

# Knowledge, Attitudes, and Practices toward Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome among Dental Students in a Private Dental College in Nepal: A Cross-Sectional Study

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## Abstract

**Background:** “Human immunodeficiency virus” (HIV) infection and Acquired Immunodeficiency Syndrome (AIDS) are a globally emerging public health problem. The present study aims to assess the Knowledge, Attitudes, and Practices toward HIV/AIDS among Dental Students of a private dental college, Nepal.

**Materials and Methods:** A cross-sectional survey was carried out on 200 dental students at a private dental college, Rupandehi, Nepal. The students were completed a pre-tested, close-ended questionnaire assessing the knowledge, attitude, and practices of students to treat HIV/AIDS patients. Descriptive statistics were performed to describe demographic variables, HIV-related knowledge, attitudes, and behavior, and the findings were given in terms of percentage, mean, and standard deviation. One-way analysis of variance tests were used to examine the differences in knowledge and attitudes about HIV/AIDS between genders and their academic years.  $P < 0.05$  was set to determine statistical significance.

**Results:** A total of 200 students responded to the survey. The mean knowledge score of the participants according to year of study was (mean knowledge score: 79.30%), mean attitude score (70.1%), and mean practices score (65.4%) which was statistically significant. Pearson’s correlation was used to compare knowledge and attitude, assuming knowledge as the predictor variable and attitude as the outcome variable. There was a correlation between knowledge and attitude score ( $P \geq 0.05$ ).

**Conclusion:** This study showed that students were likely to translate their knowledge about HIV/AIDS transmission into healthy behavior. Health and education sectors need to review the way in which they are delivering the information in relation to HIV/AIDS risk awareness and practices to treat people living with HIV/AIDS and to develop and implement new policies to promote HIV/AIDS prevention education among university students.

**Key words:** Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome, Dental, Knowledge, Nepal, People living with HIV/AIDS

## INTRODUCTION

Human immunodeficiency virus (HIV) infection and acquired immunodeficiency syndrome (AIDS) are globally emerging public health problems.<sup>[1]</sup> The risk of HIV spread

and acquisition has both increased by a factor of 10 in the presence of untreated sexually transmitted diseases.<sup>[2]</sup> According to the World Health Organization (WHO), in 2011, an estimated 34.2 million people were living with HIV, and of those, 2.5 million were newly diagnosed worldwide, and about 2.2 million of them were adults.<sup>[3]</sup> HIV is a disease that results in decreased chemotaxis, defective granuloma formation and maintenance, impaired antigen processing and presentation, and a generalized loss of CD4+ T cells.<sup>[4]</sup> HIV targets the immune system of the body and makes it weak to combat infection. AIDS is the third stage of HIV infection with one or more diagnosed opportunistic infections.<sup>[5]</sup> Oral manifestations

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associated with HIV or HIV treatment occur in 50–70% of all people living with HIV/AIDS (PLWHA) and can be indicative of the stage and severity of HIV infection. Such manifestations lead to pain and dysfunction in the mouth, and when not properly maintained or treated, they negatively affect systemic health and quality of life.<sup>[6]</sup> With improved survival rates, it is expected that more PLWHA will be seeking dental care in the near future. Because of the possible transmission of HIV through direct contact with blood, the risk of cross-infection comes into particular focus in dental practice.<sup>[1]</sup> The risk of occupational transmission of the virus from a patient to a healthcare provider has been estimated at 0.3% after a single percutaneous exposure to HIV-infected blood.<sup>[8]</sup> According to the WHO, it is imperative for all dentists to treat HIV-positive patients.<sup>[1]</sup> Dentists have a professional and ethical responsibility to provide treatment to patients with HIV and AIDS, particularly since oral lesions, such as hairy leukoplakia, candidiasis, and Kaposi's sarcoma, are commonly found in HIV-infected patients.<sup>[7]</sup> It is unethical and unlawful for a dentist or dental student to refuse to treat an HIV-positive patient. Few accidents are associated with treating HIV/AIDS patients, and it poses a significant risk to the dental student's health, career, and families and also to patients under their care. Hence, it is imperative to continue to gauge the level of HIV/AIDS knowledge among the dental students at regular intervals. The purpose of the present study is to assess the dental student's knowledge regarding HIV/AIDS, their attitude or willingness to treat, and practices to treat PLWHA.<sup>[8,9,10]</sup>

## METHODOLOGY

A cross-sectional study was conducted among the dental students studying in a private dental college in Nepal. The study was conducted for a period of 3 months from January 2023 to March 2023. Among dental students, only those who had begun patient care or previously had clinical experience were eligible to be surveyed. The student's participated were divided into three groups – Group-A: post-graduate, Group-B: Internees, and Group-C: Final year student. After a short briefing about the study, those students who were willing to participate in the survey were included in the sample. Students who participated in the pilot study during validity test of the questionnaire were excluded from the study. A written informed consent was obtained from all the study participants. Ethical clearance was obtained from the UCMS Ethics Committee before beginning the study. The questionnaire was developed from literature reviews and consulting with experts from other departments. A pretested, closed-ended question based on previously validated questionnaires from the literature was

used for the study. The questionnaire had 32-item consisted of 3 major elements included (a) HIV/AIDS knowledge questionnaire; (b) an attitude to treat HIV/AIDS patients; and (c) practices to treat HIV/AIDS patients. Everyone who participated was requested to provide information on their age, gender, and academic year. All the students participated voluntarily, and they were informed about confidentiality and anonymity. A closed-ended 11 questions about HIV infection were included in the survey to gauge respondent's knowledge. To respond to the questions, participants had two choices: Correct or incorrect. The questionnaire also included eleven additional items for assessing attitudes toward PLWHA. On a five-point Likert scale, the response was scored using the options strongly agree, agree, neutral, disagree, and strongly disagree. The scores for a positive attitude ranged from five to one and vice versa for a negative attitude. A positive, negative, or inactive attitude was defined as a score of 75% or more, between 50 and 75%, and <50%, respectively. Furthermore, ten-item questionnaire on a 4-point scale (strongly disagree, disagree, agree, and strongly agree) was used to assess the practices of treating PLWHA in this study. The scale ranged from 1 to 4, with higher scores indicating a stronger desire to treat PLWHA. A simple mean was used to get the composite score for knowledge, attitude, and wiliness to treat PLWHA. Data were analyzed using the Statistical Package for the Social Sciences version 22.0. Descriptive statistics were performed to describe demographic variables, HIV-related knowledge, attitudes, and behavior, and the findings were given in terms of percentage, mean, and standard deviation. One-way analysis of variance was used to examine the differences in knowledge and attitudes about HIV/AIDS between different groups. Pearson's correlation was used to compare knowledge and attitude, assuming knowledge as the predictor variable and attitude as the outcome variable. For all the statistical analyses, the probability of type I error ( $\alpha$ ) was set at 0.05. Hence,  $P \leq 0.05$  was considered statistically significant.

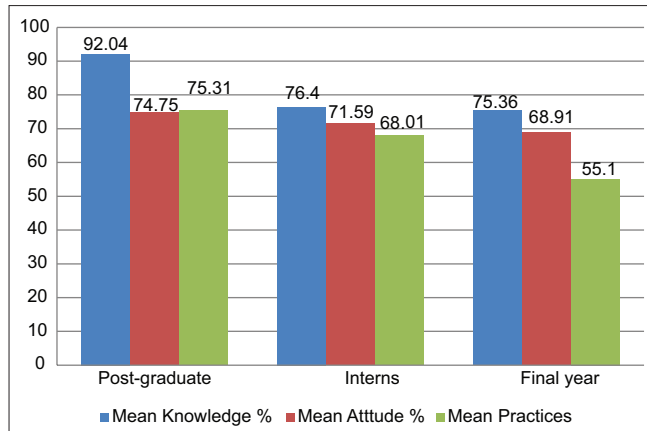
## RESULTS

The study was conducted among 200 dental students aged 21–28 years. 132 (66%) are between the ages of 21 and 24, while 68 (34%) are between the ages of 25 and 28. In this study, the females, 124 (62%), were more than the males, 76 (37%). Among the study participants, 123 (61.5%) students were studying in their final year, 69 (34.5%) were doing internships, and 8 (4%) were doing postgraduation [Table 1].

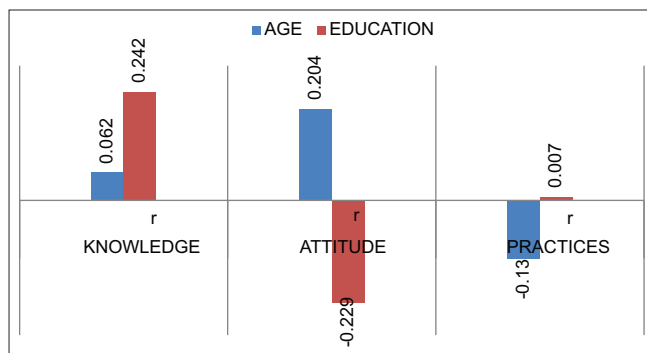
The maximum score (100%) was for the questions “Can HIV infection spread by touching, kissing, and sharing food

**Table 1: Demographic distribution of the population**

| Variables    | n   | Percentage |
|--------------|-----|------------|
| Age (years)  |     |            |
| 21–24        | 132 | 66         |
| 25–28        | 68  | 34         |
| Sex          |     |            |
| Male         | 76  | 37         |
| Female       | 124 | 62         |
| Education    |     |            |
| Postgraduate | 8   | 4          |
| Interns      | 69  | 34.5       |
| Final years  | 123 | 61.5       |



**Figure 1: Mean knowledge, Attitude, and Practice score (%) of study participant's toward people living with HIV/AIDS**



**Figure 2: Diagonal matrix correlations among variables**

and drinks?” and “Can HIV/AIDS patients be suspected from oral manifestations?” by post-graduate students, and the minimum score (44.7%) was for the question “Does a negative ELISA test rule out HIV infection?” by the final-year students [Table 2]. The majority of the postgraduates and interns showed excellent knowledge about HIV/AIDS as compared to their final years [Table 3].

The difference in knowledge score about HIV/AIDS in three groups (post-graduate – 92.04%, interns – 76.40%, and final year – 69.83%) was statistically significant ( $P < 0.05^*$ ) [Table 3]. Females (124) have a higher mean knowledge score (77.04%) compared to males (75.27%) [Table 4].

Out of 200 study population, majority use gloves while treating PLWHA, about 82% of population changes gloves between patients, 38.5% wear personal protective equipment (PPE), 36% participant’s change PPE in between patients, 93% participant’s change instruments in between patients, 86.5% participant’s sterilize instruments before it’s use while 43.5% participants perform extra sterilization before treating PLWHA [Table 5].

The majority of the students showed a negative attitude, except the postgraduates showed a positive attitude toward PLWHA. The attitude score ranged from 30 to 49 for the study population group, whereas difference in the attitude score of three groups (the post-graduate, interns, and final-year students showed the mean attitude score as 76.13%, 70.16%, and 64.1%, respectively) was statistically significant ( $P < 0.05^*$ ) [Table 6].

Out of the 200 study population, all the members use gloves while treating PLWHA whereas, about 82% of the population changes gloves between patients, 38.5% participants wear PPE, 36% change PPE in between patients, 93% change instruments in between patients, 86.5% sterilize instruments before use, and 43.5% perform extra sterilization before treating PLWHA [Table 7]. Difference in the mean practice score of three groups (the post-graduate, interns, and final-year students showed the mean attitude score as 75.30%, 68.01%, and 55.10%, respectively) was not statistically significant ( $P < 0.05^*$ ) [Figure 1].

Correlation analysis of age showed a positive relationship with knowledge ( $r = 0.062$ ,  $P = 0.053$ ) and attitude ( $r = 0.204$ ), which was significant, but a negative correlation with practices ( $r = -0.130$ ) [Figure 2]. Correlation analysis of years of study showed a positive relationship with knowledge ( $r = 0.242$ ,  $P = 0.001^*$ ) that was significant, a positive relationship with practices ( $r = 0.007$ ,  $P = 0.923$ ) but a negative relationship with attitude ( $r = -0.229$ ,  $P = 0.001^*$ ) [Table 8]. The correlation between knowledge and attitude is positive (0.137), but the correlation between attitude and practices is negative ( $r = -0.043$ ) [Tables 9 and 10].

## DISCUSSION

This study aimed to assess the knowledge, attitudes, and practices (KAP) of dental students regarding HIV/AIDS in a private dental college in Nepal. The response rate was notably high, with over 95% of participants completing the survey, reflecting strong engagement and interest in the subject. The majority of participants were between 20 and 30 years old, with a mean age of 24 years. The overall

**Table 2: Knowledge regarding HIV/AIDS among the study population**

| S. No. | Questions  | Post-Graduate N (%) | Intern (69) N (%) | Final Y. (123) N (%) |
|--------|--|---------------------|-------------------|----------------------|
| 1.     | HIV infection can spread by touching, kissing, sharing food and drinks?      | 8 (100)             | 57 (82.6)         | 101 (82.1)           |
| 2.     | Saliva can be a vehicle for transmission of HIV infection?                   | 7 (87.5)            | 43 (62.3)         | 76 (61.7)            |
| 3.     | HIV/AIDS patients can be identified by physical appearance?                  | 7 (87.5)            | 46 (66.7)         | 78 (64.2)            |
| 4.     | Needle stick injury can transmit HIV virus?                                  | 8 (100)             | 65 (94.2)         | 113 (91.8)           |
| 5.     | Aerosols from hand piece can be a vehicle for transmission of HIV infection? | 6 (75)              | 50 (72.4)         | 85 (69.1)            |
| 6.     | ELISA/TRIDOT tests are screening tests for HIV infection?                    | 7 (87.5)            | 46 (66.7)         | 82 (66.7)            |
| 7.     | Western blot test is a confirmative test for HIV infection?                  | 7 (87.5)            | 49 (71)           | 65 (52.84)           |
| 8.     | Medical and paramedical staff is more prone for HIV infection?               | 8 (100)             | 60 (87)           | 85 (69.10)           |
| 9.     | Treatment of HIV/AIDS patients requires special dental clinics?              | 7 (87.5)            | 57 (82.6)         | 100 (81.3)           |
| 10.    | HIV/AIDS patients can be suspected from oral manifestations?                 | 8 (100)             | 58 (84)           | 104 (84.6)           |
| 11.    | A negative ELISA test rules out HIV infection?                               | 8 (100)             | 47 (71)           | 55 (44.71)           |

**Table 3: Mean knowledge score to treat HIV/AIDS patients among study population**

| Educational level | Knowledge score (Mean±Std. dev.) | Min. | Max. | Anova  |         |
|-------------------|----------------------------------|------|------|--------|---------|
|                   |                                  |      |      | F      | p       |
| Post-graduate     | 20.24±1.414 (92.04%)             | 18   | 22   | -      | -       |
| Interns           | 16.81±1.656 (76.40%)             | 12   | 20   | -      | -       |
| Final year        | 15.35±1.692 (69.83%)             | 12   | 20   | -      | -       |
| Overall           | 17.46±2.640 (79.39%)             | 12   | 22   | 16.053 | 0.001** |

\*\*Correlation is significant at the 0.05 level (2-tailed)

**Table 4: Gender wise mean knowledge score of study population (n=200)**

| Gender  | N   | Knowledge score (Mean±std. dev.) | 95% Confidence interval for mean |             | Anova |   |
|---------|-----|----------------------------------|----------------------------------|-------------|-------|---|
|         |     |                                  | Lower bound                      | Upper bound | F     | P |
| Male    | 76  | 16.56±1.66 (75.27%)              | 16.18                            | 21.64       | -     | - |
| Female  | 124 | 17.04±2.16 (77.04%)              | 16.66                            | 17.42       | -     | - |
| overall | 200 | 16.86±2.00                       | 16.58                            | 17.14       | -     | - |

knowledge about HIV/AIDS transmission was encouraging, with 68–93% of participants correctly answering the questions. Interns and final-year students demonstrated high levels of knowledge (76.3% and 69.83%, respectively), though slightly lower than findings reported by Patil *et al.* However, postgraduate students exhibited even greater knowledge and a more positive attitude toward treating PLWHA, contrasting with the study by Chauhan *et al.*, which found lower knowledge but a higher willingness to treat HIV/AIDS patients.<sup>[11]</sup> A key finding was that more than 80% of participants correctly identified that HIV is not transmitted through casual contact, such as sharing food, kissing, coughing, or saliva exposure.<sup>[12,13]</sup> This is significantly higher than the study by Achappa *et al.*, where only 5–8% of medical and dental interns and 15–20% of nursing interns had this correct understanding. This suggests improved awareness among dental students in Nepal, possibly due to updated curricula and increased public health campaigns.

Despite these positive findings, gaps in knowledge remain, particularly regarding HIV testing protocols. For instance, only 44.7% of final-year students correctly identified that a negative ELISA test does not definitively rule out HIV infection. This highlights the need for targeted education on confirmatory testing procedures, such as Western blot and polymerase chain reaction testing, to ensure accurate clinical decision-making. While knowledge levels were satisfactory, attitudes toward treating PLWHA were less favorable.<sup>[14]</sup> The willingness to treat HIV/AIDS patients was observed in approximately 70% of participants, which is higher than the study by Dhanya *et al.*<sup>[4]</sup> However, a substantial proportion of students still expressed hesitation, similar to findings by Seacat *et al.* and Azodo *et al.*, who reported negative attitudes among dental students.<sup>[15,16]</sup> The study by Shankar *et al.* on medical students in Nepal revealed a similar pattern – while knowledge about HIV/AIDS was high, attitudes remained equivocal.<sup>[17]</sup> This suggests that despite understanding the scientific aspects of HIV transmission, underlying fears and stigma persist. The reluctance to treat PLWHA may stem from misconceptions about occupational exposure risks and inadequate exposure to real-life clinical scenarios involving HIV-positive patients. The Centers for Disease Control and Prevention recommends standard precautions, including wearing gloves, goggles, hand hygiene, and proper handling of sharp instruments. However, our study found that adherence to these guidelines was inconsistent. While 100% of students reported using gloves, only 38.5% used PPE beyond gloves, and merely 31.5% used extra PPE when treating PLWHA. These findings align with those of Zhong *et al.*, who reported low compliance with PPE usage and additional sterilization measures when handling HIV-positive patients.<sup>[18]</sup> An important concern is that many PLWHA do not disclose their seropositivity to healthcare providers due to fear of stigma or lack of awareness of their own status. This underscores the necessity for universal precautions in all dental procedures to protect both healthcare workers and patients from potential cross-infection. A positive correlation was found between higher education levels and

**Table 5: Attitude score regarding HIV/AIDS among the study population**

| S. No. | Questions  | Post-graduate (8) N (%) | Intern (69) N (%) | Final Y. (123) N (%) |
|--------|--|-------------------------|-------------------|----------------------|
| 1.     | It is my moral responsibility to treat HIV/AIDS patients?  | 100%                    | 92.7%             | 84.3%                |
| 2.     | One can safely treat HIV/AIDS patients?  | 87.5%                   | 80.3%             | 74.5%                |
| 3.     | I will treat HIV/AIDS patients for elective treatment?   | 87.5%                   | 91.5%             | 77.4%                |
| 4.     | Risk of HIV contagion is high, hence special precautions have to be followed to treat HIV/AIDS patients? | 100%                    | 82.2%             | 81.1%                |
| 5.     | Patients with HIV infection can lead a normal life?  | 87.5%                   | 72.5%             | 65.6%                |
| 6.     | Status of HIV infection of a patient should be disclosed to all the family members of the patient?       | 87.5%                   | 71.4%             | 68.9%                |
| 7.     | I will deliver emergency care to HIV/AIDS patients if need arises?                                       | 87.5%                   | 80.6%             | 74.7%                |
| 8.     | All patients treated in dental clinic should be considered potentially infectious?                       | 87.5%                   | 75.5%             | 68.7%                |
| 9.     | If I know my friend or my spouse has HIV infection, I end the relationship?                              | 12.5%                   | 21.4%             | 15.4%                |
| 10.    | If my colleague or assistant is HIV-infected I will stop working with him/her?                           | 37.5%                   | 26.24%            | 25.16%               |
| 11.    | Dentists with HIV/AIDS should not be allowed to practice?  | 62.5%                   | 77.5%             | 68.4%                |

**Table 6: Mean attitude score to treat HIV/AIDS patients among study population**

| Educational level | Attitude score (Mean±Std. dev.) | Max. | Min. | Anova |         |
|-------------------|---------------------------------|------|------|-------|---------|
|                   |                                 |      |      | F     | P       |
| Post-graduate     | 42.85±1.506 (76.1%)             | 45   | 40   | -     | -       |
| Interns           | 38.58±4.880 (70.16%)            | 49   | 30   | -     | -       |
| Final year        | 35.25±2.836 (64.1%)             | 45   | 30   | -     | -       |
| Overall           | 38.56±3.730 (70.12%)            | 49   | 30   | 5.77  | 0.004** |

\*\*Correlation is significant at the 0.05 level (2-tailed)

**Table 7: Practice to treat HIV/AIDS patients among study population**

| PRACTICES                                  | N   | %    |
|--|-----|------|
| a. Wear gloves                             | 200 | 100  |
| b. Change gloves between patients          | 163 | 81.5 |
| c. Wear PPE (excluding gloves)             | 77  | 38.5 |
| d. Change PPE (excluding gloves)           | 72  | 36   |
| e. Review patient’s medical history        | 168 | 84   |
| f. Change instruments between patients     | 186 | 93   |
| g. Sterilize instruments before use        | 173 | 86.5 |
| h. Wear extra PPE only when treating PLWHA | 63  | 31.5 |
| i. Perform extra sterilization with PLWHA  | 87  | 43.5 |

**Table 8: Mean Practices score to treat HIV/AIDS patients among study population**

| Educational level | Practices score (Mean±Std. dev.) | Max. | Min. | Anova |         |
|-------------------|----------------------------------|------|------|-------|---------|
|                   |                                  |      |      | F     | P       |
| Post-graduate     | 21.09±3.323 (75.3%)              | 28   | 14   | -     | -       |
| Interns           | 19.04±2.71 (68.01%)              | 26   | 12   | -     | -       |
| Final year        | 15.43±2.65 (55.10%)              | 24   | 12   | -     | -       |
| OVERALL           | 18.52±3.45 (66.10%)              | 28   | 12   | 4.99  | 0.008** |

\*\*Correlation is significant at the 0.05 level (2-tailed)

**Table 9: Diagonal matrix correlations among variables**

| VARIABLES | Knowledge |         | Attitude |         | Practices |       |
|-----------|-----------|---------|----------|---------|-----------|-------|
|           | r         | p       | r        | p       | r         | p     |
| AGE       | 0.062     | 0.381   | 0.204    | 0.004** | -0.130    | 0.066 |
| EDUCATION | 0.242     | 0.001** | -0.229   | 0.001** | 0.007     | 0.923 |

\*\*Correlation is significant at the 0.05 level (2-tailed)

**Table 10: Diagonal matrix correlations among variables**

| VARIABLES | Knowledge |       | Attitude |       | Practices |       |
|-----------|-----------|-------|----------|-------|-----------|-------|
|           | r         | p     | r        | p     | r         | p     |
| Knowledge | -         | -     | 0.137    | 0.053 | -0.65     | 0.363 |
| Attitude  | 0.137     | 0.053 | -        | -     | -0.043    | 0.547 |
| Practices | -0.65     | 0.363 | -0.043   | 0.547 | -         | -     |

\*\*Correlation is significant at the 0.05 level (2-tailed)

better KAP scores. Postgraduates had superior knowledge and more favorable attitudes than interns and final-year students, suggesting that increased exposure to clinical practice enhances confidence and reduces misconceptions. However, despite increasing knowledge levels with advancing education, adherence to infection control practices remained suboptimal. This supports findings from Poudel *et al.*, where healthcare workers displayed strong theoretical knowledge but often overlooked safety measures in practice. To bridge the gap between knowledge and practice, dental education must emphasize hands-on training, experiential learning, and case-based discussions. The recommendations could improve the KAP of dental students regarding HIV/AIDS. Students should gain more supervised experience in treating PLWHA to reduce fear and build confidence. Training sessions focused on stigma reduction, ethical responsibilities,

and universal precautions should be mandatory. Small group discussions and case-based learning should be incorporated to improve critical thinking and decision-making in real-life scenarios. Including an empathetic component in the curriculum has been shown to significantly improve attitudes toward PLWHA.

### Limitations

This study was conducted at a single dental institution, which may limit the generalizability of the findings. In addition, self-reported data may introduce bias due to social desirability effects. Future research should include a larger, multi-institutional sample and assess the long-term impact of educational interventions on students' attitudes and practices toward treating PLWHA.

### CONCLUSION

This study highlights that while dental students in Nepal possess adequate knowledge regarding HIV/AIDS transmission and prevention, negative attitudes and inconsistent adherence to infection control practices persist. Increasing exposure to real-life cases, strengthening infection control training, and implementing stigma-reduction programs within the dental curriculum are essential to preparing future dentists to provide competent and compassionate care for PLWHA.

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