

**Towards Enhanced Awareness of HIV/AIDS among the Staff of
Department of Women Development in Nepal**



**A Research project submitted to
Van Hall Larenstein University of Applied Sciences in
Partial Fulfilment of the Requirements for the
Degree of Master in Management of Development,
Specialization “Rural Development of HIV/AIDS”**

By

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CIA	Central Intelligence Agency
CRC	Convention on the Rights of Child
DDC	District Development Committee
DG	Director General
DWD	Department of Women Development
FGD	Focus Group Discussion
GAD	Gender and Development
HIV	Human Immune Deficiency Syndrome
IEC	Information, Education and Communication
IFC	International Finance Cooperation
MOWCSW	Ministry of Women, Children and Social Welfare
NCASC	National Centre for AIDS and STD Control
NGOs	Non-Government Organizations
PLWA	People Living with HIV/AIDS
STI	Sexually Transmitted Infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Session
USAID	U.S. Agency for International Development
VCT	Voluntary Counselling Testing
VDC	Village Development Committee
VHL	Van Hall Larenstein Universities of Applied Sciences
WDO	Women Development Office
WHO	World Health Organization
WUR	Wageningen University and Research Centre

ABSTRACT

The research was conducted in Department of Women Development (DWD) in Lalitpur, Nepal. The goal of the research was to study HIV/AIDS knowledge and attitude among DWD staffs, in order to contribute towards the prevention of HIV among the staffs by making recommendations for improving their knowledge and attitudes.

A desk study and case study on thirty three staffs from DWD was used to achieve the objective of the research. Semi structured questionnaires were used to collect data from 25 field staff and a focus group discussion was held with seven heads of various sections in DWD. An in-depth interview was held with the director general by use of a checklist to gain more insights on the knowledge and attitudes of the DWD management towards HIV/AIDS.

The study found out that the level of knowledge on HIV/AIDS among the field staffs is higher compared to the level of knowledge among the managerial staff. All the field staff had knowledge on transmission of HIV/AIDS as exhibited by the 100% response affirming that HIV/AIDS can be transmitted by transfusion of contaminated blood and unprotected penetrative sex. Among the section heads there were some who objected to this. On the other hand among the two categories, there are some misconceptions on modes of transmission of HIV/AIDS. One of the section heads believed that HIV/AIDS could be transmitted through sitting, walking and sharing an office with an infected person while among the field staff 20% and 16% of the respondents who thought that sharing an office and walking with an infected person would transmit HIV/AIDS, respectively. The level of knowledge on HIV/AIDS prevention was also found to be high among all the staff. 96% of the field staff knew that HIV/AIDS can be prevented by avoiding sexual contact with HIV/AIDS infected person and abstinence. The risk factors that would make the DWD staff to be susceptible to HIV infection were differences in salaries, mobility of staff to work stations as well as to residential workshops and the limited knowledge of HIV/AIDS. This was expressed by 96% of the field staff who were certain that employees who stay with their families have low risk of being infected while 68% stated that employees who have salaries significantly higher than the general population were more at risk of being infected by HIV. Two of the seven sectional heads said that the staff with higher salaries could be at risk of being HIV infected while two said that if the salary is high they can use safety precautions such as condoms while one said it depends on individual behaviour. The director general affirmed that the major risk factors that influence DWD staff susceptibility to HIV infection was lack of knowledge. Only two of the thirty three staff interviewed had who taken voluntarily test for HIV. It was also found that the DWD staffs were not willing to disclose their HIV/AIDS status. The staffs were not willing to openly discuss HIV/AIDS issues within the office. They had judgmental attitude towards HIV positive persons as they regarded them as being promiscuous.

To enhance the knowledge on HIV/AIDS among the DWD staff, the study recommends capacity building among the DWD staff on basic facts about HIV/AIDS. The staffs need to be trained on the risk factors, modes of transmission and how to handle the people living with HIV/AIDS. This will help to improve attitudes of DWD staffs about HIV/AIDS and reduce stigma and discrimination. DWD should provide information, education and communication material about HIV/AIDS for the staff at all levels. For prevention on HIV/AIDS in DWD staffs there should be provision of condom in suitable places for the staffs for use. There is need for the DWD management to have knowledge on transmission, prevention and the risk factors associated with HIV/AIDS. This will help them to incorporate the HIV/AIDS issues in policies and programs for HIV/AIDS mainstreaming. There is need for the organization to develop a HIV/AIDS at workplace policy and appoint a HIV/AIDS focal person who oversees the implementation of the above recommendations. The focal person will be the contact point for HIV/AIDS mainstreaming in the organization.

CHAPTER ONE INTRODUCTION

1.1 Background of the study

HIV/AIDS has been a burning issue for several decades. Like many developing nations, Nepal is no longer free from the epidemic of HIV/AIDS. HIV prevalence rate in Nepal has been on the increase from the reporting of the first case in 1988. According to the Central Intelligence Agency (CIA, 2010), the adult HIV prevalence rate is 0.5% and Nepal ranks in 79th position in the world. By mid-2008, more than 1,750 cases of AIDS related diseases and over 11,000 cases of HIV infection were officially reported, with twice as many men reported to be infected than women (World Bank, 2008). However, the actual number of people infected with HIV could be much higher. At the end of 2007, Joint United Nations Program on HIV/AIDS (UNAIDS) estimated that 70,000 people were living with HIV/AIDS, out of which 92% were aged between 15 to 49 years (UNAIDS, 2008). Death cases from HIV/AIDS are reported to be 5000 (CIA, 2010). It is evident that the pandemic affects the sexually and economically active age groups in our country.

In Nepal, heterosexual contact has been found to be major mode of infection. However other mode of infection includes intravenous drug use, homosexual contact, prenatal transmission and blood products (Karki, 2008). The epidemic was worsened by various factors such as poverty illiteracy, lack of accessibility to voluntary counselling and testing services, stigmatization and discrimination. In Nepalese society, only heterosexual relations are deemed as legal while all other forms of sex are deemed illegal and culturally unacceptable. Women cannot negotiate for safe sex due to inequality between man and women which is attributed to the culturally based notion of male dominance and strength versus the female submissiveness. Traditionally women are supposed to be passive, obedient and self-sacrificing in their sexual relationship with their respective partners. Male control over female sexuality is a crucial mechanism used by men to maintain their social and economic dominance over women. This male dominance has also promoted violence against women in a number of occasions.

The HIV/AIDS epidemic threatens institutions by lowering the capacity of its staffs to deliver the services. HIV/AIDS alters organizational working capacity, particularly women by increasing cost because of absenteeism because of illness because of taking time off to take care for sick members of their families because they have to go to for funeral ceremonies consume time (Barnet and Whiteside, 2006 cited in Gumisiriza, 2008). Workers failing physical and emotional health will be less productive because they are unable to carry out the jobs being demanded. Retirement or premature death of employee(s) has to be replaced by new staff member(s) which leads to loss of skilled human resources and increment in the cost of organization: This applies to Department of Women Development (DWD) which is a department under the Ministry of Women Children and Social Welfare (MOWCSW) as well.

MOWCSW of the Government of Nepal was founded in 1995 after the Beijing Conference with the mission to reduce poverty, promote gender equality, and equity and empowerment of women and children. MOWCSW is the central apex body for policymaking, planning, and programming of overall development, and coordination of all the activities related to women, children and social welfare including senior citizens, orphans, helpless women and disabled and handicapped people (MOWCSW, 2010). The Ministry incorporates women's concern and issues in the national and sectoral development policies and protects women's right and authority through the enactment of necessary laws.

DWD is the only department under the MOWCSW whose mandate is to raise the living standards of marginalized and deprived women groups. DWD safeguards women's rights by mainstreaming them in socio-economic and political terms through awareness, capacity

development and social mobilization. DWD cannot continue to offer these services without considering HIV/AIDS since it affects them (staff members) and the women (their clientele). The staffs need to anticipate and adapt to the changing needs brought about by the epidemic both within and outside the organizational environment. This demands a quick response from women based institutions such as DWD under the Ministry to raise awareness amongst the staff working at policy level and to minimize the projected impacts within their departments and their external programs. Based on the aforementioned information, there is a need to assess the HIV/AIDS awareness level within the Department of Women Development.

1.2 Problem statement

The DWD staff may be susceptible to HIV infection, both within the workplace and out of the workplace. With the increased susceptibility the staff may be infected by HIV. When the staff members in a workplace are infected, then organization would be vulnerable to the impacts of AIDS. According to a study carried out by World Health Organization (WHO 2006 cited in Kinoti, 2006) on the impacts of AIDS on organizations in the developing countries, 34% of absenteeism among staff was due to personal illness and 6% of the staffs were absent attending to a sick person. Other impacts of AIDS on an organization include increased medical expenditure, loss of organizational memory, loss of morale of staff and increased workload due to absenteeism.

To safeguard the organization from the said impacts and thus maintain its effectiveness, it is important for DWD to embark on enhancing the staff knowledge on HIV/AIDS to prevent HIV infection. However, DWD has insufficient information on the level of awareness on HIV/AIDS among its staff.

1.3 Objective

The objective of this research was to contribute towards safeguarding the effectiveness of DWD by providing information on the level of HIV/AIDS awareness i.e. the knowledge and attitudes among the staff of DWD in Lalitpur, Nepal.

1.4 Main Research Question

What is the level of knowledge and attitudes concerning HIV/AIDS among the DWD staffs in Lalitpur, Nepal?

Sub questions

- What is the level of knowledge of DWD staffs concerning mode of transmission, preventive measures and risk factors towards HIV/AIDS?
- What are the attitudes of DWD staffs concerning stigma and discrimination of HIV/AIDS?
- What are the characteristics of DWD that would enable or hinder HIV/AIDS mainstreaming?

1.5 Significance of the study

There is no cure for HIV/AIDS till to date and it can be deemed as a global tragedy. Creating awareness is an important strategy to protect the DWD's staffs from HIV/AIDS. No research has been conducted in DWD about HIV/AIDS in Nepal. The present study was to provide basic knowledge about the staff of DWD on HIV/AIDS-related attitudes and knowledge.

All the staff members of the organization need to understand how HIV/AIDS is transmitted and how it can be prevented. They should also know about risk factors to handle HIV/AIDS related issues. In the rural communities of developing countries like Nepal, people are facing HIV/AIDS as one of the most serious challenges. Although the DWD is one of the responsible

organizations to help control and reduce the spread and impacts of HIV/AIDS, all staffs members of DWD have not received proper training on knowledge about HIV/AIDS which could make them susceptible to the disease. The trained staffs can play a role of creating the awareness of HIV/AIDS among the rural communities particularly, women. DWD is bound to benefit by engaging its staff members in such training programs since it facilitates the management to develop relevant internal policy frameworks from its employees' gainful contribution to the responses of HIV/AIDS.

The study will also benefit development partners (donors) and such supporting organizations by helping them understand clearly how the epidemic affects their efforts and thus come up with appropriate interventions for helping organizations such as the DWD in taking a more active role in addressing HIV/AIDS-related issues among their staff members.

1.6 Limitation(s) of the study

HIV/AIDS is a delicate issue and so, not everybody would be willing to talk about it openly even when anonymous questionnaires aimed to study and analyze their understanding about the pandemic are distributed. Most of the respondents in DWD were female so it was easy to discuss on the topic but in focus group discussion there was hesitation by the female members to discuss openly about the sexual behaviours in presence of male respondents. This is because HIV/AIDS is a social and cultural issue. In the Nepalese society women refrain from dealing the sexual issues in front of men, since talking openly on this issue is seen as being disrespectful. But this situation was overcome by convincing them to talk about this matter because the issue had severely affected our society and DWD being a social institution need to discuss about this sensitive issue.

The question on sexual behaviours on HIV/AIDS of respondents was not asked because there are the cultural taboos in the country. The sexual behaviour is not openly discussed in Nepal and talking sex is considered impolite. Thus, the response rate may be lower. These were the major drawbacks in this study.

1.7 Ethical considerations

In order to ensure ethical adherence in this study, the respondents were asked to participate voluntarily and a consent form was signed by the respondents. All the data collected were handled with confidentiality and were used for the research purposes only.

1.8 Organization of the report

Chapter one of this reports includes the background of study, problem statement, objective of study, main research questions and sub-questions. This chapter also describes the significance and the limitation of the study. Chapter two gives an overview of conceptual ideas for the study regarding knowledge and attitudes towards HIV/AIDS. Chapter three is about the research methodology, sampling procedures, the respondents, data collection methods and data analysis. Chapter four introduces DWD, the organizations goals, mandate and the structure. Chapter five presents the results and findings from the field work, observation and secondary information. Chapter five presents the empirical findings while chapter six discusses the findings and compares with the existing literature. The last chapter is about conclusion and recommendation of the study.

CHAPTER TWO LITERATURE REVIEW

This chapter introduces the concepts of knowledge and attitude. It also describes knowledge on transmission, prevention and risk factors related to HIV/AIDS. In addition, it includes attitude towards stigma and discrimination, awareness and behaviour towards HIV/AIDS. The concepts of susceptibility and vulnerability to the impact of AIDS have been explained in this chapter.

2.1 Knowledge

According to Leeuwis and Ban (2004), “*knowledge*’ refers to the perceptions and principles associated to biophysical and social functions including the social processes”. It can be perceived as the fundamental means by which one can give meaning to his/her world. In other words, it refers to a recall of factual information, and is a criterion to guiding appropriate behaviour. Indeed, knowledge is the most important tool to affect behavioural change (Gbefwi, 2004).

Knowledge is the information and understanding of a person or of human beings about a related subject. This study refers to the issues related to HIV/AIDS in order to grasp a proper understanding about the various modes of transmission, preventive measures and the risk factors which may make people susceptible to HIV infection. Although the concepts of knowledge and attitude are closely related, they are however different and it is very important to understand that there is no simple connection between knowledge and attitude (Du Plessis, *et al.*, 1993).

According to the United Nation General Assembly Special Session on HIV/AIDS (UNGASS), knowledge should incorporate the various ways of preventing sexual transmission of HIV and also the major misconceptions about HIV transmission have to be clarified (UNAIDS, 2005, cited in Oyewale, 2008).

Basing upon the definition of knowledge according to Oyewale (2008), knowledge in the context of this study was defined, in the broadest sense, as the basic information and understanding of HIV/AIDS among the DWD staff. It included the level of awareness and sources of HIV/AIDS information; the knowledge on modes of HIV transmission; misconception(s) related to HIV transmission; method(s) of prevention against HIV; and knowledge on risk factors of HIV/AIDS. The study sought to find out whether people understood the difference between HIV/AIDS.

2.2 Knowledge on HIV transmission

This section discusses knowledge on how HIV/AIDS can be transferred from one person to another. The most common routes of transmission of HIV/AIDS are being discussed below:

2.2.1 Sexual transmission

Transmission through sexual intercourse accounts for about three quarters of all HIV infections world-wide. More than 80% of HIV infections in Nepal are transmitted through sexual intercourse. The sexual transmission can be through unprotected penetrative sexual intercourse like oral, vaginal and anal. In other worlds, HIV infection is a sexually transmitted disease (UNAIDS, 2001 cited in Basaula, 2007). According to National Centre for AIDS and STD control (NCASC, 2009), heterosexual transmission is dominant in Nepal. From a study of Socio-Demographic Profile of HIV Patients at Seti Zonal Hospital, found out that 88.3% HIV was transmitted through sexual contact in Nepal (Paudel, *et al.*, 2008). Therefore, it is essential for DWD staffs to know about the importance of safe sexual practices in order to curb the transmission of HIV/AIDS through unprotected sexual activity.

2.2.2 Through blood and blood products

HIV can be transmitted through blood transfusion with contaminated blood, injecting drugs using contaminated needles and equipment, and other means such as tattooing, or use of medical or other instruments that are contaminated. According to the WHO (n.d. cited in Examiner, 2010), five to ten per cent of all new HIV cases in Africa are due to contaminated blood and blood products used for transfusion. Therefore, it is imperative that the DWD staffs gain knowledge regarding the risks associated with blood transfusion and the importance of the usage of disposable medical needles and equipments.

2.2.3 From mother to child

Mother to child transmission is one of the most common and important sources of HIV infection in children. The transmission risk is the greatest during labour and delivery, but can also occur during pregnancy, or through breast feeding. Mother to child transmissions accounts for 90% of all cases of HIV/AIDS in children (NCASC, 2008).

When we discuss about various modes of transmission, it is of utter importance that people realize that one cannot get HIV from shaking hands with someone being infected with the virus, using their cutlery glasses and plates, using the same toilet, sneezing or coughing, sharing bath, kissing, hugging, eating from same plate, and dog, cat or insect bites [Van Hall Larenstein Universities of Applied Sciences (VHL), 2009].

These are the misconceptions and myths associated with the modes of HIV transmission. In this research, the DWD staff's knowledge on the misconceptions was studied.

2.3 Knowledge on HIV prevention

One could argue that the most effective ways to prevent HIV transmission through sex are not having any sex at all or through the practice of abstinence, staying faithful to one uninfected lifelong partner, and consistent condom use. Thus, strategies to distribute condoms and promote their usage are compatible with promoting abstinence or faithfulness. Using condoms is the smallest behaviour change that can be made in order to make risky sexual behaviour safer. The condoms could be male or female condoms. As a personal strategy to avoid HIV infection, condom use requires people to be highly motivated, always able to access good-quality condoms, to have them available when needed and most importantly, to be able to negotiate condom use with the partners (VHL, 2009).

Regmi (2006) advises that there is need to always use disposable syringes and needles. Used syringes and needles contain traces of blood, so in case the user is HIV positive, this blood will be infectious. Therefore, knowledge regarding always using new needles, syringes, blades and razors should be promoted. There is need for blood to be screened for HIV to ensure that it is HIV free.

For the case of mother to child transmission, there is need for the women to take advises before planning to get a baby. This minimizes the risk of the babies being infected through an infected mother.

2.4 Knowledge of risk factor(s) on HIV/AIDS

There are a number of risk factors that ought to be considered regarding HIV transmission. The DWD staff knowledge about the risk factors associated with HIV/AIDS was studied. According to the International Finance Cooperation (IFC, 2002) employees who earn salaries significantly higher than the general population are more at risk of being infected by HIV. This study defined the differences in salaries to be the differences among the different cadre of staff in DWD.

Migration/mobility is a risk factor to the spread of the epidemic. Employees who are separated from their families for long periods of time might be more at risk of HIV infection than those who remain at home (IFC, 2002). The study also looked into the differences on HIV/AIDS knowledge among the DWD staff as a risk factor to the spread of the epidemic. Employees who do not have sufficient knowledge on HIV/AIDS could be at a higher risk of being HIV infected. They may not know the modes of transmission and how to prevent themselves from the infection.

In Nepal, the following factors are considered to be the key risk factors involved in the rapid spread of HIV; high rates of male migration, prostitution, poverty, injecting drug use, and gender inequality. This is coupled with low levels of education and literacy rates and widespread discrimination (United States Agency for International Development, 2005). Nepal remains one of the poorest countries in the world, with more than 30% of its population living below the poverty line, which has resulted in a high rate of migration mostly to India for work opportunities (USAID, 2005). Some of the risk factors that might lead to higher occurrence of HIV/AIDS are being discussed below: (WHO, 2006 cited in Mulumba, 2008).

2.4.1 High level of poverty

The rapid spread of HIV/AIDS in Nepal can be attributed to the poor economic condition of people and low level of the awareness on HIV/AIDS (Regmi, 2006). The heterosexual transmission is exacerbated by the high prevalence of STIs, poor status of women, and high risk sexual practices. The problem has been seen mainly in women due to unsafe sexual activities. Most women are responsible for solving the hand-to-mouth problem in their families and due to the lack of lucrative employment opportunities; they are indirectly forced to engage in the commercial sex industries. Other causes behind greater number of infections in women are polygamy, divorce, domestic conflict, child marriage, social conflict and lack of health service (Nepal, 2010). Due to poverty, many rural migrant adolescent girls are forced to engage in transactional sex, particularly in some major cities in India. In many circumstances, many innocent girls are being trafficked to Indian brothels exposing them to risky situations that could make them susceptible to the HIV infection.

2.4.2 High mobility

Migrants including long distance truckers, uniformed security personnel and employees, who usually move from one village to another and in and out of the country, leave their partners behind back home. This potentially puts them and their partners at risk of contracting the HIV infection. Seasonal labour migrants (mostly to India) constitute about 41% of the total HIV cases in Nepal. The seasonal labour migrants play an important bridging role in transmitting the infection to their regular sexual partners in the general population. The trafficking of young girls and women is considered to be another contributing factor to HIV transmission in Nepal, however reliable data are not yet available (USAID, 2005).

Migration has systematically contributed to a growing sex industry and high risk behaviour. In some sectors such as mining, infrastructure construction, agribusiness abroad, long-distance transportation and trucking, there is migration of labourers for seasonally and long term (Department of Foreign Employment, 2008). Mobility is necessary for economic survival of many households in both rural and urban areas in Nepal. These migrant workers travel to all parts of India and usually without their regular partners. They live there for periods ranging from 3-6 months to several years at a stretch before returning home. There is unreliable evidence that many men become HIV infected when they engage in unsafe sexual practices while in India making women having unprotected sexual intercourse with those men vulnerable to a much higher risk of being infected by HIV or contracting other STDs (Save the Children, 2001).

2.4.3 Socio-cultural beliefs and practices

Certain beliefs and practices such as having multiple sex partners and forcing women to have sex in order to make them feel passive, obedient, self-sacrificing and submissive to men further facilitate the transmission of HIV/AIDS. Socio-cultural factors include norms, values and beliefs that prevent both women and men from getting critical information about sex, sexuality and HIV/AIDS.

Nepalese people are encircled by the culture of silence around sexual matters. Cultural value such as shyness prevents open discussion and education on sexuality and reproduction. So, the adolescent girls acquire HIV related information from their contemporary colleagues but not from their guardians. People find it odd and disturbing to listen to and discuss about issues related to sex among the family members. The Nepalese deeply-rooted socio-cultural values, attitudes and beliefs are seemingly one of the most significant threats in mainstreaming HIV/AIDS.

Nepal is a multicultural and multi-ethnic society with over one hundred ethnic and caste groups (Dahal, 2003 cited in Wasti, *et al.*, 2009). HIV/AIDS is indeed a social and cultural issue in Nepal. Superstition, religious belief and traditions dealing with issues related to sex are still unacceptable and considered to be impolite in Nepalese societies. It is forbidden to openly discuss and talk about sex and sexual behaviour in Nepal. In general, parents and elders usually do not talk openly about sex with an adolescent. This is one of the cultural constraints that have led to the lack of knowledge and information in the young generation concerning safe sex and HIV/AIDS.

2.4.4 Gender issues

In the Nepalese society, the different forms of gender-based violence such as physical, sexual, psychological and economic make women more prone to HIV/AIDS infection. Some instances of domestic violence include marital rape, sexual harassment, sex-selective abortions, infanticide, forced early marriage and girls being trafficked leading them to leave their homes in search of means to fulfil their basic needs to earn their own living which makes them more open to the risks of HIV infection. The dominance of male interests and lack of self-assertiveness on the part of the women in sexual relations put both men and women at risk to the virus and women being the subordinate partner are not in a position to negotiate safe sex in Nepalese societies.

Nepal is also a monogamous society. Extra marital sex, pre-marital sex and living relationships are strictly out of norm and unaccepted for both the sexes. However, these norms do not apply to men and women equally because the society is male-dominated. Females who violate the norms are harshly criticized and in certain cases, are subjected to social alienation or exclusion. But it is regarded as a normal means to indulge in "pleasure" for men in the society. Thus, women always have to adhere to be careful and virtuous and contracting HIV than men. Though, HIV infection would be a shock for the families and society if either of the sex contracts the disease but in case of women, it is too hard to accept. In a gender discriminated society like that of Nepal, women are socially and economically dependent on their male counterparts in the family making them hard to expose their illness even to her family and husband because the consequences may be domestic violence and exhalation, or even worse.

2.4.5 Alcohol and drug abuse

Alcoholism and drug abuse can lead to transmission of HIV/AIDS. When people are drunk or have used intoxicating drugs, they tend to forget to adhere to the HIV/AIDS preventive measures such as using condoms during sexual activity. This is because their ability to make informed consents and judgement would be tampered with by the alcohol and drugs. This undoubtedly exacerbates the risks to the HIV infection (Mulumba, 2008).

2.4.6 Conclusion

From the aforementioned information of knowledge on risk factors, it can thus be concluded that acquiring knowledge or having the correct information on HIV/AIDS is key to attitude and behavioural change.

The above risk factors may make the DWD staff susceptible to HIV infection. Risk factors such as; alcohol and drug abuse, social cultural beliefs and practices and gender issues highly depend one's behaviour and beliefs. These factors are surrounded by societal norms and values and the researcher would not be able to know their effects at the organizational level. This study therefore considered only mobility, salary differences and the knowledge on HIV/AIDS as the risk factors that could make the DWD susceptible to HIV infection at workplace.

2.5 Awareness of HIV/AIDS

Awareness of HIV/AIDS refers to the knowledge about what HIV/AIDS is, how it can be transmitted, what the preventive measures exist against HIV and the impact of AIDS on the organization. The modes of transmission can be through unprotected penetrative anal, vaginal or oral sex and blood transfusion as discussed above. It can also be transmitted through contaminated needles and 'mother to child' transmission that have been explained in a greater detail in section 2.2. To prevent the transmission of the pandemic, people should be made more aware about some of the basic facts about HIV/AIDS including the risk factors (Sitagita, 2010).

Nowadays, HIV/AIDS has been regarded as one of the biggest threats to human beings. As much as people are aware of the name HIV/AIDS, a lot of them are unaware about what HIV/AIDS actually is and how it can affect their lives. In order to raise awareness about HIV/AIDS and its spread, there is need to build up public consciousness about the transmission, prevention and attitudes towards HIV/AIDS (Sitagita, 2010).

2.6 Attitude

Attitude is defined as the way of thinking- behaviour and personal opinion(s) about anything around us. From this study's perspective, it relates to how people observe and perceive HIV infected individuals from a personal point of view (Skill-Universe, 2010). Attitudes are based on principles and are influenced by various factors such as environment and surroundings that one lives and works in, as well as his/her personal, cultural and religious factors. Hence, attitude in terms of our subject of study can be considered to be an established belief about HIV/AIDS (Shimbuli, *et al.*, 2009). Attitudes related to HIV/AIDS refers to the feelings, opinions, intentions and beliefs among and about people infected with HIV and issues related to the HIV/AIDS (Oyewale, 2008).

A person's attitude generally includes two parts: cognitive and affective (Naidoo and Wills, 2000, cited in Oyewale, 2008). The former part comprises of the knowledge and information possessed by a person, while the latter includes their feelings and emotions as well as their assessment of what is important. Several traits have been used to explore HIV/AIDS related attitudes among the DWD staffs. Such characteristics include stigmatization and discrimination towards people living with HIV/AIDS in the society and awareness among DWD staffs about the risks of HIV infection. The other characteristics are cultural norms and values associated with HIV testing, disclosure of status of HIV/AIDS and the willingness of the DWD staff members to discuss about issues related to HIV/AIDS.

Therefore, attitude is the manner in which a DWD staff thinks and feels about HIV/AIDS and also towards people living with HIV/AIDS, prevention, disclosure, perception of risk, care and support (Shipalana, 2009).

If the DWD staffs are not well-informed about HIV/AIDS, their attitude towards people living with HIV/AIDS might be negative. The insufficient knowledge tends to increase their risks of getting infected. It is also very likely that this negative attitude could be transferred to the other DWD staffs as well. But when the staffs are well equipped with information about HIV/AIDS, the transfer of knowledge and skills is always possible. Educational workshops can assist in this transfer of knowledge. However, it is essential to conduct an assessment of their understanding level on HIV/AIDS before planning such educational and training programs (Shipalana, 2009).

2.7 Attitudes towards HIV/AIDS related stigma and discrimination

The negative attitudes, prejudice, abuse and maltreatment towards the people living with HIV/AIDS (PLWA) generates HIV/AIDS related stigma in a workplace and the community. The HIV/AIDS stigma is a main deterrent against responses to curb the epidemic. It results into being ignored by family, peers and the wider community. The PLWA may be psychologically damaged and can negatively affect the success of testing and treatment. In addition, there can be poor treatment in health care and education settings and erosion of rights of PLWA at the workplace (AVERT, 2010).

In an organization where there are negative attitudes and prejudice against PLWA, the co-workers and supervisors may segregate them. The segregation may lead to self-isolation by the PLWA, ridicule from colleagues or PLWA may experience discrimination in assignment of duties or they can be laid off from their duties. At the workplace, the fear of being discriminated against may cause the workers not to undertake the voluntary counselling and testing (VCT). The staff may not look for available prevention and care services even if they could be available in the organization (Population Council, 2010).

HIV related stigma has a significant impact on the uptake of HIV testing, negative attitude of service providers to such infected patients, adherence to HIV treatment and follow up (O'Brien, 2009 cited in Wasti, *et al.*, 2009). Most of the Nepalese PLWA does not know their status because they do not go for the voluntary counselling and testing and so; many may continue to engage in unsafe sexual practices.

According to UNAIDS (2004 cited in Mulumba, 2008), there are many factors that contribute to the HIV/AIDS related stigma. HIV/AIDS is regarded a hostile disease which is associated with deviant behaviours such as sex between men, commercial sex workers and injecting drug use. These practises are denounced in Nepalese community. PLWA are considered to be irresponsible for their own actions, HIV/AIDS is associated with bad deeds in early life and unforgivable sins such as promiscuity that deserve to be punished.

At the work place, discrimination occurs when the workers are handled unfairly and unjustly based on their actual or presumed HIV status (ILO, 2010). Discrimination may involve testing for HIV before employment or mandatory HIV testing during employment and denial of employment to PLWA. Furthermore, an organization may stigmatize PLWA by not handling their HIV/AIDS status and reassignment with confidentiality.

HIV/AIDS related stigma and discrimination can have severe impacts at the work place. It may cause delays in the implementation of work schedules because of the isolation of PLWA. The isolation leads to differences in knowledge since the staffs do not meet as often. Due to the demoralization caused by stigma, the staff of an organization may be absent from duty leading to low productivity in the organization. In severe cases, death of staff member due to AIDS related sickness may cause the employees to be demoralized. The organization will lose skilled staff, leading to loss of human resource. The employees of the affected organization may need to take time off from their regular schedules in order to attend funeral services of their colleagues. They may get emotionally unstable after the loss of a human life (Gumisiriza, 2008). There is a reduction in the number of working days because of sickness of staff. Some members

of staff who have started showing signs fear to go and work because they do not want employers and colleagues to know their status due to self-stigmatization. These impacts of AIDS on an organization may make the organization vulnerable and ineffective.

In order to counter the negative effects of HIV/AIDS related stigma, organizations need to adopt non-discriminatory HIV/AIDS workplace policies. These policies can make employees feel relatively secure that they will not lose employment. Workplace policies assist organizations to manage sensitive issues, such as confidentiality of medical information and continuation of employment for HIV-positive staff. It ensures that all testing and counselling services are performed on a voluntary rather than mandatory basis.

2.8 Behaviours

A specific behaviour is defined by a combination of four components: action, target, context, and time e.g., implementing a sexual HIV risk reduction strategy (action) by using condoms with commercial sex workers (target) in brothels (context) every time (time). A person may have positive or negative feelings toward performing the defined behaviour (Family Health International, 2004).

The *intent* to perform behaviour is the best predictor that a desired behaviour will actually occur. In order to measure it accurately and effectively, *intent* should be defined using the same components used to define behaviour: action, target, context, and time. Both attitude and norms, as described above, influence one's intention to perform behaviour. Sexual behaviour refers to how a person relates to activities related to sex.

In context to a developing nation like Nepal, sexual behaviours of people are generally acknowledged according to its cultural norms and values. They believe that sexual behaviour is casual sex when one relates with non-regular partner(s), premarital or extramarital sexual relationship and frequently visited sex workers. Young people nowadays are practicing risky sexual behaviour such as having multiple partners and non-use of condoms. There are also strong cultural taboos against premarital and extramarital sexual relationship. It is a taboo to talk about sexuality in Nepalese society and people generally feel embarrassed about buying condoms from pharmacies (Poudel, *et al.*, 2008 cited in Wasti, *et al.*, 2009).

Due to the Nepalese cultural norms and values, this study did not ask specific questions relating to sexual behaviour of individuals.

2.9 Susceptibility

In the context of the present study, susceptibility is defined as the chance that one can become infected by HIV. There are two components (Loevinsohn and Gillespie, 2003): the first one is related to the behaviour of the person and risky environment; a particular situation where a person can be exposed to the virus. The second one is once being exposed to the virus, what are the chances of actually being infected by the virus.

2.10 Vulnerability to the impact of AIDS

Vulnerability refers to the likelihood of a significant impact occurring at a certain level such as individual, household and community. These impacts are not one time event, but rather processes, often hidden, slow-moving and often destructive in nature (Loevinsohn and Gillespie, 2003).

An organization is said to be vulnerable to the impact of AIDS when it is likely to suffer harm from the effects of sickness and death due to AIDS (Holden, 2003). For organizations to be less vulnerable to the impact of AIDS there is need to invest in the health of its employees (Shupalana, 2009). The morale of employees will be boosted when they know that their employer

cares for them. This will make the employees more eager to learn more on HIV/AIDS. With the increased knowledge, the lifestyles of the staff are likely to change which can eventually help to change their behaviour towards HIV/AIDS. This will definitely be valuable to the organization as well, since by possessing a healthy workforce. The healthy workforce will assist the organization to achieve its objectives in a much effective and efficient manner. Therefore, DWD is bound to benefit from a healthy workforce whose risk of contracting HIV is less.

CHAPTER THREE RESEARCH METHODOLOGY

This chapter discusses the research methodology employed in this study. It describes how the desk study and the case studies were conducted. In the desk study, literature review was carried out from different reliable sources of information. A semi-structured questionnaire, focus group discussion, in-depth interview and observation were used in case study as methods of data collection. This chapter also describes about site selection, method(s) of data analysis, conceptual framework and research frame work.

3.1 Selection of the site

The study was conducted in the Department of Women Development which is the head office of women development at Lalitpur district of Nepal. Lalitpur district is located near Kathmandu district – which is the capital city of Nepal. Lalitpur district covers an area of 392.84 square kilometres. According to Central Bureau of Statistics (2007), the population was reported to be 337,785 among which 49% were female and 51% were male. Currently, there are 68 staff members working in the Department of Women Development.

The selection of the site was based on the aim and knowledge of the research and incorporates those who have been working in this sector of HIV/AIDS for fifteen years. DWD has worked in uplifting the status of women by endeavours to eliminate poverty. Poverty has been identified as one of the driving factors behind HIV/AIDS infection.

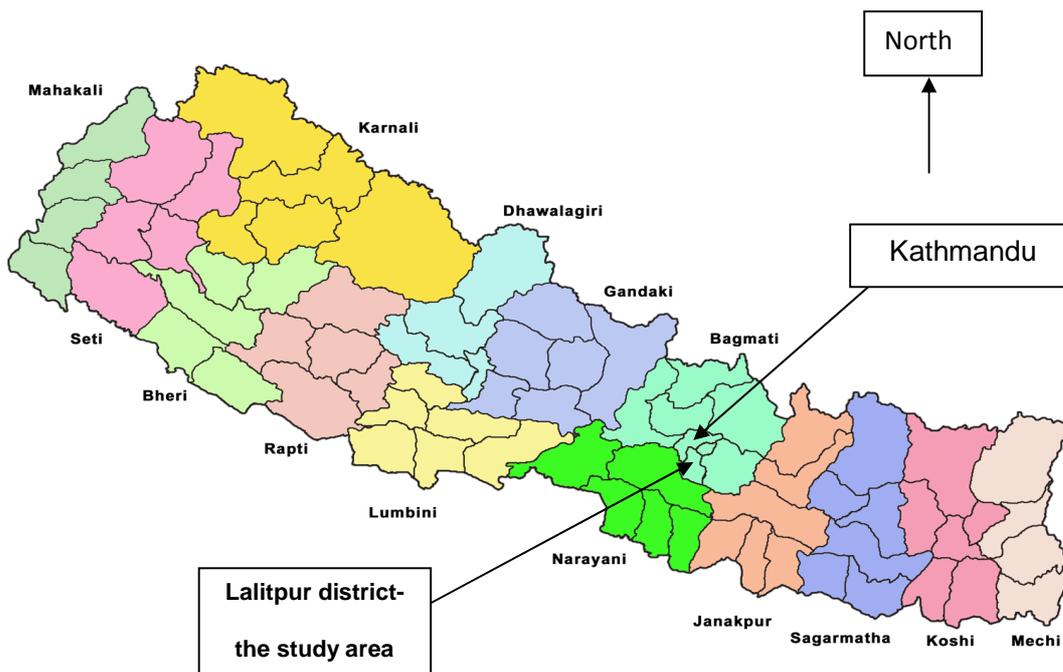


Figure 1: Map of Nepal

Source: Sahara Nepal (2010)

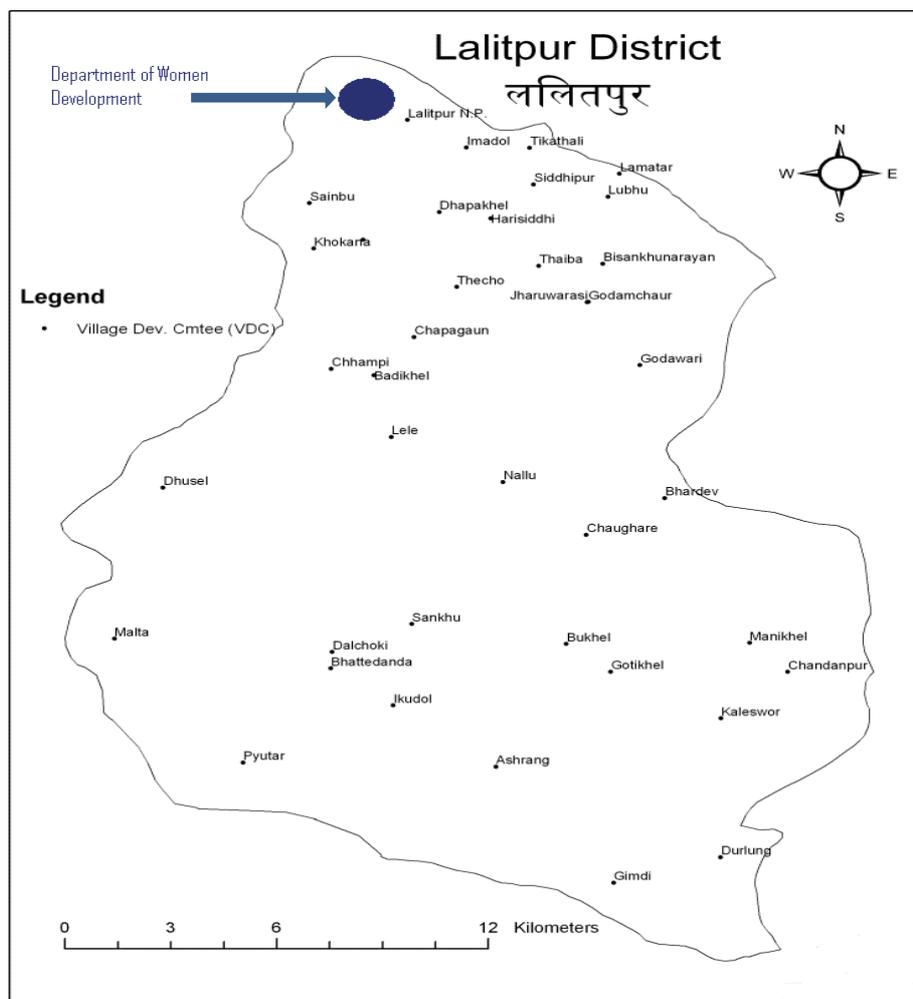


Figure 2: Map of Lalitpur District

Source: Digital Himalaya, (2010)

3.2 Method of data collection

The study used a qualitative approach and was based on the empirical data using both primary and secondary sources of information. During the study, two strategies for data collection were used namely desk research and case study.

3.2.1 Desk study

The desk study was a through literature review mainly related to knowledge and attitude of DWD staffs towards HIV/AIDS. The library of WUR and internet search was the major source for information for the desk study.

During the course of the literature review, information were extracted from articles and publications related to HIV/AIDS by different authors. Such gathered information was then analyzed using facts and data related to the topic. The data were also collected from the publications of government agencies such as Ministry of Women Children and Social Welfare, Department of Women Development, Women Development Office (WDO) in Lalitpur district, Nepal.

In addition, the knowledge and attitude of staffs about HIV/AIDS were collected from books, journals, reports and internet search. The review of literature also focused on gathering other relevant information such as knowledge, attitude, and risk factor(s) towards HIV/AIDS of the DWD staffs.

3.2.2 Case study

The aim of the case study was to collect the primary source of information from the field for the purpose of this study. These methods used during the case study comprised of semi structure interviews with twenty five DWD field staffs, focus group discussion with seven section heads and in-depth interview with the Director General (DG) of DWD. Observations were made within the offices and the field to check for awareness raising materials being used in DWD and WDO.

Semi-structure Interviews

There are twenty five field staffs from the Lalitpur district office of DWD. All of them were purposively selected for the interview. These staffs are in charge of the duty of delivering services of DWD to the public and are also in contact with the department's clientele and it would be important to know about their awareness level and attitude towards HIV/AIDS. The field staffs were interviewed by using a semi-structured questionnaire (annex A), one by one at a time.

Focus Group Discussion (FGD)

Focus group discussion in this study was an important tool used in order to identify knowledge, attitude and risk factors towards HIV/AIDS of the section heads of DWD. There are seven sections in DWD as shown on Figure- 5., the heads of the seven sections, one from each section, were selected for a focus group discussion. The section heads were selected because they were in charge of programme planning, and also supported in the formulation of policy concerning DWD. A checklist (annex B) was used to generate data on the knowledge and attitude on HIV/AIDS of the seven section heads. The method aided the study by enabling to validate the answers acquired from the semi-structured interview. Further, focus group discussion has a high apparent validity since the idea is easy to understand and the results are believable.

In-Depth Interview

An in-depth interview was conducted with the Director General of the Department of Women Development using a checklist (annex C). The checklist gathered the information on the position of DWD on staff awareness of HIV/AIDS. It was used to triangulate the information that was gathered from the field staffs and the section heads of DWD. The Director General was selected because he is responsible for resource allocation for developing the competences of the staff towards HIV/AIDS knowledge.

Observation

The researcher made observations during the field visits made to interview the field staff. The researcher observed the attitudes and behaviour towards HIV/AIDS in study sites of DWD, the display of information in the office.

3.3 Method of data analysis

The collected first-hand information was the main source of analysis for this study. The data collected was analyzed and compiled in a systematic way and presented both in descriptive and tabular forms. Both quantitative and qualitative approaches of data analysis method were applied and are presented in the report.

The data was arranged and classified based on the related information and separated based on their nature. In some parts of the analysis, simple statistical tools were used such as the frequency of the response and are presented in simple percentage, graphs and figures. The qualitative information was presented in a descriptive way and analysis was interpreted into the findings.

3.4 Conceptual framework

The conceptual framework of this study is based on the understanding that there is insufficient knowledge about HIV/AIDS among the DWD staffs. By imparting knowledge of HIV/AIDS to the DWD staffs, it helps to enhance the awareness level of DWD staffs on the topic. The combination of both the knowledge and awareness leads to behaviour and attitudes either positive or negative. Negative attitude and behaviour of DWD staffs make them more susceptible to HIV infection resulting in sickness among them which may lead to absenteeism, reduction in productivity and an eventual loss of skilled DWD staffs followed by vulnerability to impacts of AIDS in the organization as shown in the figure 3 below.

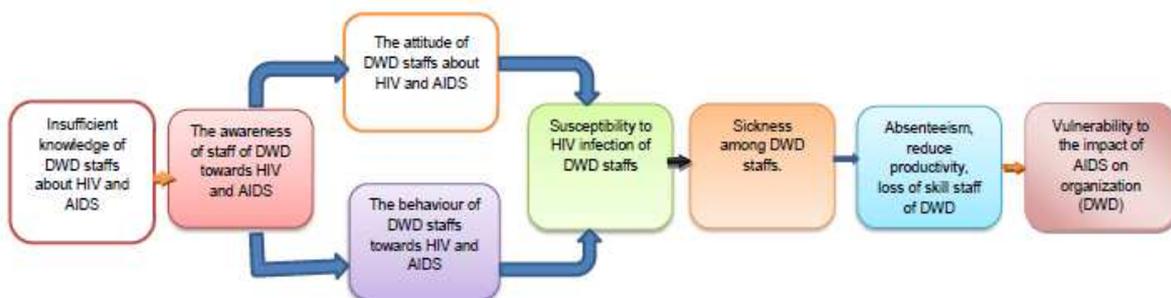


Figure 3: Conceptual frame works

Source: Based on literature review

3.5 Research framework

The framework upon which this research has been built upon is being depicted below:

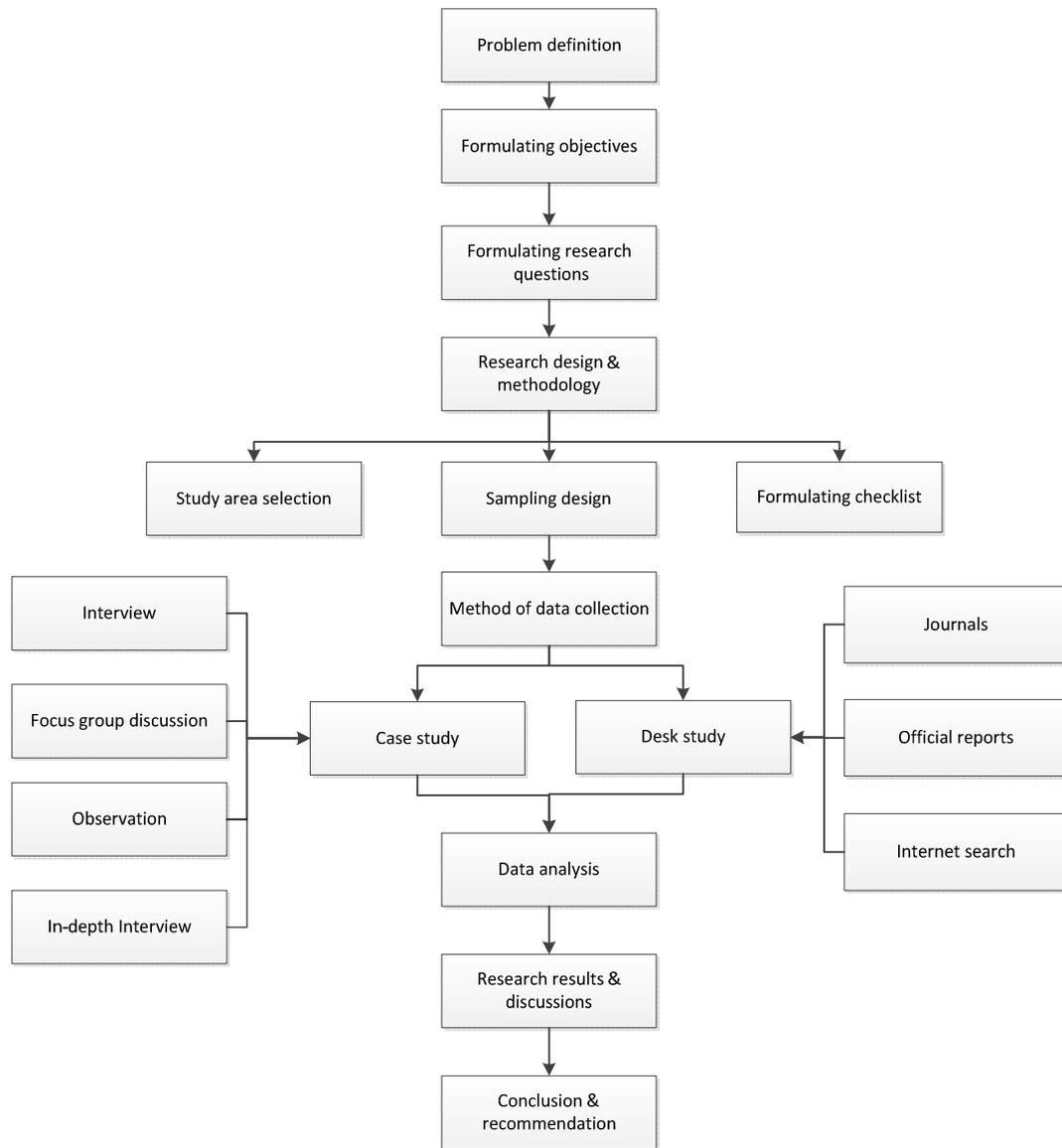


Figure 4: Research framework

CHAPTER FOUR INTRODUCTION OF DEPARTMENT OF WOMEN DEVELOPMENT

4.1 Background

The Government of Nepal made its first commitment towards women's development in its Sixth 5-year plan (1980-1985). Successive plans have put progressively greater emphasis on women's development. The Tenth plan (2002-2007) was built on the Ninth plan which incorporated gender and development (GAD) concept with gender mainstreaming, women's empowerment and gender equality. These were as the main policies for establishing gender as the focal point for all development policies, strategies and programs. At an international level, Nepal committed to establish and strengthen a national mechanism for advancement of women at the fourth World Conference on Women in Beijing (1995). As a result, the Ministry of Women, Children and Social Welfare (MOWCSW) was founded in September, 1995. MOWCSW is the focal Ministry that is responsible for coordinating policy and planning and overseeing all activities related to women, children and their social welfare. MOWCSW's goal is to empower women on the basis of gender equality and bring them into mainstreaming into development [Department of Women Development (DWD), 2009].

DWD under the MOWCSW is implementing its programs all over the country. DWD has the mandate to improve the quality of low income and disadvantaged women, raise their socio-economic status and bring progress in gender equity towards the process of poverty reduction of the entire nation. It especially focuses on poor disadvantaged women, their children and families. DWD is implementing the Women Development Program with right-based and integrated approaches.

The Government of Nepal has delegated special tasks to DWD upon its establishment. The tasks are to implement approved programs related to women's development and assist the Ministry in policy formulation and legislation concerning women's development. DWD monitors and evaluates programs related to women's development and conveys necessary skills training to women. Along with accomplishing functions related to women's empowerment, controlling the trafficking of girls, prostitution, domestic violence and other offences against women, it also collects and publishes information related to women's development. It performs functions related to national or international seminars, symposia and conferences on women (DWD, 2009).

The DWD has the overall responsibility of planning, implementing, monitoring and evaluating women development programs. The department implements the programs through offices in all the 75 districts in Nepal. Group formation, training, community development and institutional development components are directly implemented through the cadre of the department. For more effective and realistic plans and programs, DWD collaborates with government organizations, non-governmental organizations (NGOs), financial institutions as well as with other donor agencies. In the execution process, the department regularly reviews the programs, prepares and implements various implementation manual, set norms and monitors the programs accordingly.

4.2 DWD's Strategy

Based on national policies, DWD develops its own policy and strategy for translating them into actions being within its mandates, women empowerment, with gender mainstreaming and gender equality as the major policy strategies of DWD. The DWD's strategic plan has set the following vision, mission, goals and operational strategies and priorities:

The vision of DWD is "Equitable and Prosperous Family" and the mission is to raise the family living standards of marginalized and deprived women as well as protecting their rights by

mainstreaming them into socio-economic and political term through awareness raising, capacity development and social mobilization. To achieve this, the department implements the various program at the district level.

Goals

The following goals have been identified:

- To develop competent and self-reliance women's organization at local level through social mobilization and awareness rising of the poor, socially, economically and culturally deprived women,
- To mainstream gender by empowering women,
- To raise awareness on superstitions, girls trafficking, domestic violence and other crimes against women to control these crimes in participation of men,
- To initiate and coordinate to ensure access to and control in the resource and employment opportunities,
- To build institutional capacity in providing expertise in gender mainstreaming as "Center of Excellence" and to contribute in developing capacity of concern agencies/mechanism for gender responsive governance,
- To establish information and resource centres at district and centre levels to assist in the implementation and monitoring of women empowerment programs,
- To develop, monitor and resource system in order to find out whether the programs have produced the desired results and to solve problems that occur during implementation.

Operational strategies

In order to achieve the goals above, DWD gives priority to institutional development of women's organization to organize social mobilizers to affiliate with the Village Development Committee (VDC), community and women's organizations and assists in the prevention and control of all kinds of violence against women. It performs tasks as the implementer, focal point, facilitator and coordinator responsible for mainstreaming gender in its plans and programs. Forming a women's group organization resourceful by providing seed fund and revolving fund to women increasing their participation in all sectors is another strategy being adopted by DWD. In a nutshell, DWD is the monitoring system to establish, develop information and documentation centre.

4.3 Roles of DWD at the National level

DWD has the following major roles:

- To assist the MOWCSW in developing policies and acts for women development;
- To support WDOs for implementing approved comprehensive women development programs; child, senior citizen, differently able people rights and welfare program; and also to function as the Gender Focal Agency for mainstreaming gender, child, senior citizen, differently able people rights through coordination, facilitation and networking;
- To function as the oversight agency capable of providing backstopping to Women Development Offices (WDOs) to enable them to carry out their new role of facilitating, networking, monitoring and supervising;
- To develop the capacity of staff members;
- To advocate for gender and child rights and network with different stakeholders;
- To build relationship with different funding partners to source funding for its mission, vision and goals and to monitor its programs.

4.4 Roles of DWD at the District level

At the district level, DWD implements through its WDO in 75 districts as per the businesses allocated to them, which can be grouped into three main categories:

A. Implement approved comprehensive, socially inclusive, disadvantaged people focused empowering Women Development Program consisting of the following components: Institutional development – women organization, women's empowerment, gender and reproductive health, skill development, disadvantaged women focus program, gender mainstreaming and women's awareness program.

B. Implement child, senior citizen, and differently able people's program as directed by the Ministry.

C. Function as the Gender Focal Agency.

4.5 Structure

The department of women developed is headed by the Director-General. The department has two wings which are headed by directors – Planning wing and an Administration wing. The two wings are sub-divided into three or four specific sections. Each district has Women Development Offices (WDOs) which are headed by Women Development Officers. At the sub district level some districts may have Unit or Representative Offices. DWD has 970 staff members; 68 at the DWD centre and 902 in the districts. In a district, there could be 16 to 25 WDO staffs depending on the intensity of activity in the district. WDO recruits social mobilizers to assist in implementation of activities at the village level. These are volunteers from the local community, willing to assist WDO to achieve its goals. Most of the volunteers are female and currently there are 942 social mobilizers working for WDO (DWD, 2009).

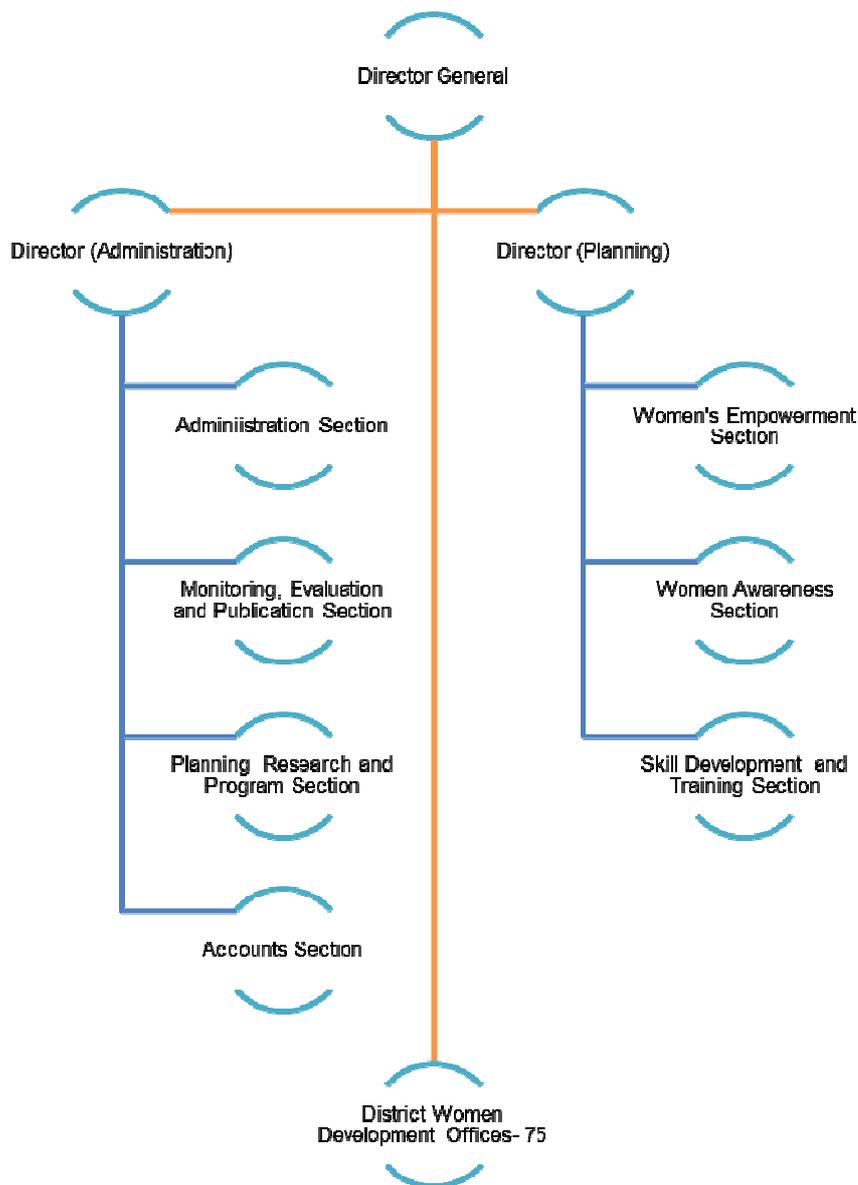


Figure 5: Organizational Hierarchy of DWD

Source: DWD (2009)

4.6 DWD in the context with HIV/AIDS

Women Development Program is one of the most popular programs of Government of Nepal. Over the last two decades, this program has been highlighted since women are disadvantaged, particularly those in the rural areas. Rural women are deprived greatly in various fronts like poverty, illiteracy, health, education, social and cultural discrimination. All these factors contribute to a high risk of susceptibility to HIV and the vulnerability to the impacts of AIDS. The spread of HIV infection in Nepal has probably reached to every nook and corner of the country.

With the mainstreaming mandate, a new dimension has been added to the Women Development Program. These dimensions include gender mainstreaming, women's empowerment and social inclusion. The seven priorities of the program are gender equity,

reproductive health awareness, economic prosperity, institutionalization, community affiliation, adolescent girl development and men's participation (DWD, 2009). The reproductive health awareness and adolescent girl development program includes how to make girls' future life better (choose future) such as discouraging child marriage and awareness about HIV/AIDS.

The organization's commitment in responding to HIV/AIDS has not been clearly defined but nevertheless, it is gender responsive. Some of the objectives that are related to responding to HIV/AIDS are being identified below (DWD, 2009):

- To advocate and sensitize on gender, Convention on the Rights of Child (CRC), Convention Elimination of all forms of Discrimination Against Women (CEDAW) to group members, their partners as well as officials of line agencies, Village Development Committees (VDCs), and District Development Committees (DDCs).
- To improve the socio-economic status of women in the society.
- To increase awareness and sensitize adolescents' girls on reproductive behaviours, social issues such as HIV/AIDS and girl trafficking.

DWD conducts a one hour session on introduction about HIV/AIDS in reproductive health training to DWD staffs which is not sufficient for service providers to implement programs and policy making in HIV/AIDS. In DWD, there are no direct HIV/AIDS responsive mechanism and work place policy to support PLWA and DWD staffs respectively. There are not enough resource materials, Information Education Communication (IEC) materials and there is also a lack of efficient recording and documentation system of PLWA having no sex aggregated data in relation to HIV/AIDS collected or analyzed. In DWD, there is no provision of HIV/AIDS testing mechanism. However, sexual harassment policy has been drafted.

The issue of HIV/AIDS are not reflected in policy and programmes because they are not addressed by policy makers and the management level staffs. These issues are mostly addressed in donor driven programmes but there is no separate budget allocation in HIV/AIDS program by DWD. DWD field staffs working directly with PLWA understand their needs. But when they report or demand the need or the addition of different types of programs and budget for the implementation of programs in HIV/AIDS to the management committee and seniors, they are overruled due to the hierarchal system in the institution.

CHAPTER FIVE PRESENTATION OF FINDINGS

This chapter presents the findings from the thirty three respondents interviewed from DWD. The staffs were, twenty five field staffs that work at the community level and are responsible for HIV/AIDS activities if any; seven section heads and the director general. The chapter synthesizes the findings in relation to the objective of the study and interprets the knowledge and attitude towards HIV/AIDS within the organization.

The three categories of respondents were asked different questions based on the nature and role of their job in the organization. In some cases, same questions were asked to more than one category of respondents for two reasons. One was to crosscheck some data and the second was to know the differences in views among the different categories of people. The essential elements for HIV/AIDS knowledge and attitudes within an organization were derived from the existing literature as described in chapter two.

Observations made at the field sites and in the offices, there were no posters, pamphlets, brochures and booklets on about HIV/AIDS awareness. The researcher observed that, there were no condoms placed in suitable location(s) for the easy access by the staffs. Due to cultural norms and values, there were no open discussion about HIV/AIDS in office and in-between the DWD staffs. It was observed that DWD held meetings on different issues of organization, but not on issues relating to HIV/AIDS.

5.1 Knowledge on mode of transmission of HIV among DWD staffs

The study found out that the knowledge levels among the field staff about the modes of HIV transmission was high. Figure 6 below shows that all the respondents (100%) had knowledge on transmission of HIV/AIDS by blood donation and unprotected sex. Among the staffs 92% said that HIV/AIDS can be transmitted through sharing needles among intravenous drug users while eight percent said that sharing of the needles would not transmit HIV/AIDS. Knowledge on whether HIV could be transmitted through breast feeding or to unborn child through an infected mother was known by 76% and 80% of the field staff respectively. This showed that the staff knew HIV/AIDS could be transmitted to children through infected mothers. However, 20% of the field staff stated that HIV/AIDS could not be transmitted from mother to child through breast feeding or while in the womb on the other hand, 4% said that they did not know whether a child could get infected by HIV through breast feeding. 80% of the field staff knew that HIV/AIDS could be transmitted through having multiple sexual partners while 20% said that this was false. From the FGD held with the sectional heads, six of the seven participants identified the ways through which HIV/AIDS could be transmitted as; using contaminated needles and syringes; unprotected sex and blood transfusion while one stated that sitting and sharing meals with an infected person would transmit HIV.

This result implies that among the sectional heads and field staff there was sufficient knowledge on the modes of transmission of HIV/AIDS. However, there was a gap on knowledge level amongst the staff. The gaps are depicted by the staff who reported on false statements, those that they did not know and the one sectional head who did not know the modes of HIV/AIDS transmission. The gaps can lead to spread of HIV/AIDS based on ignorance.

Initially, the sectional heads were asked to differentiate HIV/AIDS. They stated that HIV is the initial stage and AIDS is the disease. The section heads had heard about HIV/AIDS eleven to twenty years ago through media, their former schools and training from the women development programs. Regarding the cure of HIV, the group said that it cannot be cured but life could be extended by proper care and medication. One participant said that HIV can be cured and AIDS cannot. Three of the participants said that HIV infected persons can be identified by symptoms like long term fever, diarrhoea and cold while three said that it can only be identified through

blood test. One of the participants said that it cannot be identified through symptoms. This shows that among the sectional heads there was insufficient knowledge on how one can be said to be HIV infected or not. They thought that one can tell an infected person by looking at them.

About training on HIV/AIDS awareness over the last five years, four respondents said that the organization provided reproductive health training including HIV/AIDS whereas the rest said that the organization did not provide any awareness training on HIV/AIDS.

From the in-depth interview with the DG, the main modes of transmission of HIV/AIDS among the DWD staffs could be through sexual intercourse and blood transfusion. The DG stated that the role of DWD in the management of HIV/AIDS is to raise awareness on HIV/AIDS and to provide knowledge and training on reproductive health.

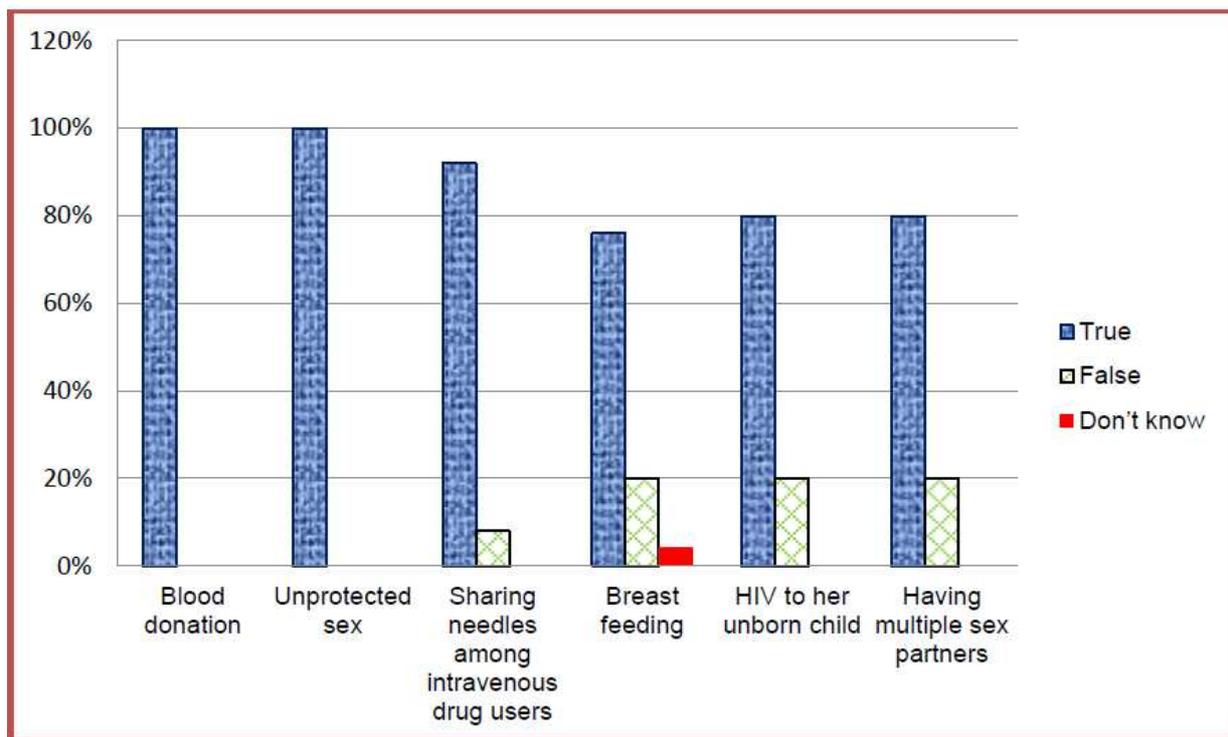


Figure 6: Responses from the field staff on their knowledge on modes of HIV transmission

Source: Field study (2010)

5.2 The misconceptions about the modes of transmission on HIV

The study established that despite the high levels of knowledge among the staff regarding the modes of HIV/AIDS transmission, there are some misconceptions about it. Figure 7 below presents some of the misconceptions among the field staff. The level of the misconceptions was not negligible it had a significant difference on the knowledge of HIV/AIDS among the field staffs. On the misconception that HIV/AIDS could be transmitted by sharing water glass with an infected person, all (100%) of the staff knew this was false. Some field staff (28%) believed that HIV/AIDS could be transmitted through mosquitoes and insect bites but a large proportion (78%) knew that it could not. 36% of the staff believed that HIV/AIDS could transmitted through kissing while 64% knew that this was not true. Majority of the respondents (96%) knew that HIV/AIDS could not be transmitted by sweat and tears from an infected person while 4% reported that they did not know if HIV could be transmitted through sweat and tears of an infected person. When asked whether sharing an office with coughing colleagues or walking with and infected person

would transmit HIV/AIDS, 80% and 84% of the respondents believed that it could not, respectively. On the other hand, 20% and 16% of the respondents thought that sharing coughing with colleagues in office and walking with an infected person would transmit HIV/AIDS, respectively.

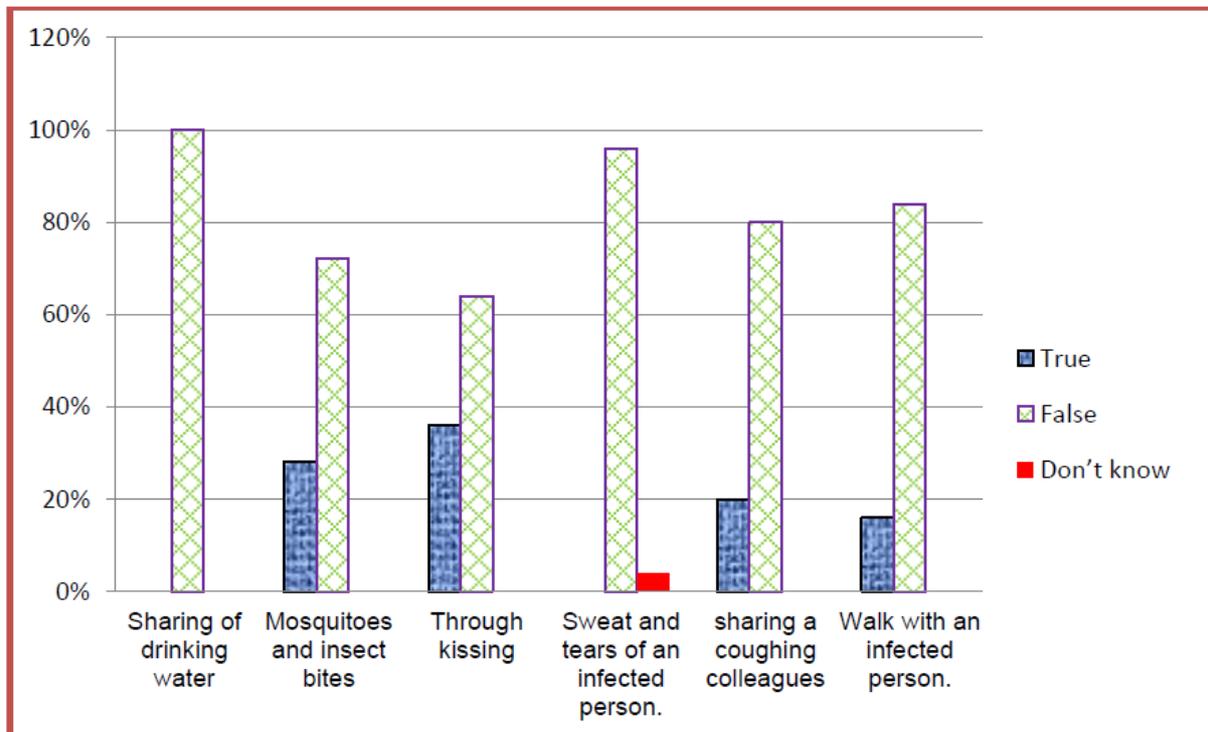


Figure 7: Responses from the field staff on their misconceptions regarding the modes of HIV transmission

Source: Field study (2010)

There was also misconception among the section heads, results from the FGD held with the sectional heads showed that one of the participants said that HIV/AIDS can be transmitted by sitting, eating and through kissing with an infected person.

5.3 Knowledge on prevention of HIV among DWD staffs

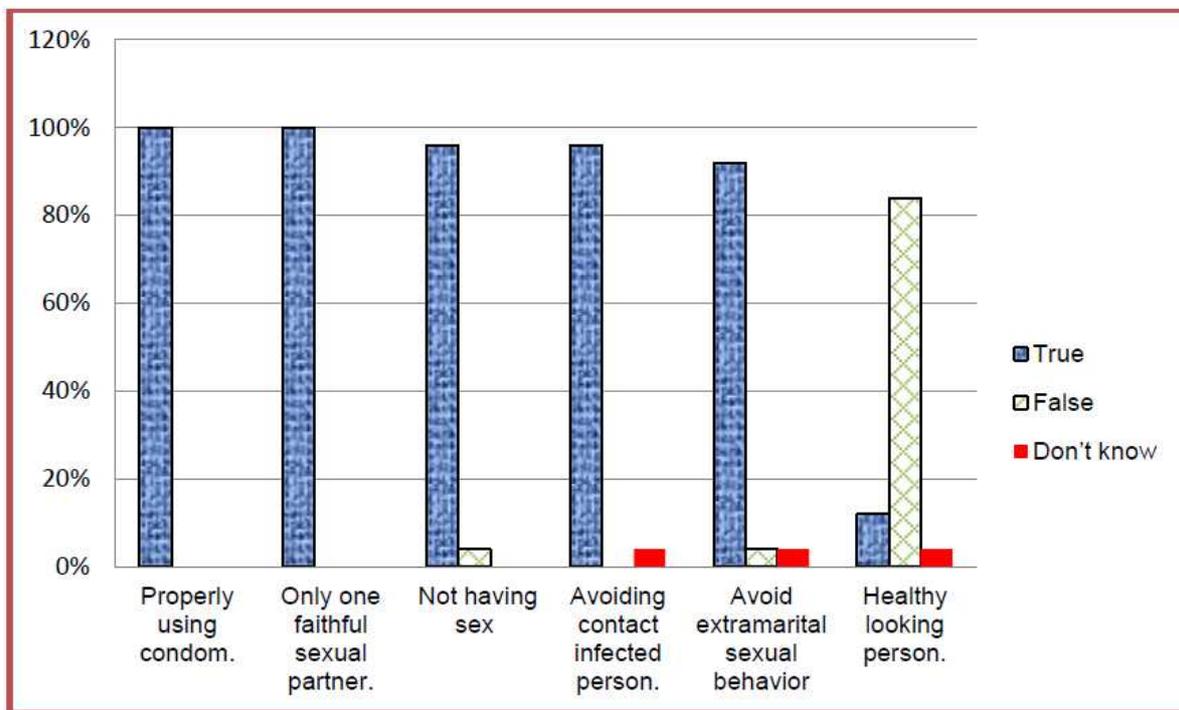


Figure 8: Responses on existing knowledge on prevention of HIV among the field staffs

Source: Field study (2010)

Figure 8 shows that almost all the respondents have knowledge in the prevention of HIV/AIDS. Hundred percent respondents believed that HIV/AIDS is prevented through proper use of condoms and there should be only one faithful sexual partner. In addition, 96% of the respondents believed that HIV/AIDS can be prevented by avoiding contact with HIV/AIDS an infected person and abstaining (not having sex at all). 92% of the respondents stated that HIV/AIDS could be prevented by avoiding extramarital sexual behaviour. 84% shared the opinion that having sex with healthy looking person is not being safe from HIV/AIDS whereas 12% opposed it. Among the field staff four percent were not aware whether HIV/AIDS can be prevented by avoiding contact with HIV/AIDS infected person, having sex with healthy looking person or avoiding extramarital sexual behaviour.

The FGD with sectional heads found out that they believed that there is minimum chance to transmit HIV among faithful sexual partners. They reported that HIV/AIDS in the organization can be prevented by giving information and awareness campaign about HIV/AIDS to DWD staffs.

The DG expressed similar remarks by stating that HIV/AIDS can be prevented in the organization by creating awareness about HIV/AIDS and by providing condoms to the staffs but there has been no formal program on HIV/AIDS within DWD. He said that there was no provision to supply female and male condom from the government.

5.4 Risk factors that make the DWD staffs susceptible to HIV

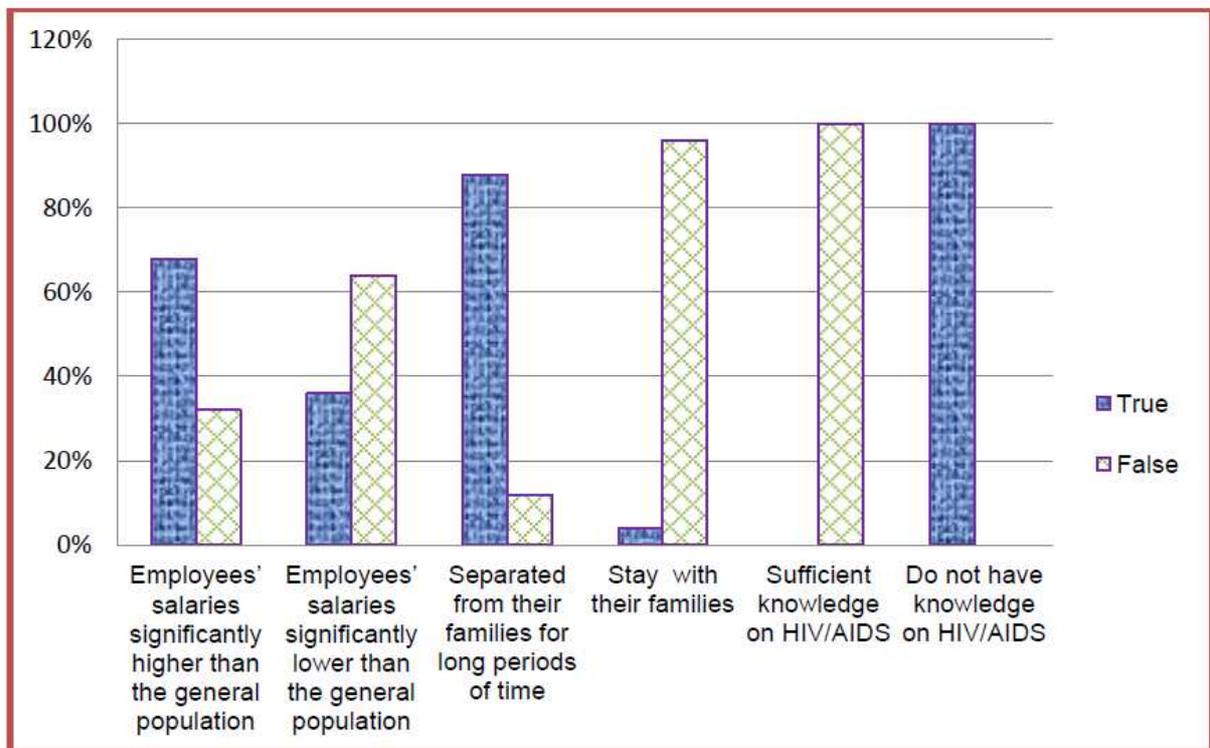


Figure 9: Responses on the risk factors that could make the field staff susceptible to HIV

Source: Field study (2010)

Figure 9 indicates that all the respondents knew that employees who have sufficient knowledge on the risk factors about HIV/AIDS are at a lesser risk of being HIV infected. On the other hand, 96% assumed that employees who stay with their families have low risk of being infected. 88% believed that employees who are separated from their families for long periods of time might be at a higher risk of being HIV infected than those who remain at home.

Additionally, 68% of the respondents approved those employees who have salaries significantly higher than the general population were more at risk of being infected while 64% said that employees having significantly low salaries than the general population are more at risk of being infected by HIV.

Sectional heads believed that HIV/AIDS could be transmitted through unprotected sexual encounters made during field visits and workshops. They associated this with the frequency of field visits by staff and the number of residential workshops. They reported that the staffs were away from their duty stations at least five to fifteen times per year which makes them susceptible to HIV infection. The sectional heads stated that there is a relationship between differences in salary levels among the staff and susceptibility to HIV. Two of the seven sectional heads said that the staff with higher salaries could be at risk of being HIV infected while two said that if the salary is high they can use safety precautions such as condoms while one said it depends on individual behaviour. One sectional heads strongly believed that the salary levels among the staff and susceptibility to HIV has no relationship while one had no knowledge about it the relationship.

This shows that the sectional heads had some knowledge on income as a driver to the pandemic; however there is need for more information. They knew about mobility as a risk factor that is why they identified the frequency of field visits and residential trainings as risk factors.

The study gathered information from the DG his opinions on the major risk factors that influence DWD staff susceptibility to HIV infection. He identified lack of knowledge as the main risk factor. Further, he said there was no policy from the government and lack of system to deal with HIV/AIDS discrimination and sexual harassment at work. In addition to this, DG clarified that there is no any networking and coordination in the responses towards HIV/AIDS with other organizations. The DG identified the Department of Health, government of Nepal as some of the appropriate partners that DWD can work with to improve on effectiveness in addressing issues of HIV/AIDS positive staff members.

5.5 Attitudes towards HIV/AIDS related stigma and discrimination

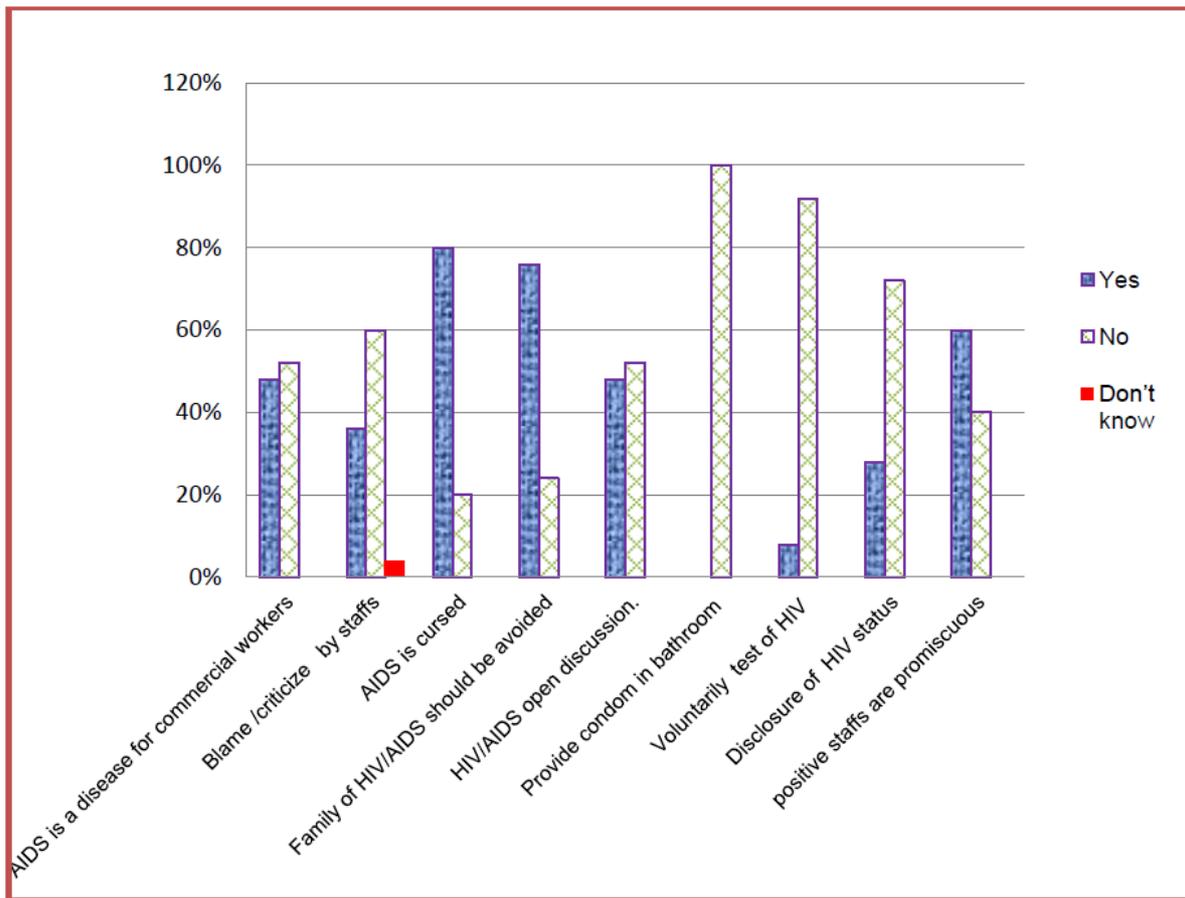


Figure 10: Responses on attitudes towards HIV/AIDS related stigma and discrimination among the field staff

Source: Field study (2010)

Figure 10 above shows that all the respondents stated that organization does not provide condom in bathroom for use by its staff and 92% had not taken HIV voluntary test. Failure of the organization to provide the staff with the condoms implied that the staffs were being put at a higher risk of susceptibility. This could be termed as discrimination against protected services. On the other hand, the staff feared to take the voluntary test of HIV because they feared to be

stigmatized by family and colleagues. 80% of the respondents believed that AIDS is a curse, 76% proposed that a family of an HIV/AIDS affected person should be avoided while 60% stated that staff members living with HIV/AIDS should be blamed or criticized and that the HIV positive staffs are promiscuous. When asked whether they would disclose their status to the other staff, 72 % denied. 52% of the respondents disagreed on the open discussion of HIV/AIDS issues in office.

The section heads said that HIV-infected-persons at the workplace can perform normal activities if they are encouraged and are provided with sufficient nutrition. This implies that the heads had a positive attitude towards the people living with HIV/AIDS.

The DG had no information about the staff living with HIV/AIDS since none had reported formally. There is no support programme for staff living with HIV/AIDS. This showed that DWD is not fostering an enabling environment for the people living with HIV/AIDS to declare their status.

CHAPTER SIX DISCUSSION

This chapter is divided into four major sections to discuss the findings of this study. The first section discusses the knowledge of mode of transmission of HIV/AIDS among the DWD staffs; the second section describes their knowledge on prevention of HIV/AIDS. In the third section the DWD staffs' attitude towards stigma and discrimination on HIV/AIDS is discussed and the last section discusses about the knowledge on risk factors that make the staff susceptible to HIV infection.

6.1 Knowledge on mode of HIV transmission

From the findings, it was revealed that the majority of the respondents had average basic knowledge level on HIV/AIDS. This basic knowledge includes the understanding of HIV/AIDS and the different modes of HIV transmission. Majority of the respondents said that HIV is transmitted through unprotected penetrative sex and blood donation.

Since there has been no study in Nepal from a similar sector, the findings of this study were compared to a study by Katwal (2006) who found out similar results in the study of Knowledge and Attitude on STDs-HIV/AIDS among higher secondary school students at Damak municipality, Jhapa district. The population is different but the results were compared since the population was from Nepal. More than 98 percent of higher secondary school students said that HIV/AIDS is transmitted through blood transfusion and 96 percent of the students said HIV is transmitted by sexual contact and infected needles. 89% of the students under the study identified HIV transmission to be through infected mother to her baby while 6% said it could be transmitted by kissing. Similar results were also reported from the study of Socio-Demographic Profile of HIV Patients at Seti zonal Hospital, Nepal by Paudel, *et al.*, (2008); that is 88.3% HIV was transmitted through sexual contact.

All DWD staffs knew that HIV/AIDS is not transmitted through sharing of drinking water glass, by kissing, sweat and tears of an infected person, mosquito or insect bite and shaking hands. Despite the abundant knowledge on the modes of transmission, some of the participants said that it can be transmitted through kissing. This showed that some staff did not have knowledge of transmission about HIV/AIDS. In addition, some field staff did not know about other modes of transmission such as breast feeding and infected mother to unborn child. Based on the data, majority of the respondents seem to have knowledge on modes of transmission of HIV while some had erroneous concepts. Some of the erroneous concepts were portrayed by those who indicated that HIV can be transmitted through sharing office with a coughing colleague and walking with infected persons. On the other hand, the four percent of the field staff reported that they have no idea of the modes of transmission. The proportion of those who do not have any idea and those with erroneous concepts indicate that not all staffs have knowledge on the modes of transmission. According to Family Health International (2004) a person may have positive or negative feelings toward performing the defined behaviour, this mean that if the staffs have the misconceptions on HIV/AIDS transmission they may choose to have negative feelings towards PLWHA, this may lead to stigma.

According to the civil service act in Nepal, the director general and section heads are transferred after two years to different departments. Sometimes, they are assigned to new sectors implying that they might have scanty knowledge about HIV/AIDS. Most of the section heads did not get any training about HIV/AIDS over the last five years. This made it difficult for them to integrate HIV/AIDS issues in planning and policy. This is exhibited by some section heads who did not know the modes of transmission of HIV/AIDS as discussed in chapter five. According to James and Mullins (2004, cited in Gumisiriza, 2008) an organization needs to train the staff on HIV/AIDS. The organizations needs to constantly remind the existing staff that would have

received the message in order to reinforce the messages, updated them with the latest information. The new entrants into an organization need to be trained so that they can bear the organization's focus on HIV/AIDS.

The director general explained that there was no program in HIV/AIDS and that DWD has no role in the management of HIV/AIDS. DWD's role was to provide training on reproductive health which includes introduction of HIV/AIDS. For an organization to be able to respond effectively towards HIV/AIDS it is important for the management to be committed to building the staff knowledge on HIV/AIDS. Shipalana, (2009) found out that when an organization invests in the health of its employees, the morale of employees will be boosted. The staffs feel cared for by their employer improving their productivity. The effort made by DWD to only give reproductive health training to the community and did not focus on the staff was not sufficient. Holden (2004 cited in Gumisiriza, 2008) emphasizes on the need for commitment of senior managers as a key factor in order to assist an organization to secure resources for HIV/AIDS programs by allocating or reallocating the existing resources for HIV/AIDS activities.

Similarly, the section heads of DWD had heard about HIV/AIDS over 11 to 20 years through different means such as media, former schools, training from women development program yet they did not implement it. This is because there was no clear cut policy and budgetary system in the organization about HIV/AIDS and was not their priority.

6.2 Knowledge on HIV prevention

Knowledge on prevention of HIV/AIDS among DWD staffs seems to be high. Staffs believed that HIV/AIDS is prevented by proper use of condom and having only one faithful sexual partner. This result is contrary to what Regmi (2006) found out. Regmi reported that among the teenagers in Nepal 32% said that HIV/AIDS can be prevented by avoiding sex with many partners.

Some of the respondents of this study said that HIV/AIDS could not be prevented by having sex with healthy looking person and avoiding contact with HIV/AIDS infected person. It was also found that it could be prevented by not having sex at all unless they are married i.e. abstaining and avoid extramarital sexual behaviour. These findings are similar to study done by Katwal (2006) among higher secondary school students. The students had knowledge on HIV/AIDS prevention 79% of the students said use of condoms is the best method for preventing transmission of HIV. Similarly, 71% of them said that sex with unknown person should be avoided, 64% respondents supported use sterilized surgical instrument and 30% respondents emphasized on not to have sex at all. The International Labour Organization (2001 cited in Gumisiriza, 2008) argues that an effective education programme gives workers the capacity to protect themselves against HIV infection. It helps to reduce HIV-related anxiety and stigmatization; which eventually contributes towards changes in attitudes and behaviour.

Although the staffs are knowledgeable but there is not supportive policy on HIV/AIDS for the staff such as work place policy. According to Gumisiriza (2008) there is needed to have workplace policies that are negotiated between the management and workers' representatives in order to avoid misunderstanding. A good HIV/AIDS at workplace would significantly reduce the impact of AIDS on an organization, however Holden (2003) emphasizes that 'careful follow up is needed, to identify where problems exists and how they might be mitigated'. An organization that has a HIV/AIDS workplace policy without good implementation will not achieve its goals.

The field staffs were found to be more knowledgeable on HIV/AIDS issues than the sectional heads and the director general. From the triangulation of information, the study established that this was because the field staffs were collaborating with other organizations at the community level. They could have been trained on HIV/AIDS. The section heads and the director general could be missing out on such opportunities.

6.3 Attitude towards HIV/AIDS

The findings from this study show that the staff had wrong attitudes towards HIV/AIDS and this could increase stigma and discrimination. There were very many misconceptions about HIV/AIDS. Most of the staffs said that HIV/AIDS is a disease of only commercial sex workers. They also believed that AIDS is a curse and that a family of an HIV/AIDS affected person is cursed and should be avoided and isolated. This portrayed a judgemental attitude whereby the staffs were criminalizing the people living with HIV/AIDS. Basaula (2007) reported different results in a study conducted in Dhading district of Nepal on knowledge and attitude of STDs and HIV/AIDS in Dalit (lower caste) Community, 64% of the respondents said that they should love and respect HIV infected persons while 36% said that the infected person should be hated in the society.

Majority of the staffs said that HIV/AIDS was not openly discussed in office but some of the staffs said that it was discussed in the training. According to Groverman (2007) organizations should encourage the staff to communicate openly about HIV/AIDS within the organization. Although DWD did not provide condoms in washrooms for use of the staffs, the staff said that if it was provided in bathroom then they could easily pick it and use. This is an initiative that would assist DWD in protecting the staff from HIV infection.

There were very few staffs who had voluntarily taken a HIV test and only few were willing to disclose own HIV status to their colleagues. According to Oyewale (2008) undertaking the HIV test is the major step confronting stigma and initiating appropriate attitudes on HIV/AIDS issues. In addition, discussing HIV/AIDS issue in public as well as disclosing result of HIV test is an important manifestation of HIV/AIDS knowledge and a major step in adopting appropriate HIV/AIDS related attitude. More than 60% of the respondents believed that HIV positive staffs are promiscuous. Data showed that DWD staff members blame/criticize the people who are HIV positive. From this survey it was indicated that attitude towards stigma and discrimination was very high in the staffs of DWD because they thought that HIV positive staffs were promiscuous and should be ashamed of themselves. This implies that there is need to train the staff on HIV/AIDS related attitude in order to reduce the attitude of blaming those who are infected. The people living with HIV/AIDS needs to be supported both at home and in the workplace. According to Shiplana (2009) the manner in which one thinks and feels about HIV/AIDS and also towards PLWA may inhibit, prevention, disclosure, increase perception of risk and inhibit care and support. This implies that the DWD staff may not disclose their status for fear of being regarded as promiscuous or wayward.

6.4 Knowledge on risk factors that make the staff susceptible to HIV infection

Some staff believed that the differences in salary among staff members of the organization influence one's susceptibility of HIV infection. This study found that the staff believed that the employees with higher salary are more susceptible to HIV infection because they can afford more money for entertainment and high frequency of sexual activities with extramarital partners and commercial sex workers. This is contrary to most studies that relate HIV/AIDS with poverty. Regmi (2006) attributed the spread of HIV/AIDS to poor economic conditions that force women to commercial sex work. This result are similar to IFC (2002) who found out that the employees who have significantly higher than general population are more at risk of HIV infection.

In DWD the staffs who earn high salary are highly educated and were found to have more knowledge and awareness of HIV/AIDS. This implies that these cadres of staff could afford the safety measures for protected sex reducing their susceptibility to HIV.

The staffs with lower salary were at less risk of HIV infection, because they have to maintain their family needs with the limited amount of money making it difficult for them to afford extra

marital sex. In contrast, they could not afford for protected sex hence susceptibility of infection could be high. On the other hand, mostly among the female, they could use favour of sex and involve in commercial sex for extra income to fulfil their needs. According to the WHO (2006 cited in Mulumba, 2008), most women are responsible for solving the food insecurity in their families and due to the lack of lucrative employment opportunities; they are indirectly forced to engage in the commercial sex industries. This implies that the female staffs of DWD were to be paid lesser salaries; then they will be at risk of being susceptible to HIV. However this is dependent one's behaviour and caution rather than the salary. On the other hand women's low level of status makes them unemployed or to work in low paid jobs in agricultural sector or in non-agricultural sector; inside or outside the country. Female unable to access basic necessities of life due to lack of money. Such female in society tend to develop different survival strategies such as exchanging sex for money (Population Bulletin, 2002 cited in Karki, 2008).

The staffs who were working in the field based offices made frequent visits for training workshops. This separated them from their regular sexual partners for long period of time. This could put them at risk of being infected since they could come in contact with commercial sex workers and HIV infected persons.

The sectional head said that there is high frequency of visit to field monitoring, conduct training and workshop so that they are more susceptible to HIV infection therefore they need to aware about the HIV/AIDS prevention. Similar findings that consider mobility as a factor that could spread HIV/AIDS have been reported in other studies. A study conducted by NCASC (2008) found that 46% of estimated HIV infections in Nepal were among seasonal labour migrants to India in 2005, It has also been suggested the several thousands of Nepalese are migrating to urban areas within the country or in abroad in search of jobs and for the better earnings (Karki, 2008). Widespread poverty drives women into sex industry such women may take maximum risk of engaging in unprotected sexual intercourse for financial favour.

The study found out that insufficient knowledge is also a risk factor that makes the staffs susceptible to the HIV infection. Staffs who have sufficient knowledge on HIV/AIDS may be aware on precautions to protect themselves against HIV infection. Most of the staffs knew that unprotected sex could transmit the HIV yet engaged unprotected sex since there was no condom provision. In Nepalese culture the society is monogamous meaning that they do not accept more than one sexual partner so that they do not want to talk openly about risk factors.

CHAPTER SEVEN CONCLUSION AND RECOMMENDATION

This study explored that the level of knowledge of DWD staffs towards transmission, prevention, risk factors and attitude on stigma and discrimination about HIV/AIDS.

7.1 Conclusion

The staff's knowledge level on the modes of transmission about HIV/AIDS was high. The study found out that the knowledge levels among the field staff on the modes of HIV transmission was high. All the respondents (100%) had knowledge on transmission of HIV/AIDS by blood donation and unprotected sex, majority of the field staff knew that HIV/AIDS can be transmitted through sharing needles among intravenous drug users, through mother to child and through having unprotected sex with multiple sexual partners. The study established that despite the high levels of knowledge among the staff regarding the modes of HIV/AIDS transmission, there were some misconceptions about it. On the misconception that HIV/AIDS could be transmitted by sharing water glass with an infected person, all the staff knew this was false. Some field staff believed that HIV/AIDS could be transmitted through mosquitoes and insect bites but a large proportion knew that it could not. Majority of the staff knew that HIV/AIDS could not be transmitted through kissing, sweat and tears from an infected person. Some staff believed that HIV/AIDS could be transmitted by sharing an office with coughing colleagues or by walking with HIV infected colleagues.

The level of knowledge among the staff concerning HIV/AIDS prevention was high since, all the respondents had knowledge in the prevention of HIV/AIDS. The respondents knew that HIV/AIDS could be prevented through proper use of condoms and there should be only one faithful sexual partner. The staff said that HIV/AIDS can be prevented by avoiding sexual contact with HIV/AIDS infected person and abstaining (not having sex at all). They knew that HIV/AIDS could be prevented by avoiding extramarital sexual affairs. However there were some misconceptions on the prevention of HIV/AIDS, the staff believed that having sex with healthy looking person is being safe from HIV/AIDS while some thought that HIV/AIDS can be prevented by avoiding contact with HIV/AIDS infected person. There was a knowledge gap between the field staff and the section heads, since with section heads believed that there is minimum chance to transmit HIV among faithful sexual partners. This is a misconception because sexual partners can be faithful but could be already infected.

The findings from the study indicate that the risk factors that made the DWD staff susceptible to HIV infection were differences in salary among staff members, frequent visits for training workshops and insufficient knowledge on HIV/AIDS. The staff believed that the employees with higher salary are more susceptible to HIV infection because they can afford more money for entertainment and high frequency of sexual activities with extramarital partners and commercial sex workers. The staffs with lower salary were at less risk of HIV infection because they have to maintain their family needs with the limited amount of money making it difficult for them to afford extra marital sex and they could not afford protected sex. This reduced their susceptibility of HIV infection. However the level of susceptibility is dependent one's behaviour and caution rather than the salary. The staffs who were working in the field based offices made frequent visits for training workshops, making them susceptible to HIV infection. The staffs are separated from their regular sexual partners close to fifteen times in a year. The section heads make regular impromptu visits to the field for monitoring and evaluation of activities. They were found to be attending residential trainings and workshops. This exposed them to susceptibility of HIV infection. The insufficient knowledge on HIV/AIDS transmission and prevention was another factor that made the staffs susceptible to HIV infection. The staffs that have sufficient knowledge on HIV/AIDS may be aware on precautions to protect themselves against HIV/AIDS. The field

staffs as well as the policy makers did not realize the relation between the susceptibility of HIV infection and the risk factors.

DWD was found not to be proactive in HIV/AIDS activities despite the fact that there is a global call for multi-sectoral response in addressing HIV/AIDS in the millennium development goals. The organization did not have information on staff who were living with HIV/AIDS and did not have support towards the same. There was no provision of condoms in safe places for use by the staff. None of the staff had taken a voluntary test of HIV due to stigma associated with HIV/AIDS in the organization. This showed that DWD is not fostering an enabling environment for the people living with HIV/AIDS to declare their status. This showed that there is a negative attitude towards the people living with HIV/AIDS. The section heads had a positive attitude since they believed that HIV-infected-persons at the workplace can perform normal activities if they are encouraged and are provided with sufficient nutrition. Some of the field staffs were found to be judgemental as they said HIV positive staff blamed or criticized and that they were promiscuous. A high proportion of the staff proposed that a family of an HIV/AIDS affected person should be avoided and that AIDS is a curse. The staff shunned from holding open discussion of HIV/AIDS issues in office. It was also found that there were no information, education and communication materials about HIV/AIDS in DWD.

Despite the above, the study found out that there was good will among the DWD management to address HIV/AIDS. The section heads and the DG said that HIV/AIDS in the organization can be prevented by giving information and awareness campaigns about HIV/AIDS to DWD staffs. In addition, the DG said but there has been no formal program on HIV/AIDS within DWD so the department did not have provision to supply female and male condoms from the government and other stakeholders. DWD did not have any provision of HIV/AIDS testing mechanism and there is no any system to deal with HIV/AIDS discrimination and sexual harassment at work, in DWD. The study established that there was no any focal point for HIV/AIDS in the organization. This implies that within the organization no one who can take the initiative to incorporate the HIV/AIDS issues in programs and policy. The respondents expressed interest to have more knowledge on HIV/AIDS. They thought that the availability of the HIV/AIDS knowledge and skills was important in performing their duties.

7.2 Recommendations

The following are recommended to improve understanding of HIV/AIDS knowledge on transmission, prevention and risk factors among staffs of DWD in Nepal.

There is need to address the knowledge gaps that exist among the senior staff and the field staff. The field staffs seem to have more knowledge than the section heads and the director general. There is need to have a workshop on HIV/AIDS for the section heads and the director general to build their capacity on HIV/AIDS as a developmental issue.

It is important to build the capacity of the staff so that all of them have the same knowledge on HIV/AIDS modes of transmission, prevention and the risk factors. There is need to train the staff on the basic facts of HIV/AIDS in order to minimize the level of misconceptions. Emphasize needs to be put on the current trends of the epidemics since HIV/AIDS is a generalized pandemic in Nepal. The staffs need to know it is progressing among the different locations and sectors.

On the modes of prevention, there is need for trainings so that the myths and misconceptions are demystified. Such misconceptions create the negative attitudes towards people living with HIV/AIDS. This study recommends that there should be team building to have all the staff on the same level of knowledge. The gaps among the staff weaken the organization and may cause it not to achieve its goals.

DWD has a key role in promoting attitudes and values of the staff through communicating knowledge and skill that will inspire the staffs to behave in the responsible manner to minimize the risk of infection. There is need to train the staff on how to deal with the ethical dilemmas that are brought about by HIV/AIDS. This will assist the organization in embracing a positive attitude towards the people living with HIV/AIDS. By training on the professional attitudes when dealing with HIV/AIDS will be results into minimum stigmatization and discrimination.

The DWD needs to recognize HIV/AIDS as an issue that could deter it from achieving its vision of having “Equitable and Prosperous Family” in Nepal. For DWD to protect the marginalized and deprived women by protecting their rights, it is imperative for DWD to recognize HIV/AIDS as a development issue and mainstream it within its programmes activities. HIV/AIDS mainstreaming will make DWD to be HIV sensitive at work place as well as in service delivery.

There is need to have a HIV/AIDS focal point in the organization. The focal point will assist in coordinating the HIV/AIDS activities and linking the organization with other stakeholders. The focal point will be charged with the duty of ensuring that there is training for the staff on HIV/AIDS. The focal point will disseminate to the staff up to date information regarding the trends and recent development in the HIV/AIDS sector.

DWD should not leave its core functions to engage in direct AIDS work but through linkages and networking they can provide condoms, motivate the staff to take HIV tests and disseminate information, education and communication materials to their staff and their clientele.

There is need for DWD to develop a HIV/AIDS at workplace policy. The policy would help in addressing the fears of the staff as well as strengthen DWD's position in lobbying the government and other stakeholders to support programmes addressing HIV/AIDS.

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ANNEXES

Annex A: Questionnaire for DWD field staffs

You have been selected to participate in a study to assess the awareness level of DWD's staff regarding HIV/AIDS. The findings of the study helped in contributing towards safeguarding the organization's effectiveness. Your participation in answering the questions is very much appreciated and is completely voluntary. Your responses will be strictly confidential and will be used for research purposes only. Please note there is no need to include your name. Please read carefully through the questions before responding do not hesitate to ask for clarity if need be.

Personal characteristics of respondents

Age: _____ Sexes: _____
 Educational level: Primary _____ Secondary _____ Post-Secondary _____
 Designation: _____
 Years employed at DWD: _____

SECTION A: Knowledge on mode of transmission and prevention of HIV/AIDS.

Particulars	True	False	Don't know
HIV/AIDS is transmitted through blood donation.			
Infected people can transmit HIV through unprotected sex.			
HIV can be transmitted through sharing of drinking glass.			
Mosquitoes and insect bites transmit HIV infection.			
HIV is transmitted through sharing needles and syringes among intravenous drug users.			
HIV is transmitted through breast feeding.			
Pregnant women can transmit HIV to her unborn child.			
One can get infected by HIV through kissing			
HIV/AIDS is transmitted by having multiple sex partners.			
HIV can be found in sweat and tears of an infected person.			
One can get HIV infection by sharing office with a coughing colleagues			
It is dangerous to sit or walk with a HIV infected person.			

Put an (√) where applicable under True, False or Don't Know

Particulars	True	False	Don't know
HIV/AIDS can be prevented by properly using condom.			
HIV is prevented by having sex with only one faithful sexual partner.			
HIV can be prevented by having sex with a healthy looking person.			
HIV is prevented by avoiding contact with HIV/AIDS infected person.			
Abstaining from (not having) sexual intercourse is an effective way to avoid being infected with HIV.			
Avoid extramarital sexual behaviour.			

Section B: Knowledge on risk factors

In your opinion, which of the following statements is true or false?

Put an (√) where applicable under True or False

Employees who earn salaries significantly higher than the general population are more at risk of being infected by HIV.

True

False

Why do you think so.....?

Employees who have salaries significantly lower than the general populations are more at risk of being infected by HIV.

True

False

Why do you think so?

In your opinion, which of the following statements is true or false?

Put an (√) where applicable under True or False

Employees who are separated from their families for long periods of time might be more at risk of HIV infection than those who remain at home.

√ True

False

Why do you think so.....?

Employees who stay with their families are more at risk of being infected by HIV.

True

False

Please explain.....

In your opinion, which of the following statements is true or false?

Put an (√) where applicable under True or False

Employees who have sufficient knowledge on HIV/AIDS are more at risk of being HIV infected.

True

False

Why do you think so?

Employees who do not have knowledge on HIV/AIDS are more at risk of being HIV infected.

True

False

Why do you think so.....?

Section C: Attitudes towards stigma and discrimination

Particulars	Yes	No	Don't know
Is HIV/AIDS a disease of only commercial sex workers?			
Do staff members blame/criticize the people who are HIV positive?			
Are people who have AIDS are cursed?			
Should the family of an HIV/Aids affected person is cursed and should be avoided and isolated?			
Do people with HIV/AIDS have nothing to feel guilty or ashamed about?			
Is HIV/AIDS discussed openly in the office?			
Does your organization provide condom in bathroom for use by			

its staff?			
Can you voluntarily take a HIV test?			
Are you willing to disclose your HIV status with their colleagues?			
In your opinion are HIV positive staffs promiscuous?			
Is it someone's fault to contract HIV by blood transfusion?			

Annex B: Focus group discussion checklist for section heads

1. Difference between HIV and AIDS
2. When and how first heard about HIV/AIDS
3. Cure of HIV
4. Identification symptoms of a HIV infected person
5. Training on HIV/AIDS awareness since last five years
6. HIV infection Vs faithful sexual partners
7. HIV-infected-person performance at workplace
8. Prevention of HIV/AIDS in the organization
9. Frequency of the field visits by staff and residential workshops.
10. Relationship between differences in salary levels among the staff and susceptibility to HIV.
11. Modes of transmission of HIV/AIDS among the staff.

Annex C: Interview check list for the Director General

1. The modes of transmission of HIV/AIDS among the staffs.
2. HIV/AIDS prevention in the organization.
3. The role of DWD in the management of HIV/AIDS.
4. Systems in place to deal with HIV/AIDS discrimination and sexual harassment at work.
5. DWD provision for female and male condoms to reduce staff's susceptibility to HIV infection.
6. DWD involvement (directly or indirectly) with other organizations involved in the responses towards HIV/AIDS.
7. Staff members living with HIV/AIDS in the organization.
8. Support given to staff living with HIV/AIDS.
9. The appropriate partners that DWD can work with to improve on effectiveness in addressing issues of HIV/AIDS positive staff members.
10. The risk factors that influence DWD staff susceptibility to HIV infection.

Annex D: Knowledge on mode of transmission of HIV among field staffs

	Blood donation	Unprotected sex	Sharing needles among intravenous drug users	Breast feeding	HIV to her unborn child	Having multiple sex partners
True	100%	100%	92%	76%	80%	80%
False			8%	20%	20%	20%
Don't know				4%		

Annex E: Knowledge on misconception of HIV transmission among field staffs

	Sharing of drinking water	Mosquitoes and insect bites	Through kissing	Sweat and tears of an infected person.	sharing a coughing colleagues	Walk with an infected person.
True	-	28%	36%	-	20%	16%
False	100%	72%	64%	96%	80%	84%
Don't know				4%		

Annex F: Knowledge on prevention of HIV among field staffs

	Using condom Properly.	Only one faithful sexual partner.	Not having sex	Avoiding contact infected person.	Avoid extramarital sexual behavior	Healthy looking person.
True	100%	100%	96%	96%	92%	12%
False	-	-	4%	-	4%	84%
Don't know	-	-		4%	4%	4%

Annex G: Knowledge of HIV/AIDS on risk factors

	Employees' salaries	Employees' salaries	Separated from their	Stay with their	Sufficient knowledge	Do not have knowledge

	significantly higher than the general population	significantly lower than the general population	families for long periods of time	families	on HIV/AIDS	on HIV/AIDS
True	68%	36%	88%	4%	-	100%
False	32%	64%	12%	96%	100%	-

Annex H: Attitudes towards stigma and discrimination of HIV/AIDS

	AIDS is a disease of only commercial sex workers.	Blame /criticize staff members	AIDS is cursed	Family of an HIV/AIDS affected person is should be avoided	HIV/AIDS have nothing to feel guilty or ashamed about.	Openly discussion of HIV/AIDS in office.	Provide condom in bathroom for use by staff	Voluntarily test of HIV	Disclosure of HIV status	HIV positive staffs are promiscuous
Yes	48%	36%	80%	76%	52%	48%	-	8%	28%	60%
No	52%	60%	20%	24%	48%	52%	100%	92%	72%	40%
Don't know		4%								