex matter, may be the main cause behind male being highly infected by HIV. As a whole, clients of sex worker are highly (nearly half of total) infected by HIV/AIDS in Nepal. The given table clearly shows the present figure of HIV/AIDS. The aged 30-39 years people are living in more vulnerable situation. People in the age of 50 years and above are less infected as compare to other age group in Nepal.

Table 2.5: Cumulative HIV infection by age group in Nepal

Age group	Male	%	Female	%	Total	New Case in March 2007
™14	258	60.00	151	40.00	409	14
15-24	1191	61.30	752	38.70	1943	22
25-29	1528	68.70	696	31.30	2224	35
30-39	2559	75.00	857	25.00	3416	65
40 ™	774	73.60	277	26.40	1051	19
Total	6310	60.80	2733	30.20	9043	155

Source: National Center for AIDS and STD Control, March, 2007.

The high HIV infection rate is in the age group 30-39 which accounts for 37.38 percent out of total infected by HIV. Out of total, 24.6 percent infected cases are in the age group 25-29. Similarly the lowest infection (0.68%) is in the age group of 10-14.

The HIV/AIDS situation in Nepal may be higher then what we are generally believed because every year 5,000-7,000 thousand Nepalese girls are sold in India for prostitution, pornography and photographical performance (Acharya, 2001), foreign labour migrants especially youth are increasing every year for low class job, mainly in India (KC,2003) and gender based violence like sexual harassment in working, public place, force prostitution, untauchability, sexual abuse, dowry related violence, are still existing in our society (Adhikari, 2004) that also contributed for increasing HIV infection.

Nepal is committed to a number of international declarations on HIV issues. United Nation General Assembly Special Session Declaration on HIV/AIDS was held in July 2001. Following this, sixth international congress on HIV/AIDS in Asia and Pacific was held in October 2001 in which Nepal also took part. The Congress recommended the following guidelines for combating HIV/AIDS in developing countries. Taking part in the Congress, Nepal also adopted the following guidelines.

1. Multi-spectral engagement

2. Broad Political commitment

3. Civil society involvement

4. Prevention and care of HIV/AIDS.

The National Heath policy program was formulated in 1991with primary objective to provide knowledge about the modes of transmission and prevention of this disease (MOH, 1991). Second long term health plan (1997-2017) has also given high priority to increase the level of knowledge about the preventive measure from HIV/AIDS. Nepal has affirmed ICPD (1994) and Beijing conference (1995) which deals about the physical, mental and social well-being of individual. Both conferences focused on he safe effective accessible and affordable services for combating HIV/AIDS in Nepal (UN, 1994). The ICPD also emphasized the reproductive and sexual health and as well as sexual and reproductive right of everyone. Reproductive health implies that people are able to have a satisfying and safe sex life and access to appropriate health care service that keep far from acquiring HIV/AIDS infection to individual. It is a human right so every one should have the access to get information. Similarly, the Beijing conference, 1995 focused on reproductive right providing 12 different areas of development to keep women far from vulnerability of female.

2.6 The Knowledge of HIV/AIDS in Nepal

In Nepal, Knowledge of AIDS is higher. More male than female are reported to have heard about HIV and AIDS. An overwhelming majority (99%) of respondents who had heard of HIV/AIDS reported to have knowledge on its modes of transmission and adolescents and youth regardless of level of education had fair knowledge of how to prevent STD and HIV (UNFPA, 2006). UNSCO (2006) reported that majority of the street based children have a basic knowledge of HIV and AIDS but preventive knowledge is more limited.

In Nepal, knowledge of AIDS is much higher among male (72%) then among female (50%). Although the percentage of women who have heard of AIDS has

nearly doubled in the last five years from 27 percent that of 1996. Two fifth of women and two-thirds of men believe that there is a way to avoid HIV/AIDS (NCASC, 2004).As level of education increases, respondents' knowledge of AIDS also increase: knowledge of AIDS is almost universal among respondents who have passed SLC.

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

A KAP survey among 1400 young people in seven different district of Nepal shows that Nepalese are highly aware in HIV risk, but this awareness does not necessary translate into safe sexual behaviors. Although an overwhelming majority (92%) of teenagers has heard about HIV/AIDS, only 74 percent of teenagers knew that they should use condoms while having sex and only two third (69%) said that they should not have sex with commercial sex workers.(UNFPA, 2006).

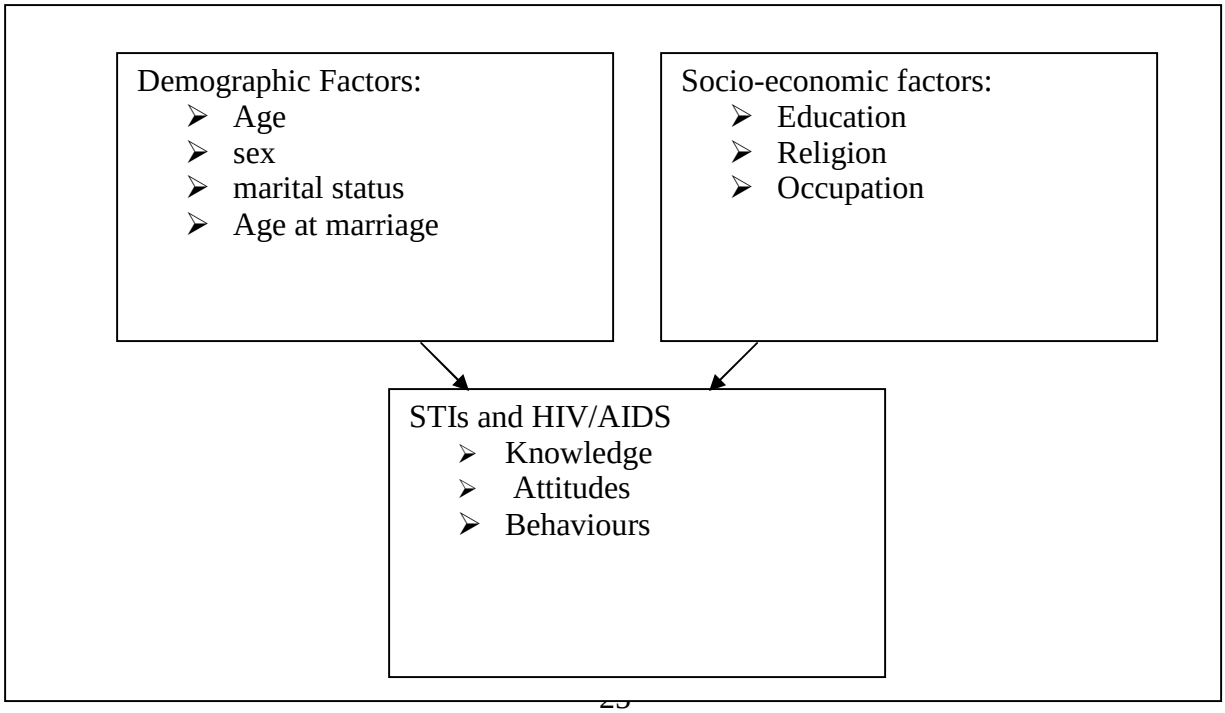
Roka (2002) has examined the knowledge of HIV/AIDS among school adolescents of Khotang district revels that the knowledge of HIV/AIDS among students is significant. Majority (90%) of the students has heard about HIV/AIDS and some misconception is also observed mainly about the mode of transmission of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

Although there are many literatures about HIV AIDS within and outside from Nepal, but there are limited literatures about pre-marital sexual behavior especially in Nepal. The studies have commonly concluded that there is variation on knowledge, attitude and behaviors about STIs and HIV/AIDS with respect to age, sex, age at marriage, level of education, and ethnicity. Furthermore, the studies on STIs and HIV/AIDS, STIs and pre-marital sexual behaviors among reproductive ages female in a certain community are very limited. In this context, this study will try to fulfill the gap in that area. In addition, this study is conducted on a Rai community of Badaka Diyale VDC in Khotang district among reproductive age (15-49) females only.

2.7 Conceptual Frame work

In this research study it has attemped to expain the effects of the several factors on knowledge, attitude and behaviour of anyone influenced by socio-economic and demographic factors. Knowledge attitude and behaviour of STIs and HIV /AIDS depends upon the socio-cultural as well as demographic factors which are presented in conceptual framework.

Conceptual Framework:



CHAPTER – III
METHODOLOGY

3.1 Methodology

Methodology refers to the sequential arrangement of all the steps involved in research particularly from identification of the problem to conclusions and recommendations that systematically require for solving the research problems. In this chapter, I have discussed about the methods, tools and techniques and the procedures that I used for the data collection, compilation and analysis. Further, with a brief introduction of the study area, I have also discussed about nature of data, sample size, selection procedures of the respondents, tools and techniques of data collection, methods of data processing, and data analysis in particular. Finally, I have also mentioned the operational definition of the various terms and concepts that I have used for this study.

3.2 Introduction of the study area

Geographically, total part of the Khotang district is hill reagion. So Badaka Diyale VDC is also a hilly place. Lies in $26^{o}20'$- $27^{o}28'$north latitude to $86^{0}26'$ t0 $86^{0}59'$ east longitude. It is one of the backward VDC of Khotang district and located near about 10 miles far from district head quarter. Also, it is nearly 12, 12 miles far from Udaypur head quarter Gaighat Bazar and Bhojpur head quarter Bhojpur Bazar. Air way facility was developed on the year 2059 B.S. in this VDC. But stop on 2060 B.S. due to cause of conflict. Nowadays such facility regain once again. Khotang district has no any road facilities until now but some ambiguous plan of Nepal government playing vital role to develop the road network to that district. The Hill regions in the north and the Himalayan range of the Udheapur district in the south parts and having good climate for human existence but transportation services have only by airplane and by porter contribution available on that VDC.

This VDC is full of multi-cultural, multi-ethnic and cast groups. There are economically full of very poor people having low education and literacy status. All most communities having very low knowledge about heath facility and different diseases of reproductive organs and reproductive system. More over knowledge is not going on improving because of abuse of alcohol and different alcoholic drugs and smokes not only on Rai communities but also on others so called high communities on that VDC.

3.3 The nature and sources of data

To draw the reliable and acceptable finding of the research questions, primarily, two types of data, primary and secondary are used in this study. However, the findings of the study are mainly based on the primary data (field survey). The primary data which is qualitative and quantitative in nature were collected directly from the respondents, under study population by means of interview, questionnaires, and observation methods. Secondary data used in this study were collected from the various national and international annual reports, newspapers, bulletins and previous dissertations published by government and non-government organizations,

3.4 The universe and sample size selection procedures

The total population of female in the Badaka Diyale VDC is about 1453. However, all of them have not on reproductive age and Rai Community. They are from Badaka Diyale VDC ward no. 8 KULABHANJYAN and ward no. 2 DUMCHA. There are 80 household of Rai community on that VDC.

There are no possibilities to take the entire household as a sample because of different limitation. Among these 80 household only 40 household is selected as a sample household in the ratio of 1:2 by simple Random Sampling Method (SRSM), alternatively. The sample population is taken from these 40 household's reproductive

age female without considering age, marital status and religious. Out of above sample figure, 102 females were selected as sample.

3.5 The data collecting methods, techniques and tools

Both qualitative and quantitative methods of data collection methods were used. The study mainly based on quantitative method. To collect the quantitative data, the semi- structured questionnaires having 47 questions with best skipping pattern was prepared and asked to each respondent under sample frame.

Besides quantitative method, qualitative method was used to collect information about knowledge, attitudes and behavioral information on STIs and HIV/AIDS, many qualitative types of information were collected. Several methods particularly observation, focus group discussion and key informants interview techniques which are describe below were used to collect qualitative information.

3.5.1 Observation

During the field study, some qualitative information required for the fulfillment of the research objectives which were gathered through direct or indirect observations. The observation was mainly focused on to know personal relationship, psychological behaviors and personal activities of the respondent. The researcher himself involved several time with a few students and dialogue to discover human perception about the issues.

3.5.2 Focus Group Discussion

In the real field survey, the focus group discussion was also conducted among 20 reproductive age females with respect to age, religion, educational level etc. The selected females were divided in two groups by educational level. The unstructured discussion was organized in the separate place. The educated females were facilitated by researcher himself. While doing FGD it was faced difficulties with girls and

uneducated female to discuss about sexual practices and STIs and HIV/AIDS related issues. In this situation I took help of friend Mrs. Muna Dulal, who facilitated for the discussion. It was by her help, all the girls and uneducated females shared their views and information. The detail of focus group is given in appendix-B.

3.5.3 Key Informant interviews

The teacher of the schools, the students who has been studying higher secondary level, was selected as the key informant. They knew about what types of information frequently borrowed by female of different ages. The questions were previously designed but all were open ended type from which the qualitative data could be generated. The voice recorder was used during conversation. The conversion (appendix-c) was in Nepali language which was converted during the analysis of this study.

3.6 The data processing, editing and coding

After the field survey, all the filled questionnaire were collected, checked and edited to find out whether there were mistake or not in skipping and other type of errors, systematically. The open ended questions were systematically re-coded after the field survey. Then the code-book was prepared in computer. The coded data were entered in SPSS (11.5 version) computer program for data processing. By the help of SPSS program, master table was prepared then the data were edited again to find out the entry error, known as data cleaning.

3.7 Data analysis and interpretation

Several data tables were prepared for the analysis. The tables have been presented along with the description in the chapters. Tables are put systematically from setting the demographic and socio-economic background of the respondents and

further the tables related knowledge, attitude and behaviors are analyzed with the help of several statistical techniques, graphs and text. The result has also shown through bar graph, pie chart and diagram as required. Finally, a descriptive report has been prepared as an outcome of the study.

3.8 Operational definitions of concept and variables

Various terms, concepts are used in this study. It is the small case study so the conclusion may not be generalized without giving the operational definition. To reach in the conclusion of the study or to give the boundary of the study, the following terms are used in the sense as defined below as the working definition for this study purpose. These terms and concepts are as follows.

Knowledge: It refers to the understanding, idea and concepts of the respondents especially about infection, causes and routes of transfusion, symptoms, prevention and control of STIs and HIV/AIDS.

Attitudes: It refers to the way of thinking and perception of the respondents towards STIs and HIV/AIDS and those who are suffering from STIs, HIV/AIDS towards positive or negative, favorable or unfavorable response of the respondents defines the attitude.

Practice: It is the behaviors either acceptable or reject able, caution or negligence in relation to STIs and HIV/AIDS. It is related to the unsafe sexual practice, unsafe sexual relation practices.

Respondent: It refers to those female who are in the age of 15-49 and permanent resident of Badaka Diyale VDC of Khotang district during field survey and randomly

selected as the sample population for this study. However, key informants are also the respondents but they are mentioned as the key informants.

Questionnaires: Written or printed list of questions to be answered by the respondent. The printed lists were used to collect the qualitative information with respondents.

Pre-marital sex: the sexual activities done before marriage.
Primary data: That information which have collected from the respondents, key informants and from focus group discussion by the researcher with various data collection tools and techniques.

Nuclear family: The family where only one generation live less than two roof together is called nuclear family.

Joint family: The family where more than one generation live under roof and share kitchen, bedroom, property etc. Commonly is called joint family.

CHAPTER-IV

SOCIO-ECONOMIC AND DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS

This chapter presents the socio-economic and demographic characteristics of the respondents. Socio-economic background provides information about religion, education, occupation and income, where demographic characteristics provide information about age, marital status and age at marriage of the respondents.

4.1 Background characteristics of the respondents

This section includes social as well as demographic characteristics of Reproductive ages women, as level of age group, religion, marital status and education. The total 102 Rai women were selected as the sample population.

4.1.1 Age composition

Table 4.1 Distribution of Respondents by age group

Age group	No of respondents	Percent
15-19	***10***	***9.80***
20-24	***15***	***14.70***
25-29	***15***	***14.70***
30-34	***18***	***17.65***
35-39	***16***	***15.68***
40-44	***12***	***11.76***
45-49	***16***	***15.68***
Total	***102***	***100.00***

Source: ***Field Survey, 2007***

From the table 4.1 it can be seen that highest numbers (18) of respondents are from age 30-34 years. Similarly, 16, 16 respondents are belonging to the age group 35-39 and 45-49 age group. This table further illustrates that the lower number 10 belong to the age group of 15-19.

4.1.2 Religion

Nepal is has been declared secular country so like national scenario, the majority of respondents are also Hindus. This is occupied more then 75 percent. The distribution of the respondents, according to their religion, are presented in table 4.2

Table 4.2 Distributions of Respondents by Religion

Religion	No of respondents	Percent
Hindu	***77***	***75.50***
Kirat	***21***	***20.60***
Christian	***4***	***3.90***
Total	***102***	***100.00***

Source: ***Field Survey, 2007***

From the above table 4.2 it shows that highest numbers (77) of respondents are Hindu. Which is about (75.50%) followed by Kirat (20.60%) and only (3.90%) are Christian.

4.1.3 Marital Status

Marital Status of respondents is presented in table no. 4.3 which only shows the married and unmarried status of the respondents.

Table 4.3 Distribution of Respondents by their marital status

Marital status	No of respondents	Percent
Married	***60***	***58.80***
Unmarried	***42***	***41.20***
Total	***102***	***100.00***

Source: ***Field Survey, 2007***

From the table 4.3, it can be seen that married respondents are (58.8%) and unmarried (41.20%).

4.1.4 Age at marriage

Age at marriage is considered as the most influencing factor to examine the knowledge, attitudes and behaviors on STIs and HIV/AIDS among reproductive age women which is presented in table 4.4

Table 4.4 Distribution of Respondents by their age at marriage

Age at marriage	No of respondents	Percent
10-14	***18***	***30.00***
15-19	***20***	***33.33***
20-24	***12***	***20.00***
25+	***10***	***16.67***
Total	***60***	***100.00***

Source: ***Field Survey, 2007***

From the table 4.4 it can be seen that one third (33.33%) of the respondents are belongs to the age at marriage 15-19 years age groups followed by 10-14 years age groups (30%),20-24 years age groups (20%) and 25+ years age groups (16.67%) only.

4.1.5 Education

Education is considered as the most influencing factor to examine the knowledge, attitudes and behaviors on STIs and HIV/AIDS among reproductive age women which is presented in table 4.5

Table 4.5 Distribution of Respondents by their education

Education of the respondents	No of respondents	Percent
Literate	***54***	***52.90***
Illiterate	***48***	***47.10***
Total	***102***	***100.00***
Educational Status		
Primary (1-5)	***30***	***55.60***
L. Secondary (6-8)	***16***	***29.60***
Secondary and above	***8***	***14.90***
Total	***54***	***100.00***

Source: ***Field Survey, 2007***

From the Table 4.5 it can be seen that majority of respondents are literate which 52.90 percent and illiterate is only 47.1 percent.

Similarly, according to the attended education of the literate respondent it is evident to see that majority have had primary level, (56%), followed by (29.60%) and secondary and above level only (14.90%).

4.2 Household characteristics

This section deals about the socio-economic status of the reproductive age women's parents as level of education, occupation, family size, income and available household facilities.

4.2.1 Parent's educational Status

Parent's education influences the behavior of their offspring, from table 4.6, it is clear that majority of respondents are illiterate and few are literate. Higher percentage respondent's fathers are literate as compared to the respondent's mother. Educational Status of Parents are presented in table 4.6.

Table 4.6 Distribution of Respondents by their Parent's educational status

Father's educational status	No of respondents	Percent
Literate	***59***	***57.80***
Illiterate	***43***	***42.20***
Total	***102***	***100.00***
Educational level		
Primary	***30***	***50.80***
L. Secondary	***8***	***13.60***
Secondary	***9***	***15.30***
S.L.C. and above	***12***	***20.40***
Total	***59***	***100.00***

Mother's educational status	No of respondents	Percent
Literate	***18***	***17.60***
Illiterate	***84***	***82.40***
Total	***102***	***100.00***
Educational level		

Primary	***17***	***94.40***
L. Secondary	***1***	***5.60***
Total	***18***	***100.00***

Source: ***Field Survey, 2007***

In the table 4.7 can be seen that literacy rate of respondent's father is higher than their mothers. It is about 57.80 percent for father while it is only 17.60 percent for mother. The level of education is also different among literate mothers and literate father; there is no any secondary level and education holder among respondents mothers. On the other hand more then 15.3 percent of the respondent's father have achieved secondary level education. This table further shows that respondent's parents have 20 percent only S.L.C. and above Educational achievements.

4.2.2 Parent's occupation

Literacy rate as well as the educational level of respondent's father is higher as compared to respondents mothers (Table 4.6) show the higher proportion of their fathers is found engaged in the nonagricultural sector then their mothers.

Table 4.7 Distribution of Respondents by their Parent's occupation

Father's occupational status	No of respondents	Percent
Agriculture	***52***	***51.00***
Service	***17***	***16.70***
Business	***18***	***17.60***
Daily wages	***15***	***14.70***
Total	***102***	***100.00***

Mothers occupational status		
Agriculture	***62***	***60.80***
Housewife	***26***	***25.50***
Business	***4***	***3.90***
Daily wages	***8***	***7.80***
Service	***2***	***2.00***
Total	***102***	***100.00***

Source: ***Field Survey, 2007***

The table 4.7 seen that most of the respondent's parents are engaged in agriculture, services and business as major occupation. Daily wage is the fourth major occupation of the respondent's father. It can be seen, from (Table 4.7), that 51 percent of respondents father and 60.80 percent of respondents mothers are engaged in agriculture and 16.70 percent of the respondent's father and 2 percent of respondents mothers are involved in service in the government and non government sectors. Similarly, 17.70 percent fathers and 3.90 percent mothers are engaged in business. 14.70 percent father and 7.8 percent mothers are engaged in Daily wages. 25.50 percent mothers aren't involved in any work, these are housewife.

4.2.3 Family Size

The size of the family is categorized in three groups, according to their numbers of the family members. They have below 5 members, 5-10 members and above 10 members. The average number of the family members is seven. The distribution of the respondents by their family size is presented in table no. 4.8.

Table 4.8 Distribution of Respondents by their Family Size

Family Members	No of respondents	Percent
Below 5	***6***	***5.90***
5-10	***88***	***86.30***
Above 10	***8***	***7.80***
Total	***102***	***100.00***

Source: ***Field Survey, 2007***

Distribution of respondents by their family size is presented in table 4.8 can be seen that majority of the respondents 86.30 percent have family size of 5-10 members, 5.9 percent have less than 5 members and 7.80 percent have 10 and above family members.

4.2.4 Monthly Income

The monthly income of the respondent's parents is categorized in four groups. They are below 1000, 1000-3000, 3000-5000, and above 5000 respectively which is presented in table no. 4.9

Table 4.9 Distribution of Respondents by their parent's monthly income

Monthly Income	No of respondents	Percent
Below 1000	***11***	***10.80***
1000-3000	***49***	***48.00***
3000-5000	***31***	***30.40***
5000 and above	***11***	***10.80***
Total	***102***	***100.00***

Source: ***Field Survey, 2007***

Distribution of respondents by their parent's monthly income is presented in table 4.9 can be seen that majority of the respondents 48.00 percent have monthly income of 1000-3000 rupees and followed by 3000-5000 monthly income having 30.40 percent. The table also shows that equal monthly income below 1000 and above 5000 which is occupied 10.8 percent only.

4.2.6 Household Facilities

Household facilities are directly related to the family income and accessibility in their locality. In this study household facilities are related to information and communication is listed in order to fiend the common means of media, which are expected help to bringing the changes in the life style of individual and behaviors as well.

Table 4.10 Distribution of Respondents by household facilities

Facilities	No of respondents	Percent

Electricity(solar and hydropower)	***46***	***45.10***
Radio	***58***	***56.90***
TV	***14***	***13.70***
Telephone	***4***	***3.90***
Total	***102***	***100.00***

Source: ***Field Survey, 2007***

Note: ***Total Percentage may exceed 100 due to multiple responses.***

Distribution of respondents by their household facilities is presented in table 4.10 can be seen that 45.10 percent of respondents have electricity in their house. Similarly, 56.90 percent have radio, 13.70 percent have TV and 3.90 percent have telephone facilities.

CHAPTER -V

KNOWLEDGE AND ATTITUDE ON STIs AND HIV/AIDS AMONG THE REPRODUCTIVE AGE RAI WOMEN

This chapter includes knowledge and attitudes of reproductive age of Rai females on STIs and HIV /AIDS. The differential of knowledge on STIs according to socio-economic and demographic characteristics is described below.

5.1 Talking about personal problems

In our society, most of the women can not say their socio-economic as well as STIs problems to their parents or husband. Can you talk about your personal problems (socio-economic and STIs) with your parents or husband? Regarding this question a few respondents can share their problems with their parents or husband which is presented in table 5.1.

Table 5.1: Distribution of respondents talks their personal problems with their parents or husband.

Responses	No of respondents	Percents
Yes	***9***	***8.80***
No	***93***	***91.20***
Total	***102***	***100.00***

Source: ***Field Survey, 2007***

Table 5.1 shows that only 8.80 percent women can share their socio-economic as well as STIs problems to their parents and 91.20 percent women can not share their problems to their parents or husband. It is clearly presents that they always ready to bear huge problems instead of sharing the problems to their parents or husband.

5.2 Parent's Response to their Daughter's Problems

The table 5.1 clearly reveals that a few respondents can share their socio-economic as well as STIs problems to their parents or husband. What type of response they got from their parents. This is presented in table no. 5.2

Table 5.2: Distribution of respondents according to their parent's responses on their problems

Parent's responses	No of respondents	Percents
Positive	***6***	***66.70***
Negative	***3***	***33.30***
Total	***9***	***100.00***

Source: ***Field Survey, 2007***

The table 5.2 clearly shows that more then two thirds of the parents are positive and only one third are the negative for women's socio-economics as well as STIs problems.

5.3 Knowledge on STIs

In this study, some questions are asked to the respondents to examine their knowledge on STIs. It was found that 75.5 percent herd of STIs while 24.5 percent are not aware of STIs. Table 5.1 shows that percentage distribution of respondents according to knowledge on STIs by background characteristics.

Table 5.3: Distribution of respondents according to knowledge on STIs by Background Characteristics

Background Characteristics	**Knowledge about STIs**					
	Yes		No		Total	
	N	%	N	%	N	%
Age group						
™24	***20***	***80.00***	***5***	***20.00***	***25***	***100.00***
25-34	***30***	***90.90***	***3***	***9.10***	***33***	***100.00***
35+	***27***	***61.40***	***17***	***38.60***	***44***	***100.00***
Religion						
Hindu	***57***	***74.00***	***20***	***26.00***	***77***	***100.00***
Kirat	***18***	***85.70***	***3***	***14.30***	***21***	***100.00***
Christian	***2***	***50.00***	***2***	***50.00***	***4***	***100.00***
Marital status						
Married	***44***	***73.30***	***16***	***26.70***	***60***	***100.00***
Unmarried	***33***	***78.60***	***9***	***21.40***	***42***	***100.00***
total	***77***	***75.50***	***25***	***24.50***	***102***	***100.00***

Source: ***Field Survey, 2007***

The Table no. 5.3 shows that the knowledge of STIs of reproductive age women can be focused in different forms according to their different demographic characteristics. The table clearly shows that 25-34 age group is the highest to hear STIs which is occupied around 91 percent and fallowed by ™24 and 35+ age group by 80 and around 61 percent.

Similarly, according to religious Kirat occupied the highest position which is nearly 86 percent and followed 74 percent by Hindus. According to marital status, the knowledge on STIs can be found slightly higher in unmarried women. The Table clearly shows that knowledge on STIs can be found in different forms according to their different demographic characteristics.

5.3.1 Knowledge on type of STIs

There are many types of STIs, some common infections, like syphilis, gonorrhea, genital warts, HIV/AIDS and Hepatitis-B commonly known STIs.

Among the various types of STIs some impotents are presented in table 5.4.

Table 5.4: Distribution of respondents by knowledge on types of STIs

Types of STIs	No of respondents	Percents
Syphilis	***50***	***64.90***
Gonorrhea	***20***	***26.00***
Genital Warts	***28***	***36.40***
AIDS	***15***	***19.60***
Hepatics-B	***30***	***39.00***
Total	***77***	

Source: ***Field Survey, 2007***

Note: ***Total Percentage may exceed 100 due to multiple responses.***

The Table 5.4 clearly shows that 64.90 and 26 percent women have knowledge about Syphilis and Gonorrhea respectively 36.40 and 39 percent respondent have knowledge about Genital Warts and Hepatitis-B. Very few 19.50 percent respondents have knowledge about AIDS in types of STIs. The reason for variation on knowledge of different types of STIs among them may due to lack of proper knowledge on various types of STIs.

5.3.2 Knowledge on symptom of STIs

Among the total 77 respondents who have knowledge on STIs, are presented in table 5.5 according to their knowledge on various symptoms of STIs.

Table 5.5: Distribution of respondents according to knowledge on symptoms of STIs

Symptoms	No of respondents	Percents
Swelling limbs node	***5***	***6.50***
Itching around genital and mouth	***49***	***63.60***

Yellowish pus-like discharge from vagina	***57***	***74.00***
Total	***77***	

Source: ***Field Survey, 2007***

Note: ***Total Percentage may exceed 100 due to multiple responses.***

The above Table 5.5 clearly shows that 74 percent women had noticed Yellowish pus-like discharge from vagina as a Symptoms of STIs where as 63.60 percent said the symptoms of itching around Genital and mouth. Only 6.5 percent respondents found swelling limbs node. Some respondent are given multiple answer.

5.4 Suffering from STIs

Among the total 102 female respondents; majority of the respondents are suffered from different kinds of STIs which is occupied by 51 percent and 24.50 percent respondents have no suffered from any kind of STIs. Similarly 24.5 percent respondent don't like to say about any STIs, whether they are suffered or not, which is presented in table 5.6.

Table 5.6: Distribution of the respondents suffering from STIs

Suffering STIs	No of respondents	Percents
Yes	***52***	***51.00***
No	***25***	***24.50***
****N/A***	***25***	***24.50***
Total	***102***	***100.00***

Source: ***Field Survey, 2007***

****N/A indicates those respondents who have not given answers that whether they are suffered from any STIs or not.***

5.5 Source of information about STIs

The sources of information are important factors for the reproductive age women to achieve the knowledge regarding STIs. The women have different sources of information on STIs.

Table 5.7: Distribution of respondents by different sources of information on STIs

Sources of Information	No of respondents	Percents
Radio	***28***	***36.36***
Television	***23***	***29.87***
Health services providers	***38***	***49.35***
Total	***77***	

Source: ***Field Survey, 2007***

Note: ***Total Percentage may exceed 100 due to multiple responses.***

The above Table 5.7 shows that health services providers is one of the main sources of information about STIs. About 49 percent women have got information from NGO/INGO. Similarly Radio and TV are other source of information from which 36 and 30 percent respondent get information respectively.

This study found that health service providers' persons and Television are major sources of information for STIs of 15-49 years Rai females.

5.6 Knowledge on Mode of STIs Transmission

There are various sources of STIs transmission. Among them some are presented in table no. 5.8 on which the respondents have knowledge on mode of STIs transmission.

Table 5.8: Distribution of respondents by transmission of STIs

Way of transmission	No of respondents	Percents
Sexual contact with infected person	***53***	***68.83***
Living together with infected person	***15***	***19.50***

Contaminated Needle/Syringes	***8***	***10.40***
Infected mother to fetus	***8***	***10.40***
Total	***77***	

Source: ***Field Survey, 2007***

Note: ***Total Percentage may exceed 100 due to multiple responses.***

The above Table 5.8 indicates that highest 68.83 percent reported to have knowledge on mode of transmission on STIs from sexual contact. Similarly, 19.50 percent living together with infected persons, 10.40 percent infected mothers to fetus and contaminated needle/syringes on mode of transmission on STIs.

5.7 Knowledge on preventive measures of STIs

From the Table 5.9, it is clear that 45.10 percent respondents have the knowledge that use of condom is true method of prevention of STIs.

Table 5.9: Distribution of respondents about knowledge on preventive measure on STIs

Preventive Method	No of respondents	Percents
Using condom	***46***	***45.10***
Sexual contact with singe partner	***56***	***54.90***
Total	***102***	***100.00***

Source: ***Field Survey, 2007***

Similarly, 55 percent of respondents said that sexual contact with single partner is one of the methods of preventing STIs.

5.8. Knowledge on HIV/AIDS

To measure the level of knowledge indicates such as heard of HIV/AIDS, transmission of HIV/AIDS, it's symptoms and preventive measures, to protect from

HIV/AIDS are used. 52 respondents have no knowledge about HIV/AIDS which is presented in table no.5.10.

Table 5.10: Distribution of Respondents Heard of HIV/AIDS

Heard of HIV/AIDS	No of Respondents	Percent
Yes	***50***	***49***
No	***52***	***51***
Total	***102***	***100***

Source: Field Survey, 2007

In Table 5.10 can be seen that out of total respondents about 49 percent had heard of HIV/AIDS and remaining 52 percent didn't hear of it.

In this study, some questions are asked to the respondents to examine their knowledge on HIV/AIDS. It was clear that from table 5.10, 49 percent heard of HIV/AIDS while 51 percent are not aware of HIV/AIDS.

Percentage distribution of respondents according to knowledge on STIs by background characteristics is as follows.

Table 5.11: Distribution of respondents according to knowledge on HIV/AIDS by Background Characteristics

Background Characteristics	Knowledge about HIV/AIDS					
	Yes		No		Total	
	N	%	N	%	N	%
Age group						
TN24	***15***	***60.00***	***10***	***40.00***	***25***	***100.00***
25-34	***18***	***54.55***	***15***	***45.45***	***33***	***100.00***
35+	***17***	***38.64***	***27***	***61.36***	***44***	***100.00***
total	***50***	***49.02***	***52***	***50.98***	***102***	***100.00***
Religion						
Hindu	***37***	***48.05***	***40***	***51.95***	***77***	***100.00***
Kirat	***12***	***57.14***	***9***	***42.86***	***21***	***100.00***
Christian	***1***	***25.00***	***3***	***75.00***	***4***	***100.00***
Total	***50***	***99.02***	***52***	***50.98***	***102***	***100.00***
Marital status						
Married	***30***	***50.00***	***30***	***50.00***	***60***	***100.00***
Unmarried	***20***	***47.60***	***22***	***52.38***	***42***	***100.00***
Total	***50***	***49.02***	***52***	***50.98***	***102***	***100.00***

Source: ***Field Survey, 2007***

The Table no. 5.11 shows that the knowledge of HIV/AIDS STIs of reproductive age women can be focused in different forms according to their different demographic characteristics. The table clearly shows that TN24 age group is the highest to hear HIV/AIDS which is occupied 60 percent and fallowed by 25-34 and 35+ age group by 55 and 39 percent.

Similarly, according to religious Kirat occupied the highest position which is nearly 57 percent and followed 48 percent by Hindus. According to marital status, the knowledge on HIV/AIDS STIs can be found slightly higher in married women. The Table clearly shows that knowledge on HIV/AIDS can be found in different forms according to their different demographic characteristics.

5.9 *Sources of information about HIV/AIDS*

The respondents can achieve the information from the various sources on HIV/AIDS which is presented in table 5.12.

Table 5.12: Distribution of respondents sources of information on HIV/AIDS.

Sources of information	No of respondents	Percents
Radio	***11***	***22***
Television	***20***	***40***
Magazine	***4***	***8***
NGO/INGOs (Including Health post)	***32***	***64***
Heath service providers	***9***	***18***
Friends	***7***	***14***
Parents	***5***	***10***
Total	***50***	

Source: ***Field Survey, 2007***

Note: ***Total Percentage may exceed 100 due to multiple responses.***

The above table 5.12 indicates that NGO/INGOs are one of the main sources of information about HIV/AIDS which is occupied 64 percent and fallowed by Television which is 40 percent. Similarly, magazine is considered as the lowest sources of the information about HIV/AIDS which is occupied 8 percent and followed by parents.

5.10 Knowledge on mode of HIV/AIDS Transmission

Out of total 102 respondents all expressed that know the ways of STIs transmission .Commonly known ways of HIV/AIDS transmission are sexual contact, sharing contaminated needle and syringes, infected blood and from infected mother to fetus. Two respondents expressed kissing as a way of transmission of HIV/AIDS.

Table 5.13: Distribution of Respondents by transmission way of HIV/AIDS

Way of Transmission	No of Respondent	Percent
Sexual contact	***49***	***98***
Contaminated needle	***14***	***28***
Infected blood	***17***	***34***
Infected mother to fetus	***13***	***26***
Kissing	***11***	***22***
Total	***50***	

*Sources**: Field survey, 2007***

Note: ***Total Percentage may exceed 100 due to multiple responses.***

Table 5.13 shows that 98 percent reported to have knowledge mode of transmission on HIV/AIDS from sexual contact. Similarly, 28 percent contaminated needle and syringes, 43 percent infected blood, and 26 percent infected mother to fetus and 22 percent kissing.

5.11 Knowledge on symptoms of HIV/AIDS

Among the various systems of HIV/AIDS, respondents have the knowledge on different symptoms which is presented in table no.5.13.

Table 5.14: Distribution of respondents by knowledge on symptoms of HIV/AIDS

Symptoms	No of Respondent	Percent
Loss of body weight by 10 percent	***10***	***20***
Diarrhea for more than one month	***23***	***46***
Fever for more than one month	***17***	***34***
All of above	***24***	***48***
Total	***50***	

Source: ***Field Survey, 2007***

Note: ***Total percentage may exceed 100 due to multiple responses.***

The Table 5.14 show that 20 percentage respondents have reported loss of body weight by 10 percent, and diarrhea for more than one month, is reported 46 percent. Similarly, 34 percent reported that fever for more than one month is another important symptom of HIV/AIDS. 48 percent have knowledge about all the above symptoms of HIV/AIDS.

5.12 Knowledge of HIV/AIDS prevention

Table 5.15 shows that 62 percent of the respondents said that don't have sex to multi-partner is one of the way to prevent HIV/AIDS. Similarly, 50 percent respondents have the knowledge that use of condom is true method of prevention of HIV/AIDS and 26 percent respondents said that use sterilized surgical instrument.

Table 5.15: Distribution of Respondents about prevention of HIV/AIDS

Prevention Measures	No of Respondent	Percent
Don't have sex to multi-partner	***31***	***62***
Use of condom	***25***	***50***
Use sterilized surgical instrument	***13***	***26***
Total	***50***	

Source: ***Field survey, 2007***

Note: ***Total percentage may exceed 100 due to multiple responses.***

5.13 Perception about the AIDS infected Person of the Respondents

From the Table 5.16, it is clearly revealed that among the all respondents 30 percent said that as AIDS infected person will die as soon as when they suffered from HIV/AIDS.

Table 5.16: Distribution of Respondents by perception about AIDS infected person

Perception	No of Respondent	Percent
All of them die	***15***	***30***
Some of them die	***15***	***30***
Don't know	***20***	***40***
Total	***50***	

Source: ***Field Survey, 2007***

30 percent respondent said some of them will die; higher percentage 40 percent respondents reported that they have no idea about it. The main reason behind this may be lack of proper knowledge on AIDS.

5.14 Vulnerable group of the society

STIs and especially HIV/AIDS are spreading rapidly as an epidemic disease in the world. There are several groups in the society in which some are considered comparatively more or less vulnerable due to their typical nature of occupation and stage of life. So to find out, who are more to the respondents of which who are more vulnerable to STIs and HIV/AIDS in our society, some questions are asked to the respondents of which are as presented below in Table 5.17.

Table 5.17 Distribution of Respondents by vulnerable group of society

Venerable Group	No of Respondent	Percent
Commercial sex workers	***43***	***86***
Drug Addicts (alcohol users)	***18***	***36***
Youth adolescent	***5***	***10***
Drivers	***5***	***10***
Total	***50***	

Source: ***Field Survey, 2007***

Note: ***Total percentage may exceed 00 due to multiple responses.***

Table 5.17 shows that out of total respondents, 86 percent expressed commercial sex workers as the most vulnerable group of society. Similarly, drug addicts 36 percent and 10, 10 percent are drivers and youth adolescent venerable group of society.

5.15 Knowledge on Treatment of HIV

HIV/AIDS is fatal and communicable disease. There is no curable treatment but some questions are asked about treatment of HIV/AIDS. Now a day, treatment is available for only increasing immunity power.

Table 5.18: Distribution of Respondents knowledge on treatment of HIV/AIDS

Treatment of HIV	No of Respondent	Percent
Yes	***52***	***51***
No	***50***	***49***
Total	***102***	***100***

Source: ***Field Survey, 2007***

Table 5.18 can be seen that 49 percent respondent reported no treatment for HIV and 51 percent said that only treatment (increasing immunity power) for HIV.

5.16 Discrimination in behavior due to STIs and HIV/AIDS

The problem of STIs is being serious. In resent years, larger numbers of girls and woman are from rural areas for different purpose within the country and out side country. Alcohols and drug abuse, violence of human rights, independency, raping and risk of spreading of STIs and HIV/AIDS, heath impacts, psychological stress, depression etc highly may occurs in Rai communities reproductive age women. In context of Nepal the main cause of STIs and HIV/AIDS is due to ignorance of the problems of girls and women in low cast communities.

From this study, we can say that those women who are suffer from HIV/AIDS; they can't express their ideas, feelings, emotion, attitudes, experience etc in community as well as other people. Socially, culturally, religiously and behaviorally, they are humiliated, as well as deprived.

CHAPTER –VI

SUMMARY, CONCLUSION AND RECOMMENDATIONS

6.1 Summary and Major Findings

This is the study on the Extent of Knowledge and Attitude on STIs and HIV/AIDS among Reproductive Age Rai Women of Badaka Diyale VDC, Khotang District.

Badaka Diyale is selected purposively and reproductive age Rai women are selected applying simple random method. This study is best on primary data. In this study 102 respondents are selected in the age group between 15-49 years.

Some of the major findings of the study are given below.

Individual and household characteristics:

- ***In about 76 percent respondents are Hindu and 20.6 percent respondents are Kirat.***
- ***One third of the married respondents are belonging to the age at marriage 15-19 years' age group and followed by (30%) 10-14 years age group.***
- ***In about 59 percent of the respondents are married and about 41 percent respondents are unmarried.***
- ***More than half of the respondents are literate and 47.1 percent respondents are illiterate. Heighest percent (55.6) respondents are primary and only 14.9 percent respondents are secondary and above.***
- ***42.2 percent respondent's father is illiterate and highest percent 50.8 percent respondent's fathers have primary education. 13.6 percent***

***respondent's** father has lower secondary and 15.3 percent have secondary.and only 20 percent SLC and above education holders.*

- ***Majority of respondent's mothers are illiterate (82.4%) and only 17.6 percent are literate.***

- ***More than half percent respondent's fathers are involves in agriculture and more than one fourth of the respondents stated that their mothers are house wives.***

- ***The majority of respondents (86.3%) have family size of 5-10 members.***

- ***About 48 percent respondent's parent's monthly income is 3,000-5,000 and only about 11 percent of them have 5,000 and above monthly income.***

- ***Nearly 58 percent respondents have radio at home and 45 percent respondents have electricity in their house and nearly 14 percent have television and about 4 percent have telephone facilities in their house.***

Some important major finding of knowledge, attitude on STIs and HIV/AIDS.

- ***75.7 percent respondent's heard about STIs and only 40 percent respondent's heard about HIV/AIDS.***
- ***Sixty five percent, thirty nine percent and twenty six percent have heard about Syphilis, Hepatitis-B and Gonorrhea respectively.***
- ***NGO/INGO, TV, Radio and health service providers are main sources of information about STIs and HIV/AIDS.***
- ***Among the respondent's (68.80%) believe that STIs are transmitted through the sexual contact.***

- ***Only 49 percent respondent's reported that they have heard about HIV/AIDS.***
- ***Ninety-eight percent of respondents believe that HIV/AIDS is transmitted through sexual contact. Twenty eight percent contaminated needled/syringe, thirty four percent infected blood and twenty six percent infected mothers to fetus.***
- ***Twenty percent respondents reported loss of body weight by 10 percent, 46 percent Diarrhea for more than one month, 34 percent fever more than one month and 48 percent all above three symptoms of HIV/AIDS.***
- ***The preventive knowledge on HIV/AIDS among respondent's is true method for preventing AIDS transmission, 62 percent respondent's said don't have sex to multipartner, 50 percent said use of condom and 26 percent said use sterilized surgical instrument.***
- ***Out of 50 who have heard about AIDS. Respondent's 30 percent expressed that all AIDS infected person will die, 30 percent said some of them die and 40 percent said that unknown about HIV/AIDS person.***
- ***86 percent expressed commercial sex workers as the most vulnerable group of society; thirty seven percent said drug addict (alcohol user) and ten percent expressed drivers and youth adolescent.***
- ***Fourty nine percent respondent's reported no treatment of HIV and fifty one percent said that treatment of increasing immunity power but not cured.***

The source of information is better according to the result of the study on knowledge and attitude on STIs, HIV/AIDS is determined by demographic factor, economic factor and social factor.

6.2 Conclusion

After analyzing the data obtained from the field study, it is found that most of the respondents among total heard of HIV/AIDS and condom. 75.5 percent respondents are heard of STIs and 49 percent heard about HIV/AIDS. However, there was rumor message among the respondent's about the mode of transmission of HIV/AIDS. Commercial sex workers, drug addict and drivers groups are first, second and third respectively highly vulnerable group of STIs and HIV/AIDS in our society. Besides knowledge, negligence also a possible cause of being victim to STIs and HIV/AIDS .Only fifty three percent respondent's are literate. Among them 55.6 percent primary level and highest level of education Secondary and above 15 percent only. It is also found that NGOs are doing help to aware about HIV/AIDS. Public awareness is the best measure and counseling services is the second appropriate measure to tackle the problems of HIV infected people. However, sound knowledge and perspective are found in the study area and their status of seeing AIDS infected person is also negative.

6.3 Recommendation

1. ***Information, education and communication are important to increase awareness of STIs, HIV/AIDS so these programmes should be focused through formal as well as informal education.***
2. ***Such program should be lunched that can increase knowledge of STIs and HIV/AIDS as well as make people more responsible about their behaviors because lack of knowledge and negligence are almost equally responsible to spread STIs and HIV/AIDS in our society.***
3. ***Lack of public awareness and negative impression towards HIV/AIDS the main cause of public hate towards infected persons. So such programmes should be lunched that can be able to inculcate them.***
4. ***In order to increase female (mothers) education, non-formal education as well as formal education should be lunched in grass-root level.***
5. ***Especially government should provide awareness programmes and free medical check-up facility to keep them healthy population.***

6 ***Education about STIs and HIV/AIDS need to be encouraged through family, community and school level.***

7 ***Seminar, gosti, interaction should be lunched in local level with related to STIs, HIV/AIDS as well as reproduction to increase awareness.***

Thus, governmental, non-governmental institutions and agencies including local bodies' organizations should be connected on above issues.

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Appendix –A

Focus Group Discussion about HIV/AIDS

CHECK LIST

- Use of free time
- Holiday time
- Returning time to room at evening s
- Frequently going place
- About visiting friend
- Place of living of friends
- Interest to see some reading materials.
- Area of interest.
- Concern towards health
- Interest to study the health related matter
- About sex
- About STIs and HIV/AIDS
- Basic Knowledge of STIs and HIV/AIDS
- Major sources of information about STIs and HIV/AIDS
- Mode of transmission of STIs and HIV/AIDS
- Different periods of HIV/AIDS
- Symptom (Major and minor)
- Prognosis
- Treatment
- Preventive methods
- High –risk group (male or female, age)
- High risk place
- Preventive measures
- Preventive knowledge

- Behaviors (way of treating towards HIV victims)

Appendix- B

Discussion with Key Informants

Check List

- Educational environment in house.
- Materials that are asked to 15-49 age females out of STIs and HIV/AIDS
- Knowledge of reproductive age females on STIs and HIV/AIDS
- Reason for high or little knowledge on it
- About conveying the massage towards reproductive age females on STIs and HIV/AIDS.
- Behaviors of reproductive age females on sex matter.
- Relation between village health worker and reproductive age female.
- Campaigning regarding STIs and HIV/AIDS in the village.
- STIs and sex related evidences.
- Knowledge of female on STIs and HIV/AIDS (Preventive, transmission)
- Access of media to extent the knowledge of STIs and HIV/AIDS

A Study on Knowledge, Attitude and Behaviours about STIs and HIV/AIDS among Reproductive age women's.

Field survey Questionnaires

Name of the respondents:-…….
Permanent Address: - village/ tole ……

Sn	variables	descriptions	Code. No.	Go To	
2.	Age	Age of the respondent			
3	Sex	Sex of the respondent	Female……...1 Male……...2		
4.	Caste	Cast of the respondent	Brahmin…….1 Chattri….....2 Rai …….....3 Dalits ……..... .....4 Limbu …….. .....5 Gurung…….... ……..6 Tamang ……. ……..7 Shrestha..... ……8 Magar 9		
5.	marital	Marital status	Married …….1 Unmarried…….2		
6.	Religion	Religion of the respondent	Hindu …… Kirat …… Buddhist…… Other ……		
7.	Address	Present place of living	At home…….1 At hostel At ranted house ……. 3 At relatives ……. 4		
8	Family	What is your family type ?	Nuclear ……..1 Joint ……...2		
9		Do you read newspaper?	Daily …….1 Sometime …….2 Rarely……3 Never ……4		

9	Can your father read and write?	Yes ……. ……1 NO ……..2	Q.11
10	If yes, what is the education status?	No schooling ……...1 Primary ……..2 Lower secondary …….3 Secondary …….4 S.L.C …….5 Intermediate …….6 Bachelor and above ……..7	
11	Can your mother read and write?	Yes ……. ……1 NO ……..2	Q.13
12	If yes, what is the education status?	No schooling ……...1 Primary ……..2 Lower secondary …….3 Secondary …….4 S.L.C …….5 Intermediate …….6 Bachelor and above ……..7	
13	What is your father's occupation?	Agriculture …….....1 Service ……2 Business ……...3 Daily Wages ……..4 Other(Specify) ……5	
14	What is your mother's occupation?	Agriculture …….....1 Service ……2 Business ……..3 Daily Wages ……..4 Other (Specify) ……...5	
15	What is the type of your family?	Nuclear …….1 Join …….2	
16	Do you have the following facility at house?	Sources / Yes / No Radio 1 2 Television 1 2 Telephone 1 2	
17	Do you use to read newspaper?	Daily ……1 Sometimes ……..2 Rarely ……..3 Never ……...4	
18	Have you even heard about Sexually Transmitted Infections(STIs)	Yes ……1 No ……2	→ 20
19	If yes, what type of STDs have you heard?	Syphilis ……..1 Gonorrhea …….. 2 Other ……..3	

20	Have you heard about HIV/AIDS	Yes……1 No……..2	→ 31
21	If yes, from which source did you	Radio 1	

	heard about it ?	Television	2	
		Magazine	3	
		GO/NGO/INGO	4	
		Health personal	5	
		Friends/Relatives…	6	
		Parent	7	
		Teacher	8	
		Text Book	9	
		Other	10	
22	Can you mention the name of program that you have heard about HIV/AIDS?			
24	Do you know about the way of transmission of HIV/AIDS?	Yes ……..1 No……2 No response ……3		→ 26
25	If yes, which of the following is the route of AIDS transmission?	Causes	Yes	No
		Unsafe sexual contacts	1	2
		Contaminated needles	1	2
		Blood transfusion	1	2
		Mother to her baby	1	2
		Brest Feeding	1	2
		Kissing	1	2
		Sleeping together	1	2
26	In your opinion, who is highly able to be infected from HIV/AIDS	Sex workers. ……1 Clients of sex workers……..2 Housewives ……3 Injected drug users……4		
27	Do you know how HIV/AIDS is prevented?	Do not have sex at all……1 Do not have sex with unknown person……2 Use condom ……3 Use sterilized surgical instruments……..4		
28	In your opinion what is HIV/AIDS?	Fatal disease……1 Sexual transmitted disease……2 Communicable disease……3 Dangerous and transmitted by careless sexual contact ……4		
29	Have your teacher ever made you aware about STIs and HIV/AIDS?	Yes……1 No ……2		

	What will you do if you meet the HIV positive person?	Love…….....1 Hate ……...2 Other(specific) ……..3	
31	In your opinion what is sex?	Basic need ……1 Need for propagating	

		generation……..2 Absurd ……..3 Other (specific)…….4	
32	What is your level of educational?	Intermediate …….1 Bachelor ……..2	
33	Have you even heard about per-marital sex?	Yes ……1 No ……2	
34	If yes, from which source have you heard about it?	Radio …….1 Television ……2 Magazine ……3 Health personnel.....……...4 Friends ……5	
35	In our opinion, where does the pre-marital sex occur frequently?	Rural ……1 Urban …….2	
36	Who, either male or female highly interest to involving in pre-marital sex?	Male ……1 Female ……2	
37	Have you ever watched the following?	Blue film ……..1 Vulgar magazine ……..2 Porn side ……..,3 Non of above …… .4 No response ……5	
38	Have you ever discussed about the pre-marital sex?	Yes ……1 No ……2 No response ……...3	
39	Have you ever kept sex?	Yes ……..1 No ……..2 Don't like to mention ……...3 No response ……..4	
40	If yes, did you do safer sex?	Yes ……...1 No ……..2 No response …….3	
41	Does our society accept pre-marital sex?	Yes …….4 No ……5	
42	Who will be the faithful sexual partner?	Girl or boy friends ……1 Co- workers ……2 CSWs …….3 Unknown person ……4 Others …….5	
43	If the society would make the sex free, the HIV prevalence rate will be higher, do you agree with this statement?	Strongly agree ……..1 Agree …….2 Disagree …….3 Strongly disagree ……4	