

CHAPTER I

INTRODUCTION

1.1 General Background

During the early phase of 1980 A.D. an abnormal infection was seen on healthy and strong youths. The diseases were destroyed the immune power. So, a natural power was started to cell AIDS. The low of inheritance power was challenging against the diseases is called AIDS. It is caused by retrovirus which destroys White Blood Cell (WBC). The AIDS stands for 'A' Acquired, 'T' immune, 'D' deficiency, 'S' Syndrome. It was discovered first in 1981 A.D., but HIV virus, was discovered in 1984 by an American scientist "Robert Gelo" at that time, it was recognized by HTL virus.

Among the blood cells of human body, white blood cell provides the power of fighting against the different diseases. HIV virus attaches the C4 lymphocyte in white blood cell, which decreases the immune power and many diseases attaches the immune power at the same time is known as AIDS.

AIDS is a condition caused by a virus called HIV. This virus attacks the immune system, the body's "security force". The when the immune system breaks down, human loses their protection capacity from disease and can develop many serious, often deadly infections. These are called "opportunistic infections" because they take advantage of the body's weakened mechanism. We have heard it said that someone "died of AIDS". This is not entirely accurate, since it is the opportunistic infections that cause

death. AIDS is the condition in which it is favorable for opportunistic infections. HIV is a virus that causes AIDS, a health condition in which a person is affected by a series of diseases because of poor immunity. HIV by itself is not an illness and does not instantly lead to AIDS. An HIV infected person can lead on healthy life for several years before he/she develops AIDS.

HIV/AIDS has been estimated that at the end of 2007 approximated 40.3 million people worldwide were living with HIV/AIDS, of which, a total of 6.4 million people belonged to the Asian region (UNAIDS, 2007). Young people bear a special burden in the HIV/AIDS pandemic. Nearly one third of these currently living with HIV/AIDS are aged 15-24. Adolescents are more vulnerable than adults to unplanned pregnancies, STIs and HIV/AIDS.

It has been documented that although premarital sex is less common in the Asian region, it is clearly on the rise. It has been observed that when adolescents involve in sexual activities, they tend to have multiple partners and use condom and other contraceptive inconsistently. Furthermore, younger women are more vulnerable to forced sex and sex in exchange for gifts and money, with increasing risk of contracting STIS including HIV/AIDS (Ashford 2005). In the context of Nepal the number of adults and children living with HIV/AIDS was estimated to be 60,618 by the year 2002. (UNAIDS, Nepal, 2003)

Eighty six percent of men have heard of AIDS, which is highest the women counterpart (52.1%). Among those who have heard about HIV/AIDS, the belief to avoid HIV/AIDS is found almost double among men than women (18 vs 42%). Women are less knowledgeable about

important ways to avoid HIV/AIDS than men. Nearly three-fifths of the women (57.7%) and one fifth of the men (19.2 %) are not aware of any important ways (ABCD) to avoid the disease (UNAIDS/Nepal 2003).

Respondents who had heard of HIV/AIDS were further asked whether a healthy looking person can have AIDS and whether HIV/AIDS can be transmitted from a mother to her child. More than two fifths of the adolescent women aged 15-19 mentioned that healthy looking person can have AIDS (42.4 %) and can be transmitted from a mother to a child (45.5 %) which is found nearly double among the male (78.8 % and female 79.8 % respectively).

Late Adolescent is the period of physical, psychological and social maturing from childhood to adulthood. These are the formative years when the maximum physical, psychological and preparation for undertaking greater responsibilities, a time of exploration, widening horizons and a time of ensured healthy, all round development can be felt. Those aged 15 to 24 years are believed to engage in high level of unprotected sexual activities both within and outside marriage. Leaving them exposed to risk of unplanned and unwanted pregnancy and contracting STDs including HIV/AIDS. Such behavior often resulting in early out of wedlock pregnancy constitutes a major threat to health of those adolescents as well as retarding their potential education career and economic development (WHO/UNAIDS, 2004).

It is customary to regard adolescent as beginning when children become sexually mature and ending when they reach the age of legal maturity. It is shown that sex is biological and at the some time, it is noted

that sex should be moral, natural and also protected due to the unproductiveness in sex many evils have been seen in societies like sexually transmitted diseases (STDs) instability in married union and depression in sex life. In these days, sexually transmitted diseases, which transit from one person to another person by unprotected sexual contact, is the major public health problem in both developed and developing countries. In most developing countries there is a large and growing population of youth. The last decade has seen a changing pattern of sexuality among this population group. Economic progress and urbanization have shifted the traditional values associated. In many societies these traditions, customs and family planning services are as yet often unprotected in terms of providing information and method of fertility regulation to the adolescents (UNFPA, 2003).

Recent behavioral data indicate the increasing vulnerability of young people to HIV/AIDS as the general and cultural gap between emerging new values (group), norms, knowledge and independence on the side of adolescents and the values, reference points and norms on the older generation is widening. Girls with their traditionally lower social status, sometimes have knowledge about STDs and HIV/AIDS but not access to means of protection (Acharya, 1999).

Condom is the only safe method for preventing STIs. Now people have started to use it more or less everywhere. It has been being used since 1976, mainly as a protective device against STIS. In Nepal, a study conducted among commercial sex workers, reported that they rarely or never use condom during intercourse with their clients. Only 3 percent claimed

that they used condom every time clients pleasure dissatisfaction were cited as the main reason for using condom, (MOH, 2004)

There are different types of STDs some of them are mainly, Syphilis, Gonorrhea, Chancroids, Herpes Genitals, Candidiasis, venereal wart, Genital herpes, Trichomoniasis, Hepatitis – B Human Genital and HIV/AIDS. (NCASC, Kathmandu) STIs is one of the main causes of HIV.

HIV is Transmitted by

A person can get infected with HIV through following ways:

1. **Unprotected Sex:** If a person engages in sexual intercourse with an infected person without using a condom, he/she can get infected. The sexual act can cause infection by both vaginal and oral. Theoretically, oral sex without condom (on men) or barriers like dental dam, vaginal dams or plastic wrap (on women) can also transmit the infection.
2. **Sharing of Needles:** If a person shares the needles or syringe used by an infected person, either for injecting drugs or drawing blood or for any other purpose involving piercing, he/she can get infected. Instruments used for piercing and tattooing also carry a small risk of infection.
3. **Unsafe Blood:** A person can get the infection, if he/she is given transfusion of infected blood.
4. **Improperly sterilized Hospital Tools:** If surgical devices like syringes and scalpels or even certain instruments, used on an infected person, are used on another person without proper sterilization they can transmit the infection.

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

The early symptoms of HIV/ infection

Many people do not develop any symptoms when they first become infected with HIV. After exposure to the virus, some people get a fluid-like illness within three to six weeks that is called acute HIV syndrome, may include fever, headache, tiredness, nausea, diarrhea and enlarged lymph nodes (organs of the immune system that can be felt in the neck, armpits and groin). These systems usually disappear within a week to a month and are often mistaken for another viral infection.

The quantity of the virus in the body will be high during this period and spreads to different parts, particularly the lymphoid tissue. At this stage the infected person is more likely to pass on the infection to others.

Some people may design to have symptom as soon as a few months, while others may by symptom free for more than 10 years. However, during the "asymptomatic" period, the virus will be actively multiplying infecting and killing cells of the immune system.

The later symptoms of HIV/AIDS

- Lack of energy.
- Weight loss
- Long lasting boats of diarrhoea
- Swelling or, hardening of glands located in throat, armpit or groin

- Frequent fever and sweat.
- Bruising more easily than normal.
- A thick, whitish coating of the tongue or mouth (thrush) that is called by a yeast infection and sometimes accompanied by a sore throat.
- Rapid loss of more than 10 pounds of weight that is not due to increased physical exercise or dieting.
- Severe or recurring vaginal yeast infections.
- Chronic pelvic inflammatory disease or severe and frequent infections like herpes zoster.
- Period of extreme and unexplained fatigue that may be combined with headaches, light-headedness and dizziness.
- Children may grow slowly or fall sick frequently. HIV positive persons are also found to be more vulnerable to some cancers.
- Periods of continued, deep, dry coughing.
- An altered state of consciousness, personality change or mental deterioration.
- Increasing shortness of breath.
- Severe numbness or pain in the hands or feet, the loss of muscular strength.
- The appearance of discolored or purplish growths on the skin or inside the mouth.
- Recurring or unusual skin rashes.
- Unexplained bleeding from growth on the skin, from mucous membranes, or from any opening in the body.

Prevention, Care and Treatment against HIV/AIDS

In this third decade of the epidemic, there is still neither a cure nor vaccine for AIDS. Life prolonging drugs have become more affordable and accessible yet treatment is still largely unavailable to most people who need it in developing countries. As of June 2005, out of the 6.5 million people needing treatment in these countries, only an estimated 1 million were receiving it. While antiretroviral treatment prolongs the lives of many AIDS patients it does not cure AIDS. More 50 HIV vaccine candidates have undergone clinical trials since 1987 and researchers continue to develop strategies for improving defenses against the virus. Despite this progress, a safe and effective vaccine is years away.

As HIV continue to spread, prevention remains the backbone of programs to curb the epidemic for the foreseeable future. However, there is a need for more comprehensive programs that encompass prevention, care, treatment, and support interventions. Comprehensive prevention programs for people living with HIV include.

- General education about the risk of sexual transmission
- Support for low-risk behaviour, including condom use.
- Diagnosis and treatment of STIs.
- Counseling and testing for HIV;
- Preventing mother to child transmission;
- Ensuring the safety of blood and blood products.
- Needle exchange programs, and
- Reducing the stigma attached to HIV and AIDS

Comprehensive care and treatment programs include antiretroviral therapy, prevention and treatment of opportunistic infections palliative and home-based care, psychological support, post exposure prophylaxis (primarily for exposure to HIV as a result of rape or needle stick), and support for orphans and children of people living with AIDS.

The various components of the prevention and care continuum are mutually reinforcing. The availability of HIV care and treatment services can be a powerful incentive for people to seek counseling and testing, without such services, people have little incentive to learn their HIV status. Counseling provides an opportunity to educate infected people about the importance of methods for preventing the infection of others.

Experts often cite counseling and testing for HIV/AIDS clinics or as routinely offered by health providers – as a crucial entry point for effective prevention, treatment, and care. Access to care and treatment also helps reduce the stigma associated with HIV, and may promote behaviour change. But convincing people to change their behaviour is difficult, especially if they can be successfully treated for AIDS. Studies in more developed countries have shown that some people practice high risk sexual behaviour when they know that effective AIDS therapies are available.

Prevention programs are much more likely to be successful if they involve policy makers and community leaders. Public policies that support HIV – prevention programs enable to protect themselves. Successful prevention programs also address that factors that put individuals, families

and communities at risk of HIV infection and that increase their vulnerability to infection.

Prevention programs are effective only if they can reach the majority of people most at risk, especially young adults and marginalized groups such as sex workers, men who have sex with men injecting drug users and sexual partners of those infected. Successful programs are tailored to focus on the main models of transmission in any given community.

In Nepal, the some prevalence STDs are Syphilis, Gonorrhoea, Chlamydia, Chancroids, Herpes Genitals, Trichomoniasis, Venereal wart, Lymphogranuloma, Venereum Granuloma inguinal, HIV/AIDS (NCASC 2004)

Managing HIV/AIDS

In 2005, an estimated 6.5 million people needed antiretroviral treatment only about 15 percent one million people had access to it. The main reasons for this short fall include the high cost of treatment. Procurement challenges in adequate health infrastructure, including a lack of health care providers insufficient political commitment at the national level. inadequate or uncertain financial resources and the persistent stigma that often prevent people from seeking care.

The clinical objectives of antiretroviral therapy are to suppress the replication of the virus and restore immune function of the body, limit the likelihood of viral resistance to antiretroviral drugs, and reduce HIV related morbidity and mortality.

Since the introduction of antiretroviral in 1996, drug therapy has transformed HIV from a progressive terminal illness to a manageable chronic disease. Drugs can slow or reverse the progression of AIDS, although they cannot cure it. The current antiretroviral drugs which fall into three main classes, work by blocking enzymes that are important for the replication and functioning of HIV in the body. A newer class of antiretroviral entry inhibitors works differently. It fights HIV after it has infected the immune system.

1.2 Historical Perspective of HIV/AIDS

First the treatment system was used in America in 1981 A.D. to healthy young people. However, it did not affect anybody. These unidentified symptoms could not become effective to deficiency power and, it became familiar as AIDS. During the period of 1983 and 1984, researcher found out the new HIV, which caused AIDS, even if it was discovered first in America in 1981. Different statistical data show that AIDS was already seen in the different parts of the world. It is told that it was originated from Southern Africa.

The AIDS was seen on homosexuals in America. It gradually spread to developed and developing countries as a pandemic disease till 1981 A.D. World Health Organization (WHO) published that were 140000 males, females and children were suffered from the disease AIDS. During that time people used to have sex with monkeys, which proves that AIDS was transformed to human being from monkeys. HIV/AIDS pandemic posed a particular challenge for the 21st century of world a real thread to significant result achieve so far in the worldwide fight against youth.

1.3 The Current Situation of STDs and HIV/AIDS in Nepal

Nepal falls on the very infected part of the world. Especially, the majority of people of the country are suffered from illiteracy, lack of awareness, unemployment, commercial sex etc. It is called the most HIV infected. According to the different statistical data, sixty two thousands people are infected by HIV/AIDS by the year 2002 (UNAIDS Report: 2003).

Most of the people are living in Nepal with poverty, illiteracy, open border between Nepal and India and adverse condition of inequality. So it meant that the condition of HIV/AIDS is very risky. Each day thirty more people are infected by HIV/AIDS. According to Central for HIV/AIDS and STD control 2007, there are total 8678, 6105 males, 2573 females living with HIV/ positive (including AIDS). 169 new cases in January 2007 only AIDS (out of total HIV) total 1248, 909 males and 339 females can be seen. 22 new causes in January 2007 (National Centre for AIDS and STIs Control Teku of January 2007).

Recent behavioural data indicate the increasing vulnerable of young people to STIs and, HIV/AIDS as the general cultural gap between emerging new values, norms, knowledge and independence on the side of people and the value reference points and norms on the older generation is wide. Girls with their traditionally lower social status, sometimes have knowledge about STIs and HIV/AIDS but no access to means of protection (Acharya, 1999). Condom is the only safe method for preventing STIs. How people have started to use it more or less everywhere. It has been used since 1976. Mainly three percent claimed that they used condom every time clients

pleasure and dissatisfaction were cited as the main reason for not using condom (MOH, 2004)

There are different types of STIs some of them are mainly syphilis, gonorrhoea chancroid, venereal wart genital herpes, granuloma inguinal, Genital herpes, hepatitis-B, Trichomoniasis and Candidiasis (NCASC-Kathmandu). STIs is one of the main cause of HIV.

However, the currently low prevalence among the general population masks an increasing prevalence in several groups. It is now evident that Nepal has entered a "Concentrated epidemic" i.e. the HIV/AIDS prevalence consistently exceeds 5 percent in one or more sub groups such as sex workers, their clients and injecting drug users. The main mode of transmission continues to be through commercial sex and the fact that the sexually transmitted disease (STD) rates are rising is an ominous sign. Although official reports claim that adequate information is not available about child sex worker and girl trafficking in Nepal, it is estimated that every year 12,000 Nepali children (ILO-Rapid Assessment) are taken to Indian brothels and the Gulf countries for the purpose of commercial sex work.

The HIV situation in Nepal is characterized by the high prevalence among groups involved in high-risk behaviour. Among the street sex workers in Kathmandu, it rose from about one percent in 1992 to about 16 percent in 1998. Among intravenous Drug users (IDUS), it rose from about two percent in 1991 to 50 percent in 1997.

The prevalence in general population in Nepal is still low, but is rising rapidly. There are indications that the transmission among housewives is increasing. Though the infection is found everywhere, it is concentrated in the capital.

Despite the current situation, the implementation of the National programme, according to UNAIDS was successful in some importance areas, the coverage of targeted 40 percent interventions focusing on sex workers and their clients was increased national wide. There is 15 percent coverage national wide on harm reduction activities. Provision antiretroviral therapy has also been started in Kathmandu. The family planning Association of Nepal (FPAN) and the International Planned Parenthood Association (IPPA) in their HIV/AIDS strategy (2002-2006) have clearly targeted migrate slum populations as being highly vulnerable to the infection.

Epidemiological Factors

- Predominant mode of transmission is sexual contact presumably mainly heterosexual.
- Limited information available about homosexual/bisexual transmission.
- Highest rates of HIV have been identified injecting drug users (IDU)
- Data indicates that risk behaviours are widespread among sex workers (SWs), their clients, IDU, labour migrants and youth
- Current estimated HIV infection rate 0.5 percent of the adult population between ages of 15-49.

- There is evidence of an explosive increase in the number of infections since 1996.

Geographical Distribution

- Highest prevalence rates found in the central region. Rural/Urban ratio to be determined.
- HIV infection has been noted in all regions of the country, although HIV infection appears to be concentrated in urbanized areas and districts with high labour migration. (National HIV/AIDS action plan 2005-2006).

1.4 Statement of the Problems

STIS and HIV/AIDS have everywhere become a major public health problem of every nation now a days. HIV cases are increasing among the youth and adolescents in Nepal. The latest reported provided by NCASC reveals the 5069 individuals having HIV. Out of which 895 have developed AIDS and 234 of them have died. (MOH, 2005).

The prevalence rate is high in developing countries where knowledge of STIs and treatment is less accessible. Out of all the major STIs are Gonorrhoea, Syphilis and Trichomoniasis in both developed and developing countries with the emergence of the HIV/AIDS the awareness of STIs became great importance and necessary too (NCASC-2003, Kathmandu).

Dalit community of Aaginchok VDC, Dhading is very poor and ignorant. Most of the youth are out of school. They utilize negligible health service. Some people move to search seasonal jobs to urban area including

Kathmandu, Pokhara and also to India. Those who are schooling also and living in community also lack of knowledge and attitude about STDs and HIV/AIDS because the discussion on the subject is insufficient and health professionals are not trained and hesitate to talk openly in such issue. A person of Dalit community is vulnerable to the STIs. It will be difficult to identify their reality about it. Without identifying their reality, it will be difficult to bring change on them from negative attitudes. Inadequate knowledge may cause of STIs and HIV/AIDS infection which ultimately harms their future and overall development of their life that such effects of individuals affect the development as well as other aspects of the countries. Thus, the promotion of Dalit's knowledge about STIs and HIV/AIDS and condom practices will be essential.

The population of 15-29 age group is at high risk of transmission of STDs and HIV/AIDS. This age group is important for the life span of human being. This phase is transition from childhood to adulthood. Many youths experience biological as well as social change during this period. In Nepalese culture and society they are in the position of entering into married life to become future parents. There is much variation from one society to another in the perception of sexual relationship and such activities permitted have encouraged before their marriage, outside marriage and even within marriage (Acharya 1999).

Accordingance with the population census of Nepal 2001 the entire population enumerated was 23,151,423. Out of this figure, including Hill Dalit 38 percent and Terai Dalit 21 percent (CBS 2001).

Adolescents are especially the risk of infections with STIs including HIV/AIDS. Young people age 20-24 are in highest risk. Teenage 15 to 19 have the next highest risk of STIs infections. Variety of factors place young people at the centre of STIS and HIV/AIDS vulnerability. Most young people become sexually active in their teens, and many before their 15th birthday factors such as increasing urbanization, poverty exposure to conflicting ideas about sexual values and behaviour and the break-down of traditional sexuality and reproduction information channels are encouraging premarital sexual activity among adolescents (UNAIDS, 2004).

Developing countries like Nepal, there are problems of early marriage. It can be seen in Dalit communities, unwanted pregnancies, spreading HIV/AIDS and other STIs untruthful information about sexuality, STIs and HIV AIDS is one of the problematic issue because, Hindu religion prohibits them to talk about their sexuality. Religion predominately prohibited sexual intercourse between two different sexes before marriage. A problem of uniformed and unprotected adolescent sexual activity is the increased exposure to STIs including with HIV/AIDS. Young population of rural area is less informed about sexuality; STIs and HIV/AIDS. They couldn't talk openly about it. Only few number of young people participate in such activities because most of them hesitate to talk about sex and sexuality. The effect of social barriers such as religion, culture, tradition etc is more in rural areas of Nepal and also varies in the ethnic communities. It is obvious from the above-mentioned statement that the situation and transmitting STIS and HIV/AIDS, no doubt is essential to identify the real knowledge attitude and behaviours of youth population about STIS and HIV/AIDS. This study aims to know the knowledge attitude ad behaviors of

youth population (15-24 years) of Dalit community of Aaginchok, Dhading. Dhading is neighbour district of capital city Kathmandu, where there is little access of mass communication education and information. In addition this district experience a high prevalence of women trafficking for commercial sex work in India. Those women return to their villages after they are identified with HIV/AIDS and many of them stay with their family and marry.

1.5 Objectives of the Study

The general objective of this study is to identify the knowledge and attitude of STIs and HIV/AIDS in dalit (Damai, Kami, Sarki) community of Aaginchok VDC Golang, Dhading.

1.6 Specific Objectives

The specific objectives of this research study will be following:

- a) To examine the socio-economic and demography background of Dalit community.
- b) To examine their level of knowledge on symptoms, mode of transmission and preventive measures of STIs in Dalit community.
- c) To identify their level of knowledge mode of transmission and preventive measure of HIV/AIDS.
- d) To identify their attitude and behaviour towards HIV/AIDS infected person, sexuality and condom use.

1.7 Significance of the Study

HIV/AIDS is most treating out of so many diseases because there are no any types of cure. Individual with STIs and HIV/AIDS may be isolated from the society and even from the family members. This situation is psychologically and emotionally traumatic to the HIV infected person. They may lose their job or, be forced to discontinues education and training opportunities. This situation may lead to frustration, stress, fear and guilt and might result in extreme conditions like suicide. If stigma and discrimination seen to infected people, may be aggressive to the extend of talking revenge with other people by spreading the infection (WHO, 2004).

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

STIs and HIV/AIDS may create disharmony in community relationship. People may loss faith and trust in each other increased number of orphans, school dropout and, campus. Mass of jobless people in the community might not only be a burden to the society but it may also give rise to crime against social values and the mortality of the society. Women

will have to face the worse effects of HIV/AIDS in all aspects of life more in the context of developing countries (WHO: 2004).

Loss of productive human resources in the community will result in decline of nation's production. On the other hand, the country will have to bear a tremendous burden to take care of HIV infected persons. This real and serious threat to the developing countries like Nepal where the economy is crippling due to various factors. If the spread of HIV infection is now slowed or stopped, the costs of above will be multiplied (MOH).

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

Family with members having HIV/AIDS has to bear a tremendous psychological stress including isolation from the society and breakdown of all social relationship, family breakdown is another serious threat to the family from such case of HIV. Husband and wife sexual partners might eventually transmit the HIV infection to each other that is spouse among partners. There is a high risk of having HIV infected children from the infected women which may ultimately end up with generation termination. Even if the children are born HIV free the parents may die leaving behind orphans with uncertain and insecure future (WHO, 2004).

Although, most of the researches on HIV/AIDS have been carried out specially, focusing to higher or secondary and campus students they are not enough. Only few of the researchers are concerned to youth people. There is no any research based on Dalit Community about knowledge, attitude and practices on STIs and HIV/AIDS. In this context, this research would be a vital source for identifying level of knowledge, attitude and practice of Dalit community. Dalit on the one hand are essential for the nations are at high risk of infection. They are physically active in sex but mentally premature for right decision making aspects. Dalit people are prevalence on HIV/AIDS in developing countries like Nepal is higher and accelerating as well.

As it is not enough, the government has adopted policy to control STIs, HIV/AIDS through formal and information education, street drama and adolescence education. This research also makes attempts to play an important role to find out necessity of the sex, STIs with HIV/AIDS prevention education and awareness programme at community level.

1.8 Limitation of the Study

Almost all the study has some sorts of limitations and this study is not an exception on this fact. On short survey itself has some limitation. So, this study has some limitations which are as follows:

- This study conducted in a Dalit community of Aaginchowk, VDC, Dhading, finding of this study does not represent for whole national level.
- This study conducted in a Dalit community. Finding of this study does not represent other communities.

- This study limited only in the subject of their knowledge, attitude towards STIs and HIV/AIDS.
- This study conducted only in 2 and 3 number wards of Aaginchook VDC, Dhading.
- This study conducted for the purpose of collecting primary data from Dalit community.

CHAPTER II

LITERATURE REVIEW

2.1 Theoretical Literature

AIDS was first discovered in 1981 in USA in a homosexual male who are suffering from disease like Kaposi, Sarcoma, phenomia armacy, RTIs and other serious diseases, which were usual among youth Americans. Similarly occurrence was noted in Europe during 1982-1983 and also found in all over the world gradually (WHO: 2003).

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

HIV transmission occurs when a person is exposed to body fluids injected with a virus such a blood, semen, vaginal segregations and breastfeeding. The primary mode of HIV transmissions are:

- a) Sexual relations with a injected person
- b) Sharing hypodermic needles or accidental pricking by a needle contaminated with injected blood

- c) Transfer of the virus from an injected mother to her baby during pregnancy, childbirth or through breastfeeding (NCASC: 2003).

The diseases that spread from one person to another person mainly through sexual contact during unprotected intercourse are known as sexually transmitted diseases. Some STIs can be transmitted by other routes also. In fact, multiple sexual contacts may lead serious health problem and causes viruses vulnerable diseases. Some time, these diseases are also transmissible through transfusion of infected blood, contaminated needles and from infected mother to her baby during pregnancy childbirths or breastfeeding. STIs have greater impact on human sexuality and morbidity. The largely affect external and internal sexual organs and cause various complications such as PID, entopic pregnancy, infertility, cervical cancer, miscarriage, still birth etc. In Nepal, there some prevalence STIs are syphilis, gonorrhea, Chlamydia, cancroids, Herpes Genital, Trichomociasis, venereal wart, Lymphogranuloma venereum Inguinal, HIV/AIDS (UNAIDS, 2003).

At the end of 2005, there were 42 millions, people living with HIV/AIDS infection is growing rapidly among women because they are both biological and socially more vulnerable to infection and often lack of control over the terms of sexual activities. Everyday, one million people contract a sexually transmitted infection; people with RTIs are at an increased risk of HIV/AIDS.

In 1994, the International Conference on Population and development (ICPD) promised basis sexual and reproductive health services to all by the year 2015. It is important for young people to be represented in countdown 2015 because they are a large part of the global community of the 6.3 billion

people earth; nearly half are under the age of 25. The choices made by this half of the population will impact the future of individual world wide (WNFPS: 2004).

AIDS, or acquired Immune Deficiency Syndrome, is caused by the human immune deficiency virus (HIV), which is spread through blood, semen, vaginal secretions, and breast milk. The most common method of transmission is unprotected sexual intercourse which as HIV-positive partner. Other routes include transfusions of HIV – infected blood or blood products; tissue or, organ transplants; use of contaminated needles, syringes or, other skin piercing equipment, and mother to child transmission during pregnancy, birth, or breast feeding. HIV is extremely fragile. It cannot survive long outside the body's fluids or tissue and cannot penetrate unbroken skin. (WHO, AIDS 2005).

The AIDS epidemic may be the most devastating health disaster in human history. The disease continues to ravage families and communities throughout the world. In addition to the 25 million people who had died of AIDS by the end of 2005, at least 40 million people are now living with HIV (WHO, 2005).

Over a period that may last from few months to up to 15 years. HIV may destroy enough lymphocyte that the immune system becomes unable to function properly. An infected person develops multiple life threatening illness from infection that normally donor cause illness in people a healthy immune system some people who have HIV infections may not develop any of the clinical illness that define the full-blown disease of AIDS for ten years or,

more. Doctors prefer to use the term AIDS for cases where a person has reached the final life-threatening stage of HIV infection (WHO, 2003)

HIV transmission occurs when a person is exposed to body fluids infected with the virus, such as blood semen, vaginal secretions and breast milk. The HIV is transmitted is only three ways:

1. The HIV can be transmitted through sexual intercourse, heterosexual or, homosexual, either vaginal sex and oral sex.
2. HIV can be transmitted through infected blood and blood products through the following
 - a. Transfusion of infected blood
 - b. Sharing of contaminated syringes and needles (common among intravenous substance users)
3. A mother who is HIV infected passes on the virus to her baby before or at birth or through breast feeding. (Bhende and Kantikar, 2004)

A person infected with HIV may not show any signs or symptoms for 5 to 10 years and may transmit the virus to others in any of the ways listed above. When AIDS finally sets in, the person may have several signs and symptoms, such as fever, loss of weight, diarrhea, persistent and severe fatigue. These symptoms are common to other conditions. No tests are as yet generally available for directly detecting the presence of HIV in the body of the infected person. The tests that are at present available (ELISA confirmed by the western Blot test) detect the presence of antibodies to the HIV in the body of the infected person. The body takes three to five months to develop antibodies to the HIV. (Bhende and Kantikar, 2004)

During the three months to 6 months "window period" a HIV infected person's tests would report a false negative and could give the HIV infected person a false sense of security which would result in his/her continuing to infect others. The only way to prevent HIV/AIDS is to prevent behaviour which would make a person vulnerable and which would expose him/her to the risk of HIV infection. The practices of "safe sex" through the use of condoms could reduce the risk of HIV infection considerably. Use of disposable needles and syringes and ensuring the supply of infection free blood and blood products are other measures needed for reducing the risk of HIV infection. A woman infected with HIV needs to seriously consider the risk of infecting her baby before deciding to go for a pregnancy. (Bhende and Kantikar, 2004)

Women's and girl's ability to protect themselves from STDs and HIV/AIDS is drastically weakened by the threat of male violence. Violence increases the risk factor for women by exposing them to force and unprotected sex. Their ability to negotiate condom use of their male partners is inversely related to the extent or degree of abuse in their relationship. (UNFPA 2005).

2.2 Empirical Literature

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

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

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

2.2.1 Global Scenario of HIV/AIDS

The statistical regarding HIV/AIDS given in this section are those released by the joint United Nations Programme on HIV/AIDS (UNAIDS) and the world health organization (WHO) in their publication "AIDS Epidemic".

According to the estimates made by UNAIDS and WHO the number of person living with HIV/AIDS as of December 1998 has grown to 33.4 million about ten percent more than the figure for the previous year.

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

UNAIDS and the WHO have estimated that approximate 40 million people living with HIV/AIDS infection is far more common in the world than previously. Among 40 million HIV/AIDS infected persons 2.5 million are children under 15 and 37 million are adults. About 5 million were injected with HIV in 2003 alone of this 700,000 are children under the age of 15 years. In 2003 total 3 million people died of HIV/AIDS. Among them 2.5 million were adults and 500,000 were children. Among infected 40 million peoples, 3 millions were died by 2004 due to HIV/AIDS which 2.5 million are adults and 5000 were children under 15 years. This overall situation indicates that children and youth are vulnerable to AIDS (UNAIDS/WHO, 2004).

Among the total young population 11.8 million young were living HIV/AIDS. Te shares of young women were 7.3 million and 4.5 million were young men (UNAIDS/UNICEF, 2001).

STIs continue to be a major and growing public health problem in many parts of the world, especially in developing countries with an

estimated annual incidence of 340 million curable STIs in 1999 (WHO, 2004).

At present the four most common curable STIs in the world, which can be cured easily by adequate antimicrobials are syphilis (12 millions), Gonorrhoea (62 million) Chlamydia infections (92 millions) genital herpes (53 millions), Lymphogranuloma venereum (59 millions) and Trichomoniasis (173 millions) in the world (WHO, 1999). The increasing mobility of population across the world urbanizations, poverty and socio-demographic changes especially in developing countries, sexual exploitation of women and changes in sexual behaviour are some of the factors which have placed on ever-increasing proportion of population of risk for STIs (WHO 2004).

The epidemic of STIs, in developing countries is characterized by high incidence and prevalence, high rate of complications increasing risk of transmission and acquiring HIV infection the increasing urbanization and industrialization in developing world leads to migration of young men and women in search of employment in urban area and even in the countries. This growing phenomenon often result in increased unsafe commercial sexual activities that help to the spread of STIs and HIV epidemic (WHO, 2004).

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

STIs increase the chance that any single sexual encounter will transmit the virus. In societies where STDs, are wide spread and where people have many sexual partners, the risk of HIV infection is dramatically increased (WHO, 2002).

2.2.2 Regional Situation of HIV/AIDS

South Africa has the world's largest number of patients' co-infection with TB and HIV. TB is the most opportunistic infection among with HIV 60,000 with Africans has both diseases. South African's cure rate for TB ranges from 35 percent Kwazulu-Natal to 10 percent in Western Cape, according to Health Minister Manto Ishabalala Msimang. The resulting average cure rate is 54 percent, WHS's goal is 85 percent (WHO, 2004).

According to UNAIDS 2004, sub-Saharan Africa has just over 10 percent of the world population, but is home to close to two thirds of all people living with HIV-some 25 million (range: 23.1-27.9 million) in 2003 alone, an estimated 3 million people (range 2.6-3.7 million) in the region became newly infected. While 2.2 million died of AIDS. Among young people 15-24 years of age 69 percent of women about 2.1 percent of men were living with HIV by the end of 2003 (UNAIDS, 2004).

In North Africa and the middle East around 480000 people (range, 200000-1.4 million) are living with HIV in this regions. This has prevalence of 0.2 percent of the adult population. Some 75000 people were believed to have become newly infected in 2003, and AIDS killed about 24000 that year. Among youth people aged 15-24, 0.2 percent of women and 0.1 percent of men were living with HIV by the end of 2003 (WHO, 2004).

Also in Eastern Europe and Central Asia diverse HIV epidemics are under way in there. About 1.3 million people (range 860000 -1.9 million) were living with HIV at the end of the 2003. During 2003 as estimated among young people aged 15-25, 0.6 percent of women and 1.3 percent of men were living with HIV by the end of 2003 (UNAIDS, 2004).

Around 1.6 million people (range 1.2-2.1 million) are living with HIV in Latin America. In 2003, around 48000 people died of AIDS, and 200000 were newly infected. Among Young people 15-24 years of age 0.5 percent of women and 0.8 percent of men were living with HIV by the end of 2003 (UNAIDS, 2004).

In Caribbean around 43000 people (range 270000-760000) are living with HIV in the Caribbean. In 2003, around 35000 people died of AIDS and 52000 were newly infected. Among young people 15-24 years of age, 2.9 percent of women and 1.2 percent of men were living with HIV by the end of 2003 (UNAIDS, 2001).

In Oceania, there is abnormality to the different country. HIV and STIs were also prevalent. In Vanuatu 28 percent had Chlamydia and 22 percent had Trichomoniasis infection. Some 6 percent of pregnant women had more than one sexually transmitted infection. Similarly in Samoa, 31 percent of pregnant women had Chlamydia and 21 percent and Trichomoniasis infection. Overall 43 percent of pregnant women had at least one sexually transmitted infection (UNAIDS, 2004).

2.2.3 Situation of HIV/AIDS in Asia

Asia is a most populated region of the world. Most of the countries are developing in there. The region includes the world's most populous countries China and India.

An estimated 7.4 million people (range 5-10.5 million) in Asia are living with HIV around half have died of AIDS in 2003, and about twice as many 1.1 million are thought to have become newly infected with HIV.

Among young people 15-24 years of age 0.3 percent of women and 0.4 percent of men were living with HIV by the end of 2003 Epidemics in this region remain largely concentrated among injecting drug users, men who have sex with men, sex workers, clients of sex workers and their sexual partners (UNAIDS, 2004).

Latest estimates show some 8.2 million people were living with HIV at the end of 2004, including the 1.2 million people who became newly infected in the past year. AIDS claimed some 540000-lives in 2004 (UNAIDS, 2004).

Asia is not just vast but diverse and HIV epidemics in the region share that diversity with the nature, place and severity of epidemics differing across the region, overall Asian countries can be divided into several categories, according to the epidemics they are experiencing. While some countries were hit early (for example, Cambodia, Myanmar and Thailand) other are only now starting to experience rapidly expanding epidemics and need to mount swift, effective responses. They include Indonesia, Nepal, Vietnam and several province in China. In Myanmar and in parts of India

and China, HIV has become well entrenched in some sections of society, despite modest efforts to half the virus spread. Other countries are still seeing extremely low levels of HIV prevalence even, among people at high risk of exposure to HIV, and have golden opportunities to pre-empt serious out breaks. These countries included Bangladesh, East Timor, Laos Pakistan and the Philippines (UNAIDS,, 2004).

Although in China, moving at a rapid pace HIV has spread to all of China's 31 provinces autonomous regions and municipalities. In some parts such as Henan Anhui and Shandong, HIV was already spreading a decade ago among rural people who sold blood plasma to supplement their incomes elsewhere, the virus has established a more recent but firm presence among injecting drug users and to a lesser extent, sex workers and their clients. Much of the current spread of HIV in China is also attributable to injecting drug use and paid sex. HIV prevalence among drug injectors was measured at between 18 percent and 56 percent in six cities in the southern. Provinces of Guangdong and Guangxi in 2002. While in Yunnan province some 21 percent of injectors tested positive to HIV in 2003. Sexual transmission of HIV from injecting drugs users to their sex partners looks certain to feature more prominently in China's fast – evolving epidemic. Some 47 percent of surveyed female drug injectors in Sichuan province and 21% in neighbouring Yunnan province reported selling sex for money or drugs in the previous month, according to recent studies. Condom use was reported by quite high but it was hardly the norm once HIV becomes well established in commercial sex circuits, onward spread of the virus could be quite rapid if current behaviour trends persist. In 2003, almost one quarter of surveyed – sex workers in Guangxi never used condoms and about one half

used them only occasionally. In Sichuan only around 40 percent of sex workers reported using condoms with all their clients in the previous months, according to a 2002 study. Little is known about the possible role of sex between men in China's epidemic a rare survey of men who have in Beijing, conducted in 2001-2002, found that approximately 3 percent of the men were HIV infected (almost all of whom had been unaware their Serostatus (WHO, 2002).

India's epidemics are even more diverse than China's latest estimates show that about 5.1 million people were living with HIV in India in 2003. Serious epidemics are underway in several states. In Tamil Nadu, HIV prevalence of 50 percent has been found among sex workers, while in each of Andhra Pradesh, Karnataka, Maharashtra and Nagaland, HIV prevalence has crossed the 1 percent mark among pregnant women. In Manipur, meanwhile an epidemic driven by injecting drug use has been in full swing for more than a decade and has acquired a firm presence in the wider population. HIV prevalence measured at antenatal clinics in the Manipur cities of Imphal and Churachand has risen from below 1 percent to over 5 percent with many of the women testing positive appearing to be the sex partners of male drug injectors several factors look set to sustain Manipur's epidemic including the large proportion (about 20 %) of female sex workers who inject drugs and the young ages of many injectors (40% of male injectors surveyed in 2002 were under 25 years of age, WHO, 2002).

There are signs the injecting drug use is playing a bigger role in India's epidemics than previously thought. Most surveillance sites for injecting drug users are in the northern states where injecting is common behavior, but other parts of the country have yielded equally troubling

evidence. In the Southern City of India Chennai, for example, 26 percent of drug injectors were already infected with HIV when a sentinel site was established there in 2000, by 2003, 64 percent was infected. In most cities where injecting drug users have been surveyed, at least one quarter of them in Chennai, about 46 percent said they liked with a wife or regular sex partner. This has probably contributed to the fact that Chennai also has among the highest HIV prevalence rates among pregnant women in the country. It is likely that partners who injected drugs infected many of those women (UNAIDS, 2004).

In South-East Asia, three countries in particular Cambodia, Myanmar and Thailand are experiencing particularly seriously epidemics Cambodia's national HIV prevalence is around 3 percent the highest recorded in Asia. Data suggest that there have been some dramatic changes in the shape of Cambodia epidemic. For instance, infection among brothel based sex workers fell from 43 percent in 1998 to 29 percent in 2002 (UNAIDS, 2004).

In Thailand the number of new infections has fallen from a peak of around 130,000 a year in 1991 to around 21,000 in 2003. This remarkable achievement came about mainly because men used condoms more, and also reduced their use of brothels. However, Thailand's epidemic has been changing over the years. There is mounting evidence that HIV is now spreading largely among the spouses and partners of clients sex workers and among marginalized sections of the population, such as injecting drug users and migrants (UNAIDS, 2004).

Indonesia's epidemic is currently unevenly distributed across the nation of 210 million people. Six of the 31 provinces are particularly badly affected. The country's epidemic is also driven largely by the case of contaminated needles and syringes for drug injection. HIV prevalence among its 125,000-196,000 injecting drug users has increased therefore from 16 percent to 48 percent between 1999 and 2003. In 2002 and 2003 HIV prevalence ranged from 66 percent to 93 percent among injecting drug users attending testing sites in the capital city, Jakarta, Indonesia's drug users are regularly arrested and sent to jail. In early 2003, 25 percent of inmates in Jakarta's Cipinang prison were HIV Positive (UNAIDS, 2004).

Papua New Guinea which shares an island with one of Indonesia's worst affected Provinces, Irian, Java, has the highest prevalence of HIV infection in the Pacific. Prevalence is over 1 percent among pregnant women in the Capital Port Moresby and in Goroka and Lae. Papua New Guinea's epidemic appears largely heterosexually driven. High level of other sexually transmitted infections indicate behavioral to be implemented as a multi – sectoral program through the government and Ngo's (UNAIDS, 2004).

Most new HIV infections in Asia occur when men by sex and large numbers of men do so. Household based surveys in a number of Asian countries suggest that between 5 percent and 10 percent of men by sex, which makes commercial sex a large and lucrative industry in Asia. Many sex workers especially very young women from rural areas are either coerced into the industry or join it under duress, because they lack other employment opportunities. Nepal have reported earning around 2200 rupees or, US\$ 30 a week, six times the average wages income (UNAIDS,2004).

2.2.4 STIs and HIV/AIDS in Nepal

In Nepal the first case of HIV/AIDS was detected in 1988. only three male and one female were detected of HIV infection for the year when it was diagnosed at first in the year 1988 since then the incidence rate is increasing each year.

The youth of Nepal is vulnerable to STIs and HIV/AIDS because there is limit idea about the information education and information to them. It is an age of sexual activities so the prevelance case is predominant in this age (NCASC, 2004)

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

STIs and HIV/AIDS have become a major public health problem in Nepal. The first case was reported in 1998 surveillance information about AIDS is scarce in Nepal; however limited data indicate that HIV is currently around 0.3 percent in general population as of 30 June 2005 (NCASC) 895 cases of AIDS and 5069 HIV infection and 234 have already died from AIDS. Out of the total HIV infected, 2715 are clients of SWS/STD (2641 male and 74 female). 658 are housewives, 582 are female sex workers (SW), 991 are injecting drug users (976 male and 15 female), 114 are children ad 9 person are blood or organ recipients (NCASC) June 30, 2005. Although

UNAIDS estimates that 61000 people are HIV positive in Nepal. Whereas according to government reports 58000 people are injected. (Kathmandu post February 12, 2005). The new cases of HIV positive (including AIDS) 76 and AIDS (out of total HIV) 7 persons are found up to June 2005 (NCASC, 2005).

The number of deaths from AIDS is much larger than the reported figures. For example, by 2002; a total of 2, 968 adult and children are estimates to have died due to AIDS. In the same year, total of 58,000 adult and 60 children are estimated to be living with HIV/AIDS. The lack of systematic collection of New HIV prevalence data over the past several years has complicated the picture of Nepal's HIV/AIDS epidemic. Until the late 1990s' the limited nature of seroprevalence data are available confined the attention of experts to prevalence among high risk groups, sex workers and injecting drug users in the nation's capital. Lack of availability of HIV diagnosis as well as AIDS case reporting reinforce the notion that HIV was confined to small population in Kathmandu, Pokhara and major transport routes in Nepal and crossing points into India (UNFPA, 2003).

2.2.5 The Potential for a Rapid Increase in HIV Prevalence

Behavioural and sero-prevalence data indicate the high potential for a generalized epidemic in Nepal. In the absence of effective interventions, even a "low to moderate" growth scenario" would make AIDS the leading cause of death in the 15-49 year old population over the coming years. For Nepal, this would mean that around 100,000-200,000 young adults will become infected and that overall 10,000-15,000 annual AIDS cases and

deaths due to related illness may be expected. (National HIV/AIDS Action Plan 2005-2006).

For Nepal, a generalized epidemic with high mortality in the productive age group would start a "vicious circle". The impact of HIV/AIDS would increase poverty and vulnerability. This increased vulnerability would lead to more HIV infections and a higher impact. Besides the negative impact on socio-economic development and the loss of productive life, the burden of disease would change dramatically over the next 10 years and would put further stress on the health sector and local communities. (National HIV/AIDS Action plan 2005-2006).

2.2.6 Injecting Drug Users (IDUs)

Bahavioural research among IDU in Nepal clearly indicates that needle sharing, the major risk factor for HIV, is common. In most Asian countries, IDUs are the first community to be affected by HIV. Nepal was the first developing country to establish a Harm Reduction Program with needle exchange for IDUs. However, due to the program's limited coverage, HIV continues to spread among this group. A March 2004 study finds that while the HIV prevalence rate among IDUs national wide was 38.4 percent, Kathmandu reported a rate of 68 percent for this group. (National HIV/AIDS Action Plan 2005-2006).

IDU in Nepal are threatened not only by their behavioural risks but also by a societal response, which ostracises drug use and uses a predominantly punitive model, coupled with limited drug treatment facilities. HIV/STI prevention services for IDU are often of questionable

quality, mainly because they are not designed with the needs of the end – user in mind. These limitations signal an ominous trend of increasing HIV prevalence among this marginalized group

2.2.7 Female Sex Workers

Due to their marginalized status in society, sex workers have little access to accurate information about reproductive health and STI. Cultural, economic and social constraints limit their access to legal protection and to medical services. Almost 60 percent of their clients who are mainly transport workers. Members of the police or military, wage earners, and migrant workers, do not use condoms, while nationally. HIV prevalence among FSWs is approx 4 percent, infection rates among street based sex workers in the Kathmandu valley are between 15 and 17 percent nationally, clients of FSWs have an estimated HIV prevalence rate of 2 percent (National HIV/AIDS Action plan 2005-2006).

A major challenge to control HIV in the country is the trafficking of Nepali girls and women into commercial sex work in India, and their return to the practice in Nepal. About 50 percent of Nepal's FSWs previously worked in Mumbai, India, and some 100,000 Nepali women continue to engage in the practice there. The National Network Against Girls Trafficking, a Coalition of approximately 40 NGOs initially established to tackle the problem of girl trafficking has also begun to address. The issue of HIV/AIDS (National HIV/AIDS Action Plan 2005-2006).

Additionally there are thousands of girls who are forced into religiously, culturally and traditionally institutionalized sex work practices

such as Deuki and Badi. According to NDHS (2004), although Human Rights Organizations have often reported on this problem, no serious steps have been taken reduce the practices significantly. Most sex workers experience increase vulnerability to HIV/AIDS due to a low level of education, which restricts access to information and health care services. They have little control over the risk in sexual encounters because the client often determines whether or not to use a condom. Moreover, violence against sex workers is common. (National HIV/AIDS Action Plan, 2005-5006).

2.2.8 Mobile Population

"Mobility has complex causes ranging from economic and /or political reason to "forced" displacement (e.g. conflict trafficking). Each of these mobile groups and their respective families are vulnerable to HIV/AIDS/STIs in different ways. According to UNHCR, there are 100,000 to 200,000 internally displaced persons (IDPs) in Nepal. And although WHO and UNAIDS do not categories IDP as a high risk group, it has to be noted that the far western region of the country where the majority of IDP are concentrated have one of the highest rate HIV/AIDS in South Asia. Infact Nepal figures as one of the eight priority countries in a report on "HIV/AIDS and IDPs" released by the UN Refugee Agency in January 2006. (Nation HIV/AIDS Action Plan 2005.2006).

Economic Migration, both interval and external is no a new phenomenon in Nepal. Estimates range from 1.5 to 2 million Nepali nationals, who work outside the country, 1 million are estimated to be in different part of India alone. Although information is limited about the

behaviour of labour migrants in their respective host countries, the assumption is that during their long absence from their families a considerable number of them become clients of sex workers, recent studies among labour emigrants revealed HIV sero-prevalence rates of between 2-10 % from migrants returning from Mumbai, India. (National HIV/AIDS Action Plan 2005-2006).

2.2.9 Sexually Transmitted Diseases

STD is a significant co-relate of HIV/AIDS epidemic. It is estimated that 200,000 episodes of STDs occur annually in Nepal. The STD prevalence rate in women is approximately 4.7 percent ranging from 2.7 percent 5.4 percent. Access to STD services is still very poor, especially among women. In addition, the use of condoms for effective infection prevalence is not yet commonly known or accepted condoms contributed to only 1.1 % of the total contraceptive prevalence rate. A present other methods of contraception are emphasized, which leave women vulnerable to infection and force them to negotiate condom use for infection prevention. (National HIV/AIDS Action Plan, 2005-2006)

2.2.10 Support of other Government Ministers

- Training of focal points on HIV/AIDS in various ministries.
- The ministries of communication, education, women's affairs and home affairs have supported efforts to propagate prevention messages, information, projects and education through various work plans, prepared and implemented by some ministries, including Defence and Labour.

- In June 2003, Nepal launched satellite digital radio broadcast for rural communities with locally – produced programmes to impart information of HIV/AIDS and gender issues. A 18 month project, the broadcast dealt with risky behaviour related AIDS and community issues such as poverty, violence against women, micro-finance reproductive health and early childhood development (National HIV/AIDS Action Plan 2005-2006).

2.2.11 HIV Situation in Dhading District

Dhading is a neighbour district of Kathmandu. The educational status is very low in this district. According to 2001 census the total literacy rate of this district 43.7 percent. Among them 54 percent are male and 34 percent are female. The program lunched by GO, NGO and INGO' are negligible also not reaching to Dalit communities of district. The Prithivi Highway is passing through its Southern parts. In highway area there is prevalence of prostitution in small hotel/shop. Thus there is high risk of causing STIs and HIV/AIDS.

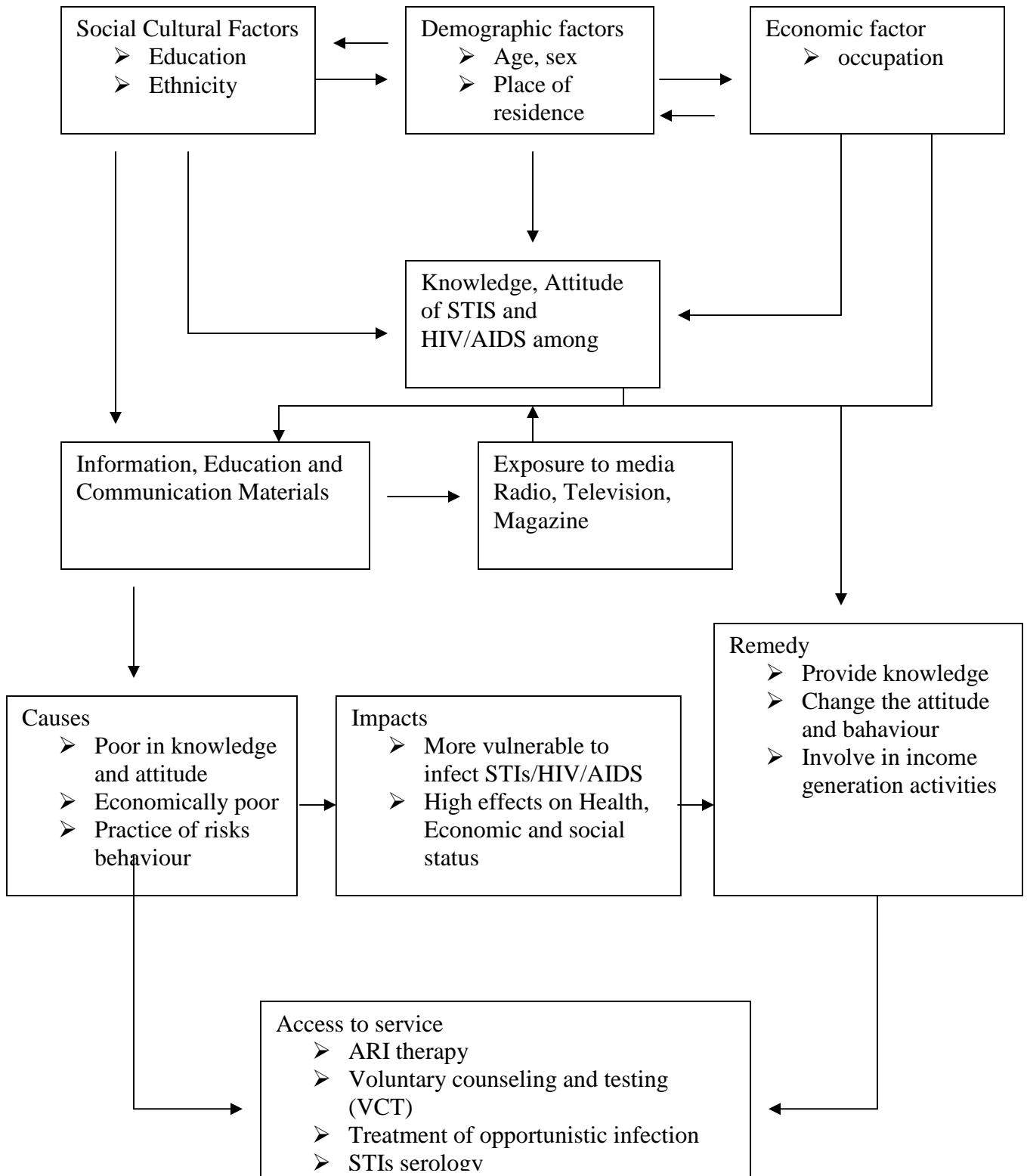
Not only is this the girls trafficking also problem in this district, for commercial sexes work to India. Many girls are trafficked to India in every year from so many parts of this district. When they come backs to home, the HIV/AIDS is also carry with them. Now a days there is also increase in the numbers of injecting drug users (IUDs) female sex workers and migrant workers with HIV/AIDS in this district. Thus this district is not avoided of HIV/AIDS case (Acharya, 2002).

There is not any published information about STIs and HIV/AIDS in Dhading District. This real database is found about STIs and HIV/AIDS in Dhading is scarce. But according to Dhading District Hospital and General Welfare Academy NGO there were 54 people living with HIV and 27 people were died up to March 2005. This figure may rise in reality.

2.2.12 Conceptual Framework of the Study

In this research study, it has attempted to explain the effect of several factors on knowledge and attitude about STIs an HIV/AIDS. In general knowledge, attitude and practices of anyone is influenced by socio-economic and demographic factors. Here socio-economic factor also affect demographic factors and level of education, place of residence also affect the level of education and ultimately affect the knowledge and attitude or, sexuality STIs and HIV/AIDS. If high level of information, education and communication (IEC) and accepts the exposure to media, there is also increase level of knowledge and attitudes towards STIs and HIV/AIDS among youth population. If there is less access to education and exposure to media, there will be also level of knowledge, attitude and practices on STIs and HIV/AIDS among the youth become more vulnerable to causing SITs and HIV/AIDS the causes bad impact on heath economic and social situation.

Conceptual Framework of the Study



CHAPTER III

METHODOLOGY

The set of methods were employed to conduct the research. The focus of this study is on assessments of youth's level of knowledge and attitude towards STIs, HIV/AIDS. This study reflected his/her situation about knowledge, attitude, behaviour on the subject. Essential methodology and procedures are applied accordingly that are explained below in brief.

3.1 Selection of Study Areas and Population

Dhading district has diverse geographical and socio cultural nature. It is located in the range of 300 (jogimara to 7110 m(Pawil Himal) high from sea level. The total areas of the district is 1925 sq.km. It lies on latitude 84 degree 35 minute east and longitude is 27 degree 40 minute northern to 27 degree 17 minute north. The total population enumerated in 2001 was 338658. The male and female population was 165864 and 172794 respectively. The district constitute of 50 VDCs. It has no municipality due to the lack of physical infrastructure and other facilities. The literacy rate of the district is 43.7 percent, which is quite below than nutritional level 58 percent.

Out of 50 VDCs of Dhading district, Sarkigaun, Thamandada, Damai gaun, Kami gaun of Aagnichok VDC was selected for the study, which is located northern part of Dhading and it has located near the Arughat bazaar of Gorkha district Geographical settlement of the VDC is totally hill Gravel road goes to the VDC from the district headquarters. There is two high

schools, one lower secondary school, 3 primary schools and 3 pre-primary schools are build up for educational improvement. One Sub-Health Post (SHP), one post office are also established. CDMA telephone, health and communication facilities but electricity facilities are still not provided due to the economic condition of the country. Population of the selected village inhabitants are Damai, Kami, Sarki, Newar, Thakuri, Magar, Brahmin and Chettri.

Dalits are aborigines of this village. The population of VDC is diverse in its socio-economic status. Total 4181 population were enumerated 2001 census in this VDC among which 1643 Dalits.

3.2 Source of Data

The primary base study usually collets the primary information using the different methods. Therefore this primary base information also were collected using pre structure questionnaire from the pre-mentioned study area though direct interview with respondents. The secondary information also has been used for comparative study collecting from the published or non-published related documents.

3.3 Sampling Techniques and Selection of Respondents

The primary base information was collected through direct interview using the purposive sampling method under the non-probability sampling technique. Other technique has been not used due to limitation of budget and time. Basically the information was collected with age 15 to 60 years. Two respondents were selected from some household as a basis of their sex (male and female).

3.4 Questionnaire Design

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

- A. Individual questionnaire
- B. Household questionnaire
- C. Knowledge and attitude of STIs
- D. Sexuality and condom use

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

3.5 Data Collection Method

Topic of STIs and HIV/AIDS is related to sexuality so its issue is sensitive for unmarried as well as married population. Generally they hesitate to answer questions about sex and sexuality. Especially women ignore about its issue.

Considering this, the interviewer/enumerators were selected both male and female. Male enumerators were for male respondent and female enumerators for female respondents. Five enumerators (3 males and 2

females) were from three Bheemodaya lower secondary school of this village. At first the enumerators were given idea about way of questionnaire fill up. The researcher team was reached the study area Saturday and Sunday before school time and after school time and selected side was near by the school. The selected respondents were asked the questions separately by the enumerators according to the designed questionnaire.

3.6 Selection of the Study Variable

Depending on the nature of study the variable are categorized as follows:

Independent variables

- A. Socio-cultural variables: Education, Ethnicity, Religion
- B. Economic variables: Occupation
- C. Demographic variables: Age, Sex and Marital Status

Dependent Variables

- A. Knowledge, attitude towards STIs and HIV/AIDS
- B. Sexuality and Uses of condom

3.7 Operational Definition of the Variables

- **Age of Respondents:** The study is limited to the Dalit (Damai, Kami and Sarki) of age group 15-60 years. Two boxes have been provided to enter the two digits age in questionnaire. So all the respondents are within this age limit.

- **Sex of Respondents:** The respondents can be categorized either male or female which in nominal scale.
- **Cast/Ethnicity of Respondents:** Only dalit caste (Damai, Kami and Sarki) group was selected for the study so other Caste/Ethnicity is not included.
- **Place of Residence:** All the respondents in this reside in rural area.
- **Religion of Respondents:** The religion of all respondents is Hindu only.
- **Marital Status:** Two categories "married" and unmarried for marital status are included in the questionnaire.
- **Family Members:** The number of persons some living same household and some living separately household. Two boxes are provided to enter the number of family members.
- **Occupation:** The current major occupation for survival is considered as their occupation in this study.
- **Education:** The highest level of education of respondent.
- **Knowledge on symptom of STIs:** The major pre-coded five symptoms of STIs were included in the questionnaire. Other responses that were given by the respondents are also included.
- **Knowledge on mode of transmission of STIs:** The major modes of transmission of STIs were preceded. There were four major modes of transmission found during the study.
- **Knowledge on Prevention Measures of STIS:** The major preventive measures of STIs were pre-coded. They were five major preventive measures found during the study.
- **Knowledge on modes of transmission on HIV/AIDS:** The major modes of transmission of HIV/AIDS were pre-coded. There were five major modes of transmission found during the study.

- **Knowledge on prevention measures of HIV/AIDS:** The major prevention measures of STIs were pre-coded. There were five major preventive measures found during the study.

3.8 Data Processing/Management

In the study, pre-coded questionnaire was used. The open answers were again coded according to the prepared codebook. The entire filled questionnaires was manually reviewed and checked before entries of data. Data were managed using data base program. Thereafter by editing entry error required tables and cross tables, were provided by using SPSS software technician assistance from SPSS program technical person.

3.9 Method of Data Analysis and Interpretation

The data were processed with help of computer using database and SPSS program and frequency tables, cross tables percentage so on were developed accordingly. The data analysis is simply based on descriptive types of analysis. The findings of the analysis have been presented in tabular forms and interpreted accordingly.

CHAPTER IV

SOCIO-ECONOMIC AND DEMOGRAPHIC CHARACTERISTICS OF THE RESPONDENTS

4.1 Individual Characteristics of the Respondents

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

4.1.1 Age-Sex Composition

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

Table 4.1 Distribution of Respondents by Age Composition

Age group	Number	Percent
15-19	16	15.2
20-24	18	17.6
25-29	10	9.5
30-34	11	10.4
35-39	12	11.1
40-44	13	12.3
45-49	8	7.6
50-54	9	8.5
55-59	5	4.7
Above 60	3	2.8
Total	105	100.0

Source: Field Survey, 2007

The table 4.1 shows that age group 15-19 years (15.2 percent), 20-24 years (17.1 percent), 25-29 years (9.5 percent), 30-34 years (10.4 percent) 35-39 years (11.4 percent), 40-44 years (12.3 percent), 45-49 years (7.6 percent), 50-54 years (8.5 percent), 55-59 years (4.7 percent) and 60 above (2.8 percent) were found.

4.1.2 Sex Composition

The sex composition of study population were shown in the table below.

Table 4.2 Distribution of Respondents by Sex Composition

Sex	Number	Percent
Males	57	54.3
Females	48	45.7
Total	105	100.0

Source: Field Survey, 2007

Table no. 4.2 shows that 54.3 percent were males respondents and 45.7 percent were females respondents.

4.1.3 Caste and Ethnicity

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

Table 4.3: Distribution of Respondents by Caste

Caste	Number	Percent
Damai	31	29.5
Kami	34	32.4
Sarki	40	38.1
Total	105	100.0

Source: Filed Survey, 2007

Table no. 4.3 shows that (29.5 percent) respondents are damai, (32.4 percent) respondents are Kami and 38.1 percent respondents are Sarki.

4.1.4 Religion

All of the selected respondents were found Hindu.

4.1.5 Marital Status

Marital status of the respondents can be considered as one of the key factors for knowledge and attitudes of STIs and HIV/AIDS. The table 4.4 shows that the marital status of respondents.

Table 4.4: Distribution of Respondents by Marital Status

Marital Status	Number	Percent
Married	58	55.3
Unmarried	47	44.4
Total	105	100.0

Source: Field Survey, 2007

From the above table shows that 55.3 percent respondents are married and 44.7 respondents are unmarried.

4.1.6 Educational Status of Respondents:

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

Table 4.5: Distribution of respondents by Educational Status

Educational Status	Number	Percent
Illiterate	25	23.8
Non-formal	19	18.1
Primary (1-5)	27	25.8
Lower Secondary (6-8)	19	18.1
Secondary (9-10)	12	11.4
SLC and above	3	2.8
Total	105	100.0

Source: Field Survey, 2007

From table 4.5 shows that (23.8 percent) respondents are illiterate, (18.1 percent) are non-former (25.8 percent), primary (18.1 percent), (11.4 percent) secondary and (2.8 percent) SLC and above.

4.1.7 Occupation of Respondents

Table 4.6: Distribution of Respondent by Occupation

Occupation	Number	Percent
Farming	31	25.5
Agriculture labour	28	16.6
Non-agri. labour	16	15.3
Business	9	8.5
Housewife	21	20
Total	105	100.0

Source: Field Survey, 2007

The above table shows that 25.5 percent respondents are farming, 26.6 percent are agriculture labours, 15.3 percent are non agri-labour, (8.6 percent) are business and 20 percent housewife.

4.2 Household Characteristics of Respondents

4.2.1 Family Size

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

Table: 4.7 Distribution of Respondents by Family Size

Size of family	Number	Percent
Less than 5 person	26	24.8
5 to 10 person	59	56.2
Above 10 person	20	19.0
Total	105	100.0

The table 4.1 shows that 26 respondents (24.8 percent) less than 5 person, 56.2 percent family size 5 to 10 person and 19.0 percent family size above 10 person were found .

4.2.2 Possession of the Facilities

The possessions of the facility of study population were shown in the table below.

Table 4.8: Distribution of the Respondents According to Facilities

Facilities	Have	Percent	Don't have	Percent
Radio	55	52.3	50	47.6
TV	8	7.3	97	92.3

Source: Field Survey, 2007

Note: Total percentage may exceed 100 due to multiple response (N = 105)

Above table shows that 55.3% respondent had radio facility and 7.3 percent respondent had TV facilities. And 47.6 percent respondents didn't have radio and 92.3 percent respondents had no TV facilities.

4.2.3 Fertile Land

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

Table 4.9: Distribution of Respondents by Fertile Land

Fertile land	Number	Percent
Less than 5 ropani	8	7.6
5 to 10 ropani	55	52.4
Above 10 ropani	42	40.0
Total	105	100.0

Source: Field Survey, 2007

This table shows that 7.6 percent respondent had less than 5 ropani fertile land, 52 percent respondents have 5 to 10 ropani land and 40 percent respondent had above 10 ropani land.

CHAPTER V

KNOWLEDGE AND ATTITUDE TOWARDS STIS AND HIV/AIDS

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

5.1 Knowledge of STIs by Sex

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

Table 5.1 : Distribution of the Respondent on Hearing of STIs according to Sex

Heard	Male		Female		Total	
	Number	Percent	Number	Percent	Number	Percent
Yes	44	78.5	26	53.1	70	66.6
No	12	21.5	23	46.9	35	33.4
Total	56	100.0	49	100.0	105	100.0

Source: Field Survey, 2007

Table 5.1 shows that out of 105, (66.6 percent) had heard about STIs and remaining (33.4 percent) had not heard it. In addition, 44 males (78.5 percent) had heard other had not heard about it. However, 26 females (53.1 percent) had heard and others had not heard about STIS. This information indicates that male had little high knowledge than their female counterpart.

5.2 Heard of STIs by Marital Status

Marital Status has taken as independent variables for this study

Table 5.2: Distribution of respondents on hearing of STIs according to Marital Status

Heard	Married		Unmarried		Total	
	Number	Percent	Number	Percent	Number	Percent
Yes	44	64.7	24	64.8	68	64.8
No	24	35.3	13	35.2	37	35.3
Total	68	100.0	37	100.0	105	100.0

Source: Field Survey, 2007

The above table shows that above (65 percent) respondents had heard about the STIs. This figure was higher for unmarried group; (64.8 percent) comparing with the married group (69.1 percent).

5.3 Heard of the STIs by Educational Level

Table 5.3: Distribution of Respondents who Heard of STIs by educational Status

Educational level	Yes		No		Total	
	Number	Percent	Number	Percent	Number	Percent
Illiterate	19	23.7	16	64	35	33.3
Non-formal	14	17.5	2	8	16	15.3
Primary (1-5)	24	30	5	20	29	27.6
Lower Secondary (6-8)	15	18.7	2	8	17	16.2
Secondary	5	6.3	-	-	5	4.8
SLC and above	3	3.5	-	-	3	2.8
Total	80	100.0	25	100.0	105	100.0

Source: Field Survey, 2007

The table 5.4 shows that out of total 35 illiterate respondents, 19 (23.7 percent) heard about HIV/AIDS. Followed by 14 (17.5 percent) respondents heard about HIV/AIDS whose educational status is non-formal, 24 (30 percent) of primary level, 15 respondents (18.7 percent) of lower secondary level and all of (100 percent) respondents heard about HIV/AIDS whose educational status is secondary and above, from the above figures, it is clear that when the raise of educational status, there is also raising the proportion of heard respondents about HIV/AIDS.

5.4 Knowledge About Types of STIs

Table 5.4: Distribution of all Respondents by Knowledge on Types of STIs

Types of STIs	Number	Percent
Gonorrhea	15	14.3
Syphilis	21	20
HIV/AIDS	69	65.7
Total	105	100.0

Source: Field Survey, 2007

The above table 5.4 shows that the HIV/AIDS is very common types of STIS which was heard by almost 66 percent respondents. The next common types of STIs are Syphilis and Gonorrhea which were heard by about 20 % and 14.3 percent.

5.5 Source of Information about STIs

The respondents got information about STIs from following sources:

Table 5.5: Distribution of Respondents According to the Sources of Information on STIs

Sources of Information	Number	Percent
Teachers	20	20.0
Radio	79	79.8
Friends	63	63.6
TV	41	41.4
Newspapers	20	17.2
Text books	17	16.2
Health personnel	16	10.1
Relatives/neighbours	6	6.1

Source: Field Survey, 2007

Note: Total Percentage may exceed 100 due to multiple responses (N=99)

Table 5.5 explains the sources of information for the knowledge of STIs. The majority of respondents to be informed were by radio (79.8 percent). The second information source was friends (63.6 percent) followed by TV (41.4 percent), teacher (20.2 percent), newspapers (17.2 percent) textbook (16.2 percent), health personnel (10.1 percent) and relatives/neighbours (6.1 percent). Although there was no access electricity the TV was the third sources of information. This can be probable due to hearing of TV programme from TV band with radio receiver and watching of TV program in the only one owner of TV family.

5.6 Knowledge on Symptoms of STIs

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

Table 5.6 gives the percentage distribution of respondents by knowledge on symptoms of STIs

Table 5.6: Distribution of Respondents by Knowledge on Symptoms of STIs

Knowledge	Number	Percent
Yes	80	76.2
No	25	23.8
Total	105	100.0

Source: Field Survey, 2007

According to the table 5.6 (76.2 percent) knew the symptoms of STIs. The respondents who knew the symptoms of STIs were asked mention the symptoms of STIs were asked mention the symptoms. The table 5.6 shows the knowledge of different symptoms of STIs.

Table 5.7 Distribution of respondents by Symptoms of STIs

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

Source: Field Survey, 2007

Note: Total percentage may exceed 100 due to multiple response (N=70)

According to table 5.8, 50 respondents (71.4 percent) reported sores abrasion around vagina itching followed of pus from penis (32.8 percent), lower abdominal pain during intercourse (27.1 percent) and bleeding other than Menstruation period (18.5 percent) as the symptoms of STIs.

5.7 Knowledge on Transmission of STIs

Table 5.8: Distribution of Respondents by Knowledge on Mode of Transmission

Knowledge	N	%
Yes	90	85.7
No	15	14.3
Total	105	100

Source Field Survey, 2007

In questionnaire, the question to assess the knowledge on transmission of STIs was included first of all respondents were asked to they know the mode of transmission of STIs or not. According to above table 90 respondents (85.7 percent) knew the mode of transmission of STIs and only 15 respondents (14.3 percent) didn't know mode of transmission.

5.8 Prevention Measure of STIs

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

Table 5.9: Distribution of Respondents by Preventive measure of STIs

Preventive Measure	Number	Percent
Use of condoms during sexual intercourse	69	86.2
Sex with only one partner	61	76.2
Abstinence during infected period	39	48.7
Always clean owns sexual organs	22	27.5
Avoid sharing foods, cloths and toilet	21	26.2

Source: Field Survey, 2007

Note: Total percentage may exceed 100 due to multiple response (N=85)

It is shown in table 5.9 that use of condom during sexual intercourse was the most preferred way of preventive from sexually , transmitted infection, which had been reported by (86.2 percent), likewise, sex with only one partner was reported by (76.2 percent), sexual abstinence during infection period was (48.7 percent), clean own sexual organs was (27.5 percent), and avoid sharing food, clothes, toilets was (26.6 percent) it has seen that there is also bad perception about preventive measure of STIs because they felt avoid of sharing foods, cloths, and toilets is a preventive measures of STIs.

5.9 Knowledge on HIV/AIDS

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

5.10 Heard of HIV/AIDS by Sex

To know the knowledge of HIV/AIDS the question have you heard about HIV/AIDS asked to the respondents. From the table 5.10 it shows that 63.9 percent respondents have heard about HIV/AIDS out of total respondents. On the contrary 36.1 percent respondents don't have knowledge about HIV/AIDS.

Table 5.10: Distribution of Respondent about the Knowledge of HIV/AIDS by Sex

Heard	Male		Female		Total	
	Number	Percent	Number	Percent	Number	Percent
Yes	46	67.7	21	56.8	67	63.9
No	22	32.3	16	43.2	38	36.1
Total	68	100.0	37	100.0	105	100.0

Source: Field Survey, 2007

According to the figure the male respondents were knowledgeable, than female respondents which was 67.7 percent and 56.8 percentage respectively.

5.11 Heard of HIV/AIDS According to Educational Status

Educational is most important variable for knowledge of HIV/AIDS. So the table is represented according to hearing of HIV/AIDS by educational status.

Table 5.11: Distribution of Respondents by Hearing of HIV/AIDS by Educational Status

Educational Status	Yes		No		Total	
	Number	Percent	Number	Percent	Number	Percent
Illiteracy	29	32.3	6	40	35	33.4
Non formal	19	21.2	4	26.7	23	21.9
Primary (1-5)	13	14.1	4	26.6	17	16.2
Lower secondary (6-8)	21	23.3	1	6.6	22	20.9
Secondary (9-10)	5	5.5	-	-	5	4.8
SLC and above	3	3.3	-	-	3	2.8

Source: Field Survey, 2007

The above table shows that out of total 33.4 percent illiterate respondents 29 (32.9 percent) heard about HIV/AIDS. Followed by 19 (21.2 percent) respondents heard about HIV/AIDS whose educational status was non-formal 13 (14.4 percent) of primary level 21 respondents (23.3 percent) of lower secondary level and (5.5 percent) respondents secondary level, and 3.3 percent respondents SLC and above. From the above figures, it is clear that when the raise of educational status, there is also raising the proportion of heard respondent about HIV/AIDS

5.12 Knowledge on Difference between HIV and AIDS

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

Table 5.12: Distribution of Respondents by Knowledge on Difference between HIV and AIDS by Sex

Difference	Number	Percent
Yes	29	27.7
No	48	45.7
Don't know	28	26.6
Total	105	100.0

Source: Field Survey, 2007

Above table 5.12 shows that out of 105 respondents 29 (27.7 percent) said that HIV and AIDS are different, which is very low. About 45.7 percent respondents said that both are same. The respondent falling in doesn't know category is 26.6 percent.

5.13 Knowledge on Transmission of HIV/AIDS

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

Table 5.13: Distribution of Respondents by Knowledge on HIV/AIDS and Sex

Knowledge	Male		Female		Total	
	Number	Percent	Number	Percent	Number	Percent
Yes	55	94.9	37	78.8	92	87.7
No	3	5.1	10	21.2	13	12.3
Total	58	100.0	47	100.0	105	100.0

Source: Field Survey, 2007

From the table 5.13 out of 105 respondents having knowledge on HIV/AIDS transmission (88 percent). Only (12.3 percent) hadn't know the mode of transmission. According to the sex, male respondents are more knowledgeable (95 percent) than female (79 percent).

5.14 Knowledge on Prevention Measures on HIV/AIDS by Sex

Table 5.14: Distribution of Respondents by Knowledge on Preventive Measure of HIV/AIDS by Sex

Respondents	Male		Female		Total	
	Number	Percent	Number	Percent	Number	Percent
Yes	43	68.3	28	66.7	71	67.7
No	20	31.7	14	33.3	34	32.3
Total	63	100.0	42	100.0	105	100.0

Source: Field Survey, 2007

From the table 5.14 it is clear that out of 105 respondents who were knowledgeable about preventive measures on HIV/AIDS 43 were males respondents (68.3 percent) and 28 females respondents were also known about preventive measures. About 20 males respondents 31.7. They didn't know about preventive measure and 14 females respondents 33.3 percent they didn't know about preventive measures.

5.15 Attitude Towards the Infected People

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

Table 5.15: Distribution of Respondents by their Attitudes towards Infected Person

Attitudes	Number	Percent
We should love and respect them	67	63.9
We should hate them	31	29.5
Don't know	7	6.6
Total	105	100.0

Source: Field Survey, 2007

According to the table 5.15, more than half (63.9 percent) respondents said that they should love and respect them. Also some respondents (29.5 percent) said that the infected person should be hated in the society. The seven respondents (6.6 percent) reported that they do not know how they should be behaved.

5.16 Information about Sexual Partner

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

Table 5.16: Distributions of Respondents having Sexual Partner (outside Marital Union for married respondents) by Married Status

Sexual partners	Married		Unmarried		Total	
	Number	Percent	Number	Percent	Number	Percent
Yes	43	75.5	25	52.1	68	64.8
No	14	24.5	23	47.9	37	35.2
Total	57	100.0	48	100.0	105	100.0

Source: Field Survey, 2007

According to table 5.16 (64.8 percent) had premarital sexual partner and 37 (35.2 percent) respondents had no premarital sexual partner. This figure shows that there was also prevalence of the premarital sex. This may cause high risk of infection of STIs and HIV/AIDS. The respondents who have sexual partner were also asked the question about sexual partner and the result is shown in the following table.

Table 5.17: Distribution of Respondents Having their Sexual Partners

Sexual partner	Married		Unmarried		Total	
	Number	Percent	Number	Percent	Number	Percent
Wife/husband	51	89.4	-	-	51	62.2
Friends	2	3.5	12	47.1	14	17.1
Prostitute	4	7.1	4	11.7	8	9.8
Neighbours	-	-	6	23.5	6	7.3
Relatives	-	-	3	17.6	3	3.6
Total	57	100.0	25	100.0	82	100.0

Source: Field Survey, 2007

From table 5.17 only 51 respondents (89.4 percent) have their own sexual union (husband/wife). The remaining six married respondents replied the sexual partner other than his or her own couple. The table also shows that 17.1 percent, respondents sexual partner were friends followed by prostitute (10 percent), neighbours (7.3 percent), as their sexual partners.

5.17 Information about Contraceptive Use

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

Table 5.18: Distribution of Respondents by Currently Use Contraceptive

Contraceptive user	Number	Percent
Yes	32	39.1
No	50	60.9
Total	82	100

Source: Field Survey, 2007

Out of total 82 respondents having sexual partner. Only 32 respondents (39.1 percent), had use contraceptive when sexual intercourse. On contrary 50 respondents (61 percent) had not use any contraceptive in the sexual intercourse.

Table 5.19: Distribution of Respondents According to Types of Contraceptive

Types of contraceptive	Number	Percent
Condom	7	21.9
Injection (Depo-Provera)	20	62.5
Pills	4	12.5
Foam tables	1	3.1
Total	32	100.0

Source: Field Survey, 2007

According to table 5.19, out of total 32 contraceptive users, 7 respondents (21.9 percent), had use condom. While the contraceptive injection (Depo-Provera) which was used by 20 respondents (62.5 percent), and pills users were 4 person (12.5 percent), only one respondent (3.1 percent), used foam tab.

5.18 Purpose of Contraceptive Use

The use of contraceptive is mainly for two purposes. One is family planning and another is preventing from STIs HIV/AIDS (mainly by condom). The table 5.19 shows the purpose of contraceptive use among the respondents.

Table 5.20: Distribution of Respondents by Purpose of Contraceptive Use

Purpose	Total		Married		Unmarried	
	Number	Percent	Number	Percent	Number	Percent
For family planning	20	62.5	17	81.0	3	62.5
For protecting from STIs HIV/AIDS	12	37.5	4	19	8	37.5
Total	32	100.0	21	100.0	11	100.0

Source: Field Survey, 2007

According to table 5.20 out of total 32 contraceptive users, 20 respondents (62.5 percent) used contraceptive for family planning purpose while 12 respondents (37.5 percent), use contraceptive for protecting from STIs and HIV/AIDS. According to the marital status, 81 percent of married respondents used contraceptive for family planning and 19 percent used for protecting from STIs and HIV/AIDS. Among unmarried respondents about 63 percent used contraceptive for family planning purpose and others (37.5 percent) used contraceptive for protecting STIs and HIV/AIDS.

5.19 Reason for Not Using Contraceptive

Some respondents who have sexual partner but they don't use contraceptive while intercourse. They were asked for the reason for not using contraceptive and the result is shown in table 5.19.

Table 5.21: Distribution of Respondents according to Reasons for not Using Contraceptives

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

Source: Field Survey, 2007

According to table 5.28 the total respondents who didn't use contraceptive were 50 out of total respondents, 9 respondents (18 %) didn't use contraceptive because they didn't get information about different contraceptive. Also 9 respondents (18 %) respondents didn't use contraceptive for the purpose of child bearing 8 respondents (16 %) felt no necessary for using contraceptive and 6 respondents (12 %) felt tedious for use followed by 5 respondents (10 %) said couldn't get pleasure, 4 respondents (8 %) said not available any where 2 respondents (4 %) don't use because they feels shyness to buy and 2 respondents (4 %) respondents didn't know the methods for using. So they didn't use contraceptive.

CHAPTER VI

SUMMARY, CONCLUSION AND RECOMMENDATION

This is the study of knowledge and attitude of STIs and HIV/ASIDS in Dalit community of Aaginchok VDC, Dhading. This study is based on primary data and quantitative type. Total 105 respondents were taken as sample size; selected with purposive sampling male and female 15-60 years. Population interviewed for this research in the Sarkigaun, Kamigaun, Damaigaun and Thamadada of Aaginchok VDC, Dhading.

6.1 Summary

6.1.1 Individual Characteristics

- The majority of respondents at 15-29 respondents age group are about 32.8 percent and minority of respondents at 55-59 years and about 4.7 percent.
- The highest no. of respondents are males 54.34 percent and females are 45.7 percent.
- Respondents are Damai 29.5 percent, Kami 32.4 percent and Sarki 38.1 percent.
- All of the respondents 100 percent are Hindus.
- The majority of respondents are married 55.3 percent.

6.1.2 Household Characteristics

- The family size of respondents is large. There is only 24.8 percent respondents family having less than 5 persons, 56.2 percent have 5 to 10 members and having more than 10 person 19 percent.
- A large proportion of respondents have Radio 52.3 percent and about 7.3 percent respondents have T.V. facilities.
- Most of respondents have fertile land less than 10 ropani 52.4 percent.

6.1.3 Knowledge and Attitudes about STIs

- Most of the respondents 66.6 percent male and 33.4 percent female, have heard about STIs.
- Unmarried respondents are more knowledgeable about STIs 64.7 percent than married respondents 64.8 percent.
- The respondents who are illiterate, heard about STIs 33.3 percent, non-formal level 15.3 percent, primary level 27.6 percent, lower secondary level 16.2 percent secondary level 4.8 percent and SLC and above 2.8 percent.
- About 65.7 percent respondents have heard about HIV/AIDS, 14.3 percent have heard about Gonorrhoea, and 20 percent respondents have heard about Syphilis.
- Most of the respondents 76.2 percent have knowledge about symptoms of STIs.
- Among the knowledgeable respondents about symptoms of STIs, majority of respondents 71.4 percent said the major symptoms of STIs is sores, abrasion around vagina, itching and followed by foul white discharge from vagina 55.7 percent; drop of pus from penis 32.8

percent, lower abdominal pain during the sexual intercourse 27.5 percent and bleeding other than menstruation period 18.5 percent as the symptoms of STIs.

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

6.1.4 Knowledge and Attitudes about HIV/AIDS

- Majority of respondents 63.9 percent heard about HIV/AIDS out of total 105 respondents.
- Male respondents are knowledgeable 67.7 percent and female respondents are 56.8 percent about HIV/AIDS.
- All of respondents have knowledge on HIV/AIDS who had educational status secondary and about it. While illiterate respondents about 35 percent knows about it.
- About 27.7 percent respondents said that the HIV/AIDS are difference, which is very low, about 45.7 percent respondents said that both are same.
- Respondents having knowledge about 87.7 percent have knowledge on transmission have HIV/AIDS. Only 12.3 percent they don't know the mode of transmission.

6.1.5 Attitude toward infected people

- More than half 63.9 percent respondents said that they should love and respect them and 29.5 percent said that the infected person should be hated in the society.
- About 73.2 percent have their own sexual union, 10 percent respondents sexual partner is friend and followed by 10.9 percent prostitute.
- Only 38.6 percent respondents use contraceptive when sexual intercourse and 61.4 percent respondent don't use any contraceptive in sexual intercourse.
- Respondents use of condom 21.9 percent, 62.5 percent use depo-provera and 12.5 percent respondents use pill.
- Respondents 62.5 percent use contraceptive for family planning purpose, and 37.5 percents use contraceptive for protecting from STIs and HIV/AIDS.

6.2 Conclusions

- Respondent's sex, age, group educational level and occupation affect the knowledge and attitude of STIs and HIV/AIDS.
- The communication facilities play important role for the knowledge and attitude on STIs and HIV/AIDS.
- The females levels of knowledge and attitude towards STIs and HIV/AIDS are poor than males.
- It seems educational status play the vital role for knowledge, attitude towards STIs and HIV/AIDS. When the educational status is high,

- there is also high level of knowledge but if the educational status is lower, the level of knowledge seems also low.
- It seems no any program is implemented in there about STIs and HIV/AIDS.
 - Economic status seems poor, which reflect to the low level of education and communication and information.
 - Some respondents have a misperception to the HIV infected people.
 - Some respondents have STIs but they do not respond openly which type of them.
 - Most of the respondents know about STIs and HIV/AIDS but they have also confusion about symptoms, mode of transfusion, preventive measures about HIV/AIDS.

6.3 Recommendations

- Appropriate health personal with basic training related to public health with the specific knowledge of reproductive health is better to be managed.
- GO, NGO, and INGO co-operatively provide training concerning the public health and reproductive health areas to the concerned people in the community and mechanism of monitoring should be developed and for remedial improvement timely follow up is to be also managed.
- Dalit (Damai, Kami and Sarki) population of the community is more prone to health related hazards and risk factors as well as they need the practical health education that is quite relevant to their necessity. Effective formal and non-formal education program have to be implemented.

- Formal education for male and female and social status should be raised.
- Conduct special programs like as peer education, sex education during on Dalit community.

6.4 Recommendation for further Research Issues

- This study is based on Dalit community, the comparative study can done Damai, Kami and Sarki caste.
- This is the study of knowledge, attitudes of Dalit population on STIs, HIV/AIDS. A Case Study of Dalit Community of Aaginchook, Dhading. Further study can be carried out in other specific community and specific age groups as well.
- This study is based on only few parameters with socio-economic and demographic variables. Using other variables like social, cultural, religious, psychological geographical and other many variables which might be useful to evaluate the knowledge and other aspects in this area, can be done other similar studies.

Appendix – I
Tribhuvan University
Central Department of Population Studies (CDPS)
Questionnaire
A Study on Knowledge and Attitudes of STIs and HIV/AIDS in Dalit
Community

A. Individual Characteristics

Code No.:

Ward No.:

1. Age (completed)

2. Caste

3. Sex .. Male1
Female2

4. Marital Status
Married1
Unmarried2
Separation3
Divorce.....4
Widow/Widower5

5. Religion
Hindu1
Buddhist2
Christian3
Others (specify) ..4

6. Literacy
Literate1
Illiterate2

7. Educational Status
Illiterate1
Primary (1-5)2
L. Secondary (6-8).....3
Secondary (9-10).....4
SLC.....5
SLC and Above6

8. Occupation

- Farming1
- Agriculture labour2
- Non-Agriculture labour3
- Housewife.....4
- Business5
- Other (specify).....6

B. Household Characteristics

9. How many members are there in your family?

10. Do you have own cultivated land?
 Yes.....1
 No.....2 (go to Q. no. 13)

11. If, yes, how much? Ropani

12. Does your family operate other land on rest?
 Yes.....1
 No.....2

13. Has your family given land on rent to another?
 Yes.....1
 No.....2

14. Which of the following facilities are there at your home?

	Yes	No
Radio	1	2
Television	1	2
Others (specify)	1	2

C. Knowledge and Attitude of STIs and HIV/AIDS

15. Have you ever heard about STIs?
 Yes.....1
 No.....2 (go to Q N. 25)

16. (If yes) from which source did you hear? (multiple response)

- Radio1
- T.V.....2
- Textbook.....3
- Teachers4
- Friends5
- Health personal6
- News paper.....7
- GO/NGO/INGO.....8
- Other (Specify)9

17. Which of the following STIs have you heard?
 Syphilis1
 HIV/AIDS.....2
 Gonorrhoea3
 Other (specify).....4
18. Do you know the symptoms of STIs?
 Yes.....1
 No.....2 (See. Q. No. 21)
19. (If yes) what are the symptoms of STIs? (Multiple response)
 Foul white discharge from vagina1
 Lower abdominal pain during intercourse2
 Sores/Abrasion around vagina, itching3
 Drop a pus from penis4
20. Do you know how can be STIs transmitted?
 Yes.....1
 No.....2 (See Q.No. 23)
21. (If yes) what are the factors for STIs transmitted? (Multiple response)
 Unsafe sexual intercourse.....1
 Living together with infected person2
 Infected mother to fetus3
 Dirtiness of sexual organs4
 Other (specify)5
22. Have you ever heard any STIs?
 Yes.....1
 No.....2 (See Q. No. 25)
23. (If yes) which STIs have you had? Specify
24. What are the methods of preventing from STIs? (multiple response)
 Use of condom during sexual intercourse1
 Sex with only husband and wife2
 Always clean owns sexual organs3
 Avoid sharing food, cloths and toilet with infected person.....4
 Other (specify)5
25. Have you ever heard about HIV/AIDS?
 Yes.....1
 No.....2
26. (If yes) from which source did you hear? (multiple response)

Radio.....	1
T.V	2
Teacher.....	3
Textbook.....	4
Fried.....	5
Newspaper.....	6
Health personal	7
Other (specify).....	8

27. Is there any difference between HIV and AIDS?

- Yes.....1
- No.....2
- Don't know.....3

28. Do you know how can be HIV/AIDS transmitted?

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

29. (If yes) How can be HIV/AIDS transmitted? (multiple response)

- Sexual contract with infected person1
- Infected blood/organs transfusion.....2
- Sharing unsterilized needle/instruments.....3
- Infected mother to fetus.....4
- Breast feeding from infected mother5
- Other (specify).....6

30. Do you know the preventive methods of HIV/AIDS?

- Yes.....1
- No.....2 (see Q.No. 33)

31. (If yes) what are the methods for preventing HIV/AIDS? (Multiple response)

- Avoid sex with multiple partner1
- Use of condom during sexual intercourse2
- Sexual abstinence.....3
- Scan blood before transfusion4
- Other (specify)5

32. State whether the following statement are true or false.

	True	False
HIV/AIDS is a disease for a specific group	1	2
Drug abuse, multiple sex partner and prostitutes....	1	2
HIV/AIDS can be transmitted through mosquito bite1		2
HIV/AIDS can be transmitted by eating, setting	1	2
Necking and Sharing cloth	1	2

Embracing and shaking hand	1	2
Use of common toilet.....	1	2
HIV/AIDS infected person should not be adjusted in a Community and should be separate.....	1	2

33. Do you know, can HIV/AIDS be cured?

Yes	1
No.....	2
Don't know.....	3

34. How should we behave to the HIV infected person?

Love/Respect hate	1
Hate them.....	2
Don't know.....	3

D. Practices of sexuality and use of condom

35. Have you ever sexual intercourse?

Yes	1
No.....	2

36. Do you have own sexual partners?

Yes	1
No.....	2

37. (If, yes) who are they?

Husband/wife.....	1
Girlfriend	2
Prostitute.....	3
Other (specify).....	4

38. Do you use any types of contraceptive while sexual intercourse?

Yes	1
No.....	2

39. (If yes) which method do you use?

Condom.....	1
Pills.....	2
Foam tablets.....	3
Injection (depo-provera).....	4
Other (specify).....	5

40. Why do you use that method, while sexual intercourse?

Protecting from HIV/AIDS.....	1
Birth control.....	2
Other (specify).....	3

41. Why do you not use contraceptive method?
 Tedious.....1
 Difficult to dispose.....2
 No available every where.....3
 Others (specify).....4

Thank you

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