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Situation Analysis of HIV/AIDS in Nepal

December 2000



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Acknowledgments

Richoi Associates would like to express its earnest and cordial gratitude to the Department of Health Services and National Centre for AIDS and STD Control (NCASC) for entrusting such a sensitive and valuable study to us.

The study team expresses special appreciation to all the individuals and institutions for providing time, information and insights, and sharing resources as well as for accessing their institutions from the design phase throughout the analysis phase of this study.

The study team is grateful and would like to thank Dr. Taranand Jha and Mr. Prachanda Man Shrestha of NCASC and Dr. Michael Hann of UNAIDS for their contribution and valuable suggestions to this study.

We are indebted to Help Group for Creative Community Development, Biratnagar, General Welfare Pratisthan (GWP), Chitwan, Central Jail, Kathmandu, Society for Education and Development Activities (SEDA), Pokhara, and Nepal STD and AIDS Research Center, Nepalgunj, for sincerely and unflaggingly organizing, managing, and facilitating the Round Table Discussions and Focus Group Discussions at various locations.

The study team would like to acknowledge sex workers, injecting drug users, rickshaw pullers and the people living with HIV/AIDS for providing their valuable time for the interviews and sharing their personal experiences.

Richoi Associates
Study Team

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Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
AZT	Azidothymidine (Zidouvedine)
BNMT	British Nepal Medical Trust
BPMHF	Bisheshwor Prasad Memorial Health Foundation
BTS	Blood Transfusion Services
CBO	Community Based Organization
CDO	Chief District Officer
CIAA	Commission to Investigate Abuse of Authority
CSW	Commercial Sex Worker
CWIN	Child Workers in Nepal Concerned Centre
DDC	District Development Committee
DHO	District Health Office
DOHS	Department of Health Services
DPHO	District Public Health Office
DSP	Deputy Superintendent of Police
EHDAG	Environment Health
FGD	Focus Group Discussion
FHD	Family Health Division
FPAN	Family Planning Association of Nepal
FSW	Female Sex Worker
GDP	Gross Domestic Product
GNP	Gross National Product
GWP	General Welfare Pratisthan
HAMS	Hospital for Advanced Medicine and Surgery
HDR	Human Development Report
HELP	Help Group for Creative Community Development
HIV	Human Immunodeficiency Virus
HMG/N	His Majesty's Government of Nepal
IDU	Injecting Drug User
IEC	Information, Education and Communication
ILO	International Labor Organization

INF	International Nepal Fellowship
INGO	International Non Governmental Organization
LALS	Life Giving and Life Saving Society
LDO	Local Development officer
LR	Literature Review
MOH	Ministry of Health
MP	Mobile Population
NAP	National AIDS Program
NCASC	National Centre for AIDS and STD control
NDCLEU	National Drug Control and Enforcement Unit
NGO	Non Governmental Organization
NGOCC	Non Governmental Organization Coordinating Committee
NRCS	Nepal Red Cross Society
PCP	Pneucystitis Carinii Pneumonia
PLWHA	People Living with HIV/AIDS
RTD	Round Table Discussion
SACTS	STD / AIDS counseling and Training Services
SCF	Save the Children Fund
SEDA	Society for Education and Development Activities
STD	Sexually Transmitted Disease
SW	Sex Worker
TB	Tuberculosis
TV	Television
UMN	United Mission to Nepal
UNDP	United Nations Development Program
UNHCR	United Nations High Commission for Refugee
UNICEF	United Nations Children's Emergency Fund
VDC	Village Development Committee
WHO	World Health Organization

Executive Summary

This study on Situation Analysis on HIV/AIDS was commissioned by the National Centre for AIDS and STD Control to assess the situation of HIV/AIDS in Nepal, with an eye toward developing strategic planning for HIV/AIDS. The study was conducted for the duration of three months, from August to October 1999. The analysis of the study was largely based on secondary data retrieved through literature review, focus group discussions, round table discussions and field visits.

The magnitude of the HIV/AIDS epidemic in Nepal seems to have been under estimated due to faulty surveillance mechanisms and poor data keeping. The discrepancy in reported versus estimated HIV/AIDS cases is a reflection of this gap.

There is no doubt that over the years, the prevalence of HIV infection has sharply increased, especially among sex workers and Injecting Drug Users. As a result, today Nepal faces a concentrated epidemic of HIV/AIDS. There is an absolute need to develop specifically -targeted intervention programs for these groups.

The mobile population -- largely be disregarded in the National HIV/AIDS prevention and control programs -- has clearly emerged as a new group vulnerable to HIV infection. The risks imposed by the mobile population to housewives and their offspring, born and unborn, as well as many others, may further expand and generalize the epidemic. A lack of adequate and effective control programs that specifically address the mobile population will only accelerate this process.

Situation Analysis has also identified other conventional groups (i.e. youths & adolescents, men who have sex with men, etc.) that are on increasing vulnerability to contracting HIV/AIDS. Simultaneously to the groups with highest HIV/AIDS prevalence as mentioned above, HIV/AIDS related issues of these groups also need to be seriously studied and addressed at the same time.

As the epidemic shifts more towards a generalized form, the number of People Living with HIV/AIDS is rapidly increasing. On top of this, care and support programs addressing the needs of PLWHAs are virtually non-existent, thus seriously denting existing efforts to address the overall HIV/AIDS situation.

The lack of functional co-ordination and networking among government undertakings and non-governmental organizations had led to ineffective and unsuccessful programs, thus further jeopardizing Nepali exposure to the HIV/AIDS epidemic.

Advocacy programs need to be spearheaded by prominent national figures, recognized by a large majority of the population, if maximum impacts and benefits are to be anticipated.

The gaps identified within each domain of this situation analysis seem to have been further stretched exacerbated by a lack of consistency in policy, continuity in leadership and credibility in the management of National HIV/AIDS program.

Overall, the situation of HIV/AIDS in Nepal is deteriorating day by day. If appropriate preventive measures are not promptly developed and implemented, HIV/AIDS will be the leading cause of death in Nepal within the next decade, triggering a major biological and social changes.

As concluded, the situation analysis has highlighted following major aspects of HIV/AIDS prevention programs that demands further response needs.

- The epidemic is still concentrated on two main groups: Sex workers and Injecting drug users. They must be treated as priority groups requiring immediate attention and targeted intervention programs, in order to control the transmission of HIV/AIDS to greater population.
- Concurrently to the priority groups, other groups (i.e. mobile population, spouse, adolescents and youths, etc.) also require further investigations and research on HIV/AIDS related issues because they are also vulnerable. These groups also need to be examined seriously because if not, the epidemic will take a generalized form.
- The success of HIV/AIDS intervention programs lies on the strength and capacity of various institutions involved. As mentioned above, institutional infrastructures within this sector is blatantly weak. All aspects of such institutions must be strengthened (including HIV/AIDS awareness activities among its workers, capacity building, management, advocacy, care and support, etc.) for successfully accomplishing the intervention programs on time, and before the epidemic spreads to the generalized population.

• Country Profile

Geopolitical and socio-economic features

• Total population	22 million	World Development Report 98-99
• Urban population	11%	World Development Report 98-99
Annual Average population growth (90-97)	2.37%	MOPE, 2000
Maternal Mortality Rate (per 100,000 live birth)	539	Department of Health Services, 2000
Infant Mortality Rate (per 1000 live birth)	64	MOPE, 1999
Estimated Average Life expectancy	58.25 years	Four Monthly Statistical Bulletin (CBS), 1999, series. 67, vol.2
Illiteracy Rate	Male: 59% Female: 86%	World Development Report 98-99
Per Capita GNP	210 (\$US)	World Development Report 98-99
Contraceptive Prevalence Rate	30%	WB Country Strategy Report 99-01
UNDP HDR	144	UNDP

Geographical Borders	The Kingdom of Nepal is situated on the Indian subcontinent, neighbored by two giants -- China in the North and India in all other directions.
Administrative Divisions	<ul style="list-style-type: none"> • 75 Districts • 58 Municipalities, 3913 Village Development Committees • Capital: Kathmandu
Special features	<ul style="list-style-type: none"> • The economy is small with low economic growth, low investments rates and a large informal sector. • Power alliances seem fragile with weak infrastructures, lack of human resources and development, high population movements, etc. • Almost 80% of the total population are Hindu. Diverse ethnic and cultural background. • Diverse geographic setting -- from the highest peaks in Northern part to low land in Terai, within span of 200 KM. • 42% (95-96) of Nepal's population lives below the poverty line according to the government data, whereas unofficial figures as estimated percentages to be more than 60%. • 20% of the country's population is adolescent, aged

between 10-19 years.

- Nepal's public health expenditure is 1.2% of GDP (90-95)
- Nepal has one of the lowest rates of utilization of health services in the world.
- Access to health services is limited because of difficult geographical terrain
- Leading causes of mortality are CDD, ARJ and many others.
- Rehabilitation, improvements and management of health services remain a key issue and a priority to MOH.
- Although government health institutions do exist at the grass roots levels, these institutions are at best providing minimal services due to limited human as well as other resources.
- HIV/AIDS programs are funded largely by foreign donation.
- Increasing funds and resources available for national institutions, NGOs and INGOs provide windows of opportunities to reestablish effective health institution.

HIV/AIDS epidemiological Situation

Background

- 1988- HIV/AIDS was first detected.
- 1987-88 Short term plan for AIDS prevention implemented
- 1990-1992 First medium Term plan for AIDS prevention and control implemented
- 1991 Sentinel Surveillance system introduced
- 1992 Counseling on HIV/AIDS introduced
- 1993-97 Second (multisectoral) Medium Term plan for AIDS prevention and Control (implementation).
- 1993 Safety of Blood introduced in policy
- 1994 First National AIDS and STD conference held
- 1995 National policy on AIDS and STD prevention issued
- 1997 Strategic Plan for HIV/AIDS/STD developed
- 1998 Second National AIDS and STD conference held

Initially, the districts of Central Region were mostly affected with HIV, gradually spreading to the eastern and Western parts of Nepal (Suvedi-1999).

Summary of HIV/AIDS Surveillance Data

	Data	Date
Year of first reported case of HIV/AIDS		1988
Estimated cumulative HIV infection	35,000	September 2000
Estimated Cumulative AIDS cases	*	
Estimated number of HIV infection	33,532	
Estimated number of HIV infection	*	
Estimated number of new AIDS cases	*	
Estimated numbers of orphans due to death of HIV/AIDS parents	25,00	WHO (1999)
Estimated numbers of deaths due to HIV/AIDS in 1999	2,535	UNAIDS
Estimated cumulative death due to HIV/AIDS until 1999	8,325	UNAIDS
Estimated HIV prevalence among adults (15-49)	0.29%	1999 (WHO)

*Please note that some of the figures are not available.

Cumulative HIV/AIDS Situation of Nepal as of Nov.30, 2000

HIV infection by Sub-group and sex

Sub-Group	Male	Female	Total
Sex workers (SW)	-	380	380
Clients of Sex workers/STD	1043	32	1075
Housewives	-	108	108
Blood Transfusion/Transplant	2	1	3
Injecting Drug use	192	1	193*
Parental Transmission	11	8	19
Total	1248	530	1778

HIV infection by age group

Age group	Male	Female	Total
0-5 years	10	6	16
6-13 years	3	-	3
14-19 years	64	143	207
20-29 years	712	276	988
30-39 years	370	87	457
40-49 years	77	17	94
50 and above	12	1	13
Total	1248	530	1778

*Mode of transmission IDU and sexual

Source: National center for AIDS and STD Control (NCASC).

These official figures represented above do not necessarily reflect on the intensity of HIV/AIDS problems in Nepal as our various forms of observations suggest.

Objective of the Study

The objectives of the study were:

1. To portray as well as analyze the existing dynamics of HIV/AIDS situation pertaining to various important aspects in context to Nepal.
2. To illustrate the gaps existing due to the wide spectrum of situations related to HIV/AIDS.
3. To identify the known and the unknown factors contributing to HIV/AIDS epidemic.
4. To highlight the national response needs which require further attention and which will, at a large scale, be reflected on the agenda for "*Strategic Planning for HIV AIDS in Nepal*".

Methodology

As agreed upon by the National Centre for AIDS and STD Control (NCASC), the following methods were used for the purpose of situation analysis of HIV/AIDS:

- a. Desk review
- b. Round Table Discussion
- c. Focus Group Discussion
- d. Institutional Interactions
- e. Individual Interactions (Key Informants survey)
- f. Observation of Physical Environment

Desk Review

The desk review -- or literature survey as it is often called -- was done from the very start of the study. All available materials related with HIV/AIDS situation in Nepal were collected, studied, and reviewed. Following this, appropriate information was collated for the purpose of the situation analysis. Most of the literatures were studies and researcher done by INGOs and NGOs including some government published documents. It must be pointed that a majority of these documents were rather old and did not necessarily represent the current situation of HIV/AIDS in Nepal. Following this, appropriate information was collated for the purpose of the situation analysis. A list of these materials is given in reference.

Round Table Discussion

Round table discussion (RTD) were held in Kathmandu as well as other sampled areas. These areas included Biratnagar, Bharatpur (Chitwan), Nepalgunj, and Pokhara. A total of nine Round table discussions were held. Each discussion, consisted of 8-12 participants, lasted for more than three hours and was facilitated by a knowledgeable professional.

In an attempt to gather relevant information with regards to IDUs, SW, MP, PLWHA, and care and support in context of HIV/AIDS situation analysis, fruitful Round Table Discussions comprised of various personnel working in the HIV/AIDS sector were engaged. A number of useful topics including shared experiences of knowledge gained through studies and research, ideas on designing policies and programs that proactively utilize the research data, and other relevant experiences comprised the output of these discussions. The multi-faceted backgrounds of the participants included individuals from government agencies, donor agencies, non-governmental agencies, and other individuals from different spectra working on the health and HIV/AIDS related issues. Please see Appendix I for details.

Focus Group Discussion (FGD)

Focus groups Discussions was held with various groups: Sex workers, Injecting Drug Users, Mobile population, and People living with HIV/AIDS. The discussions were held with targeted population in order to gain their personal insights and experience on issues related to HIV/AIDS, and to cross verify the issues that emerged during round table discussions (RTD) and literature review (LR).

Places, where FGD were held:

1. Central Jail at Kathmandu PLWHAs and IDUs
2. Biratnagar with IDUs, SWs, and PLWHAs
3. Bharatpur with Mobile Population
4. Pokhara with SWs
5. Nepalgunj with Mobile Population

The participants at the FGD consisted of 7-10 individuals, each representing their sub groups. Each discussion lasted for 2-3 hours. See Appendix I for details.

Institutional Interactions

The study team visited various institutions working in the fields of HIV/AIDS prevention and control. Various IEC materials as well as other research materials and reports were collected from these institutions for reference purposes. Similarly, feedback from these institutions also formed the basis of the report and supplemented the desk review, round table discussion, and focus group discussions. Please see appendix II for details.

Individual Interactions and Interviews

Various personalities were visited and queried vis-à-vis their views regarding the HIV/AIDS situation in Nepal as well as issues related to prevention and control. Their views are reflected in this report and also supplement the desk review, round table discussion and focus group discussion. Please see Appendix I for details.

Limitations of the Study

The research team felt that the chief fallback of this study was the duration allocated for the study. For a study that is sensitive, vital and occurs on a national level, three months does not allow nearly enough time to gather sufficient information and resources (i.e. visiting various places, contacting organizations outside the Kathmandu valley, gathering studies that are current, and meeting the targeted groups etc). Complicating matters further was the fact that allotted three months time included two major Nepali holidays, *Dashain* and *Tihar*, which further cramped the parameters of the study. Second, because it has not been until very recently that HIV/AIDS has been perceived to be a serious threat to the Nepalese socio-economic and environmental aspects, there have been a only limited numbers of studies done in this area. Most of the researches done is either very old or is specific only to certain geographical locations of particular groups. Furthermore, the majority of data that is currently available is inconsistent and lacking in uniformity. These factors make it difficult to develop comprehensive HIV/AIDS situation, at a national level, within three months.

Situation Analysis

Introduction

The actual situation of HIV/AIDS in Nepal would not be complete without examining the following important entities: sex workers, injecting drug users, the mobile population, People Living with HIV/AIDS and care & support programs. Nepal has concentrated epidemic with highest prevalence of HIV/AIDS among Sex workers and Injecting drug users. The significance of mobile population emerging as a bridging group vulnerable to HIV/AIDS and further transmitting from concentrated population to generalized population may be serious. Therefore, situation analysis has given a considerable attention to further examining their status related to HIV/AIDS issues. Focus group discussions, round table discussions, and literature review were engaged to analyze the situations faced by each of these specific areas. However, during the course of analysis, various other issues emerged.

The issues that have immersed are from more conventional groups like "youths", "men having sex with men" and "vertical transmission" and many others. Said groups, most particularly "youths and adolescents" as well as "men having sex with men," are socially and economically prone to a multitude of changes and, as such, become vulnerable to HIV/AIDS due to their knowledge, attitude, and behavior. It is also important to note that Nepal has one of the highest birth rates in the world, setting which has led to cases of infection through vertical transmission. Since children, adolescent and youths are the backbone of Nepal's development, it is extremely important to immediately identify and address issues that may cause serious damage to their life and adversely affect the entire country. HIV/AIDS being one of the sources of adverse effect on Nepali youth, the situation analysis has also attempted to illustrate the situations encompassing these conventional groups. Together, all these issues have been analyzed and presented below, alongside discussion of the implications looming for Nepal's HIV/AIDS predicament

Sex Workers

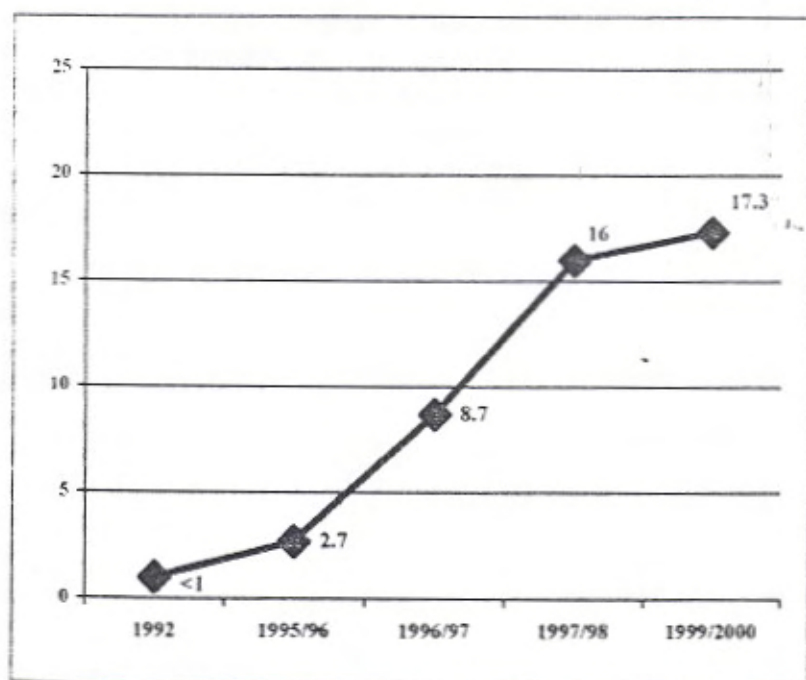
Sex work is defined here as a trade, exchange and or selling of a sex to people seeking it. It is an inevitable avenue for economic gain to people (especially women) with limited resources or access to social institutions. In Nepal, historically and to a certain degree culturally, sex work has existed for centuries. However, the magnitude of its status as a trend for fulfilling the means of economic necessity has risen exponentially in recent time. The escalation has come about for a number of reasons. Nepal's long borders to India and China (Tibet), an increasing demands for commercial sex work within the country, and the overall capitalist ideology of "sex sells" mentality that has pulled women of various backgrounds into the Nepali sex industry as an ultimate option for survival. The patterns of high migration to various cities have also propelled the industry.

Concomitant to the escalation of the Nepal sex industry has been an increase in both the supply and demands of sex workers and clientele. As such, a natural formation of non-monogamous sexual relationships involving multiple partners is observed as having increased. It is commonly accepted that the transmission of HIV/AIDS is catalyzed both through multiple sexual relationships and blood transfusion. This ironic confluence of two drastically different aspects of Nepali society has sadly maximized the vulnerability of sex workers (and their clients) to be identified as a group with partially defined by the high-risk sexual behavior which often lead to contraction of HIV/AIDS. Subsequently, there is an explicit as well as implicit need within the sex industry, as well as its related areas, to understand and analyze the situations faced by the sex workers as well as the dynamics of HIV/AIDS threatening thousands of their lives and the lives of their associates. To wit:

- It is estimated that between 5000 to 7000 Nepali girls are taken to Indian brothels every year. (Chameli, pg.1, 2000)
- 200,000 Nepali women are "prostitutes" in Indian Cities (Kathmandu Post, Aug. 6, 2000)
- There are about 33,000 Nepali girls in Bombay actively working as sex workers.
- In Nepal, there are between 12000 to 15000 women engaged in sex work, part time or otherwise.
- It is estimated that one-five HIV infected sex workers per day are forced back to Nepali borders. (ABC Nepal)

Female sex workers, as a group engaging in high-risk behaviors, have been a topic of discussion on HIV/AIDS since the initial realization of the HIV/AIDS epidemic in Nepal. Studies done in the early 90s indicated that two percent of all female sex workers in Nepal were HIV positive (RTD). Despite a decade-long focus to address this issue, the number sadly has climbed. A study done by SACTS shows that there is now a 17.3% prevalence of HIV among female sex workers in the Kathmandu Valley as indicated by the graph below.

HIV prevalence trends among FSWs 1992-2000
Source: SACTS



It is important to note that this statistic certainly is not representative of the scenario facing sex workers in the entire country. Although Kathmandu likely has the largest sex industry in Nepal, the HIV prevalence in other areas is suspected to be higher due to the minimal availability of and access to knowledge and resources.

Increasing multiple sexual contacts further intensifies the situation. The overall situation would be even more disheartening were the clients of sex workers to be studied together as a part of the larger sex industry.

Keeping in mind the gravity of HIV/AIDS prevalence among female sex workers and their clients in Nepal, attempts have been made to further illustrate the situations through the various activities as stated in the objective previously.

Substantive issues and outcomes:

The definition of the term "sex work" is clearly ambiguous. As interpreted in this study, a sex worker is someone who trades and/or sells sex for money and/or accessories. Sex workers can be full-time, part-time, girls who are trafficked to brothels, and another groups exploited for sexual favors.

Indications suggest that as social problems (i.e. poverty, unemployment, lack of access to social institutions/information, illiteracy, gender inequities, etc.) become more persistent, sexual exchange or sell also becomes an ultimate option for survival.

The number of female sex workers is increasing. The sex worker population is also highly mobile and heterogeneous. Sex Workers come from various backgrounds, though the majority hail from the lower socio-economic class, are married, and are between 15 and 28 years old. According to SACTS study conducted in Feb. 2000, in Kathmandu valley alone, 62% of female sex workers range between 20-29 years in age. The trend of street children being exploited and involved in sex work is also increasing within the valley. There are various groups of women who are identified as being vulnerable to HIV/AIDS due to the nature of their work and related issues of sexual exploitation. Specially, within the KTM valley and its metropolitan region, cabin and dance restaurants are mushrooming. Along with the delivery of relatively cheap food, some of these restaurants also satiate their customers with sexual appetite. Young girls, many of whom are migrants from other areas, are prone to these sexual acts. Thus, further increasing risks of contracting HIV/AIDS.

There has not yet been any serious effort on the part of either the government or any other organizations to specifically target the sex workers for intervention programs. Serious attempts to promote condom use, protect the sex workers from all manner of violence and to address issues many of their children face, are also lacking. Few lies on a proper collaboration, networking and capacity building within various institution ready to address sex work issues on condom promotion and proper usage, rehabilitation programs, negotiating strategies to promote client compliance on condom use, referral systems,

counseling for HIV/AIDS as well as care taking of HIV/AIDS sex work survivors. NGOs and other organizations are attempting to address these issues. However, until government takes a serious stand in favor of developing strategic planning for issues concerning their domain -- including working with regional/local level authorities to solve problems -- significant changes will not occur.

Legal/Protection

Various studies and interactions with the professionals show that there is a high level of sexual and physical abuse of the sex workers by the clients (and the police) and that there is a need for sex work to be legalized (RTD, FGD). A system of legalization would provide sex workers with better security; they would also be able to form organizations and develop specific agenda to address the issues concerning their domain.

As pointed out, significant numbers of clients do not like to use condoms. Consequently, frequent conflict arises between sex workers and their clients. A study done by New ERA in 1997 shows that about half of the sex workers in Nepal are sometimes or frequently forced to work against their will (pg. 107). The fact that clients are routinely intoxicated during their sexual encounters also tends to make their confrontation more severe. Fights between the clients and the sex workers are frequent, sometimes leading to physical and sexual abuse of sex workers. In these cases, first of all most of the sex workers don't know that they have

- i. The right to refuse having sex with clients who refuse to use condoms
- ii. The right to report rape cases during these situations

Reporting abuse to police is found to be rare because "unfortunately it seems that it was sex workers who were arrested but not the clients or *dalals* (pimps) who put them to such work (New Era)". If the police availed of the conflicts, both the sex workers and their clients are generally incarcerated. Given that clients are often financially privileged, they are often able to escape punishments by way of bribes. In these scenarios, sex workers end up in jail, often abused, with the "prettier" ones often being sexually abused by the police as well.

The lack of legal protection, abuse, and exploitation of this nature puts sex workers at a very vulnerable position. Often times, they develop so-called "adverse mentality" by which they refuse to use condoms knowing they can transmit HIV/AIDS to the clients, which the clients then spread to greater population. Moreover, many sex workers don't know about the intensity of the HIV/AIDS transmission and continue on having unprotected sex leading to spread HIV/AIDS. On the flip side of the coin, the clients refusing to use condoms and yet still having sex opens avenues of research, which needs to be examined. Most research and the studies done on this topic shows that most of the clients do not use condoms with their wives as well, thus increasing the chances of putting the "housewives" also at a high risk of contracting HIV/AIDS.

Case #11

A husband is a drug user as well as a client of the sex workers. His wife knows about this. She wants to use condoms during their sexual encounter. He refuses to use condom and physically abuses her for demanding that he use it. She wants him to get tested for HIV/AIDS; he refuses it. She wants to get a divorce, but there are legal and social restrictions. They both end up HIV/AIDS positive. (Case Study, RT)

Collective Mobilization

Dispersion factors involving sex workers, the lack of progress in formally recognizing prostitution as an organization, and hardship of working with sex workers because of ideological differences to reducing high-risk behavior, have each made finding a solution co-relating HIV/AIDS and female sex workers most difficult. Furthermore, because there are significant flaws in HIV/AIDS prevention methods among sex workers, serious attention is needed to develop proper rehabilitation centers and other necessary resources for sex workers. There is also a need to establish adequate pre/post test counseling services, as well as sufficient condom availability and usage among sex workers and their clients, and flexible laws and policies geared toward safety of sex workers. In this sense, there is an absolute need to seek attention for collective mobilization of sex workers as seen in other places i.e. Bombay. Collective mobilization would be a very fruitful method of preventing HIV/AIDS among the sex workers (RTD). To organize collective mobilization, it is concluded that:

1. *There should be serious motives from higher-ranking national bodies to develop collective approaches to address issues facing sex workers.*
2. *Emphasize should be placed on using local resources to work with certain sex work population at particular locations. As part of these processes, education should be stressed where in the sex workers could become peer educators who could then promote AIDS awareness among further population.*

Case#2

Historically, the female Badi population in western Nepal has been engaging in the sex business. Within this decade the government has tried to rehabilitate the population to discourage them from depending exclusively on the sex business as a primary economic livelihood. As a part of this process, the Badis were given land to resettle. However, what the government did not realize was that a piece of land and no other resources would leave the Badi population starving, especially since the majority of their income generating activities relied upon sex work. As a result of this economic deprivation, the Badi have dispersed and are moving to various areas looking for clients for as low as two to five rupees. Before the government's rehabilitation, they were permanently living in one place, were safer, to a certain degree society had accepted their profession, and they also had better as well as more consistent access to condom. The insincerity and lack of thoughtfulness involved in developing sustainable rehabilitation programs has forced the Badi women to seek economic survival, once again, by re-engaging in the commercial sex market. They have turned into a tragic moving market, looking for clients on the roadside bus stops, and jungles as well as various cities and villages. Because these sexual encounters take place under such absurd conditions, the condom use has significantly decreased. Aftermath of this has serious impact on spread of HIV/AIDS among clients and further population.

Condom Use/Issues

Studies show that condom use among the female sex workers and their clients is comparatively low. The low rate of condom use has to do with the clients not wanting to use condoms, lack of knowledge as well as indifferent attitudes toward transmitting or being transmitted with various sexual diseases including HIV/AIDS. Moreover, lack of reliable condom availability has helped depress condom usage.

Case#3

Generally, sex work starts at night. Most of the shops are closed by 9 p.m. For example, if a rickshaw puller gets a spontaneous urge to visit a sex worker, where will he buy a condom? On top of this, if he is intoxicated, he will also be less likely to seek out and buy a condom. This sort of inaccessibility of condoms, as pointed above undoubtedly leads to a unprotected sex, thus putting all parties involved at higher risk of contracting HIV/AIDS.

Condom promotion and pre/post counseling programs, as well as anti-violence programs, will only be successful if commanded and regulated by higher national authorities. Having direction and guidance from national figures would give a specific agenda and clear guidelines to examine a particular issue, which also makes networking and coordination more efficient.

Examining the case study and all the other aspects that is related to condom use, certain aspects are vital to implement:

1. *There should be laws and policies geared toward safety of sex workers and develop more women friendly laws that discourage harmful behavior and encourage them to invoice and assume responsibilities.*
2. *The police and other administrative bodies should be trained to work with the clients and the sex workers to promote the use of condoms, fairly and equally. The role police can play in terms of motivating the sex workers and clients for positive behavioral change and overall creating a safe environment was felt it could be very influential (RT).*
3. *There should be laws focused toward clients and they should be interpreted and enforced.*

The long-term goal in terms of HIV/AIDS prevention programs should focus on promoting sex education to people of all groups. For this, mass awareness is necessary. To promote mass awareness, there is a need to strengthen the overall infrastructure of Nepal, mostly specifically health, education and communication institutions.

Some of the highlighting patterns concerning female sex workers:

1. Sex workers self-teach themselves to become sex workers.
2. The vast majority of sex workers join the business because of economic reasons and lack of any other alternatives. For most of them, their income from selling vegetables or alcohol is not enough to fulfill even their basic necessities. In this sense, sex work provides financial supplement.
3. A significant number of sex workers are separated from their husbands. The main reasons for their separation is because a) their husbands had married another woman and b) they were alcoholics and abusive. Although separated, most sex workers are often having sex with their husbands. Some also have client/husbands (who are often abusive) and are sexually active with them.
4. Sex workers have (had) bad relationships with their husbands, whether in the past or the present.

Case-4

One of the sex workers, who are two months pregnant, is beaten up by her husband everyday. He kicks her on stomach, punches her, and often even locks up her inside the room all day. Sometimes, he does not let her eat. She reported she feels very weak and tired. On top, he has taken away all her money and the jewelry she stole from her parents (before she ran away with him) and sold it. She was starving for three days once and that is when she decided to engage in sex business. (Pokhara, FG)

5. Most sex workers with children are independently raising their children without any support from their husbands, including the children born out of sexual encounters with the clients.

6. Sex workers have had multiple abortions. Abortions in Nepal is not legal (until without husbands consent). Most sex workers therefore end up getting unsafe and unsanitary home based abortions, thus increasing the risk of HIV infection.
7. Condom use between sex workers and their husbands or client husbands is virtually non-existent.
8. In Pokhara, the sex workers reported that after they have gone through SEDA training, they use condoms with every client at every encounter. They also said that most of the clients at first refuse to use condoms, then later agree to it upon explanation about infectious sexually transmitted diseases.
9. Most sex workers do not use any kinds of drugs. However, large percentages drink alcohol, often as an escape for them from worries.
10. Sex workers think about suicide frequently.
11. Significant populations of sex workers at some point have tried alternative employment opportunities, but could not solely depend on it. Therefore, they ended up doing sex work as a side job. A study done by New ERA in 1998 shows 56% of female sex workers are working other side jobs.

Case 5

One of the sex workers sells vegetables and runs small hotels in the morning and afternoon. At night, she engages in sex work. Even with all the money she makes, she is not even able to provide a basic, nutritious diet to her three children. She cannot even afford to buy medicine when they are sick; sending them off to a school, sadly is only a beautiful dream for her. She expresses that she does not want her children to go through the same life she has gone through and does not want them to follow in her footsteps. (FG Pokhara)

12. It is important to highlight that a lot of time their money is taken away by clients after the sexual encounter takes place or they are not paid at all. The confrontation generally ends in sex workers being physically and sexually abused.
13. The pattern has been that their clients frequently abuse the sex workers. Most of the abusive clients are rowdy young men who also use alcohol and drugs (i.e. marijuana and hashish) as pertaining to focus group in Pokhara.
14. There are limited numbers of friendly places (including social agencies, hospitals, etc.) for relaxing, releasing stress, examining health conditions, and testing for HIV/AIDS or STDs for sex workers.
15. As in case of Pokhara, most sex workers did not know about the transmission of HIV/AIDS before they were involved with SEDA. In general, sex workers seem to have heard about HIV/AIDS but did not have good ideas about what it was and how it is transmitted.

Implications

There are certain implications of these information gathered during the focus group meeting, round table discussions and literature review.

1. Sex work becomes an ultimate survival option for women with less or no access to social institutions and resources, automatically putting them at a higher risk of HIV/AIDS with high-risk sexual behavior.
2. There are various gender dynamics between sex workers, their husbands, lovers and the clients that plays out to worsen the situations for them, thus increasing the vulnerability to HIV/AIDS at a higher degree.

3. Various targeted awareness activities including sex education seem to have promoted condom use among the sex workers. Mobilizing trained sex workers to seek other sex workers is most effective in strengthening consistent condom use practices and promoting life skill training. A report by FHI/Nepal of September 2000 also suggests "a consistent use of condom by sex workers with the immediate last client has increased significantly between surveys" due to targeted intervention on highway routes.
4. A lack of a safe environment, minimum protection (by police or any other governing bodies) against abuse and maximum social instabilities in their lives has made them more vulnerable to HIV/AIDS.
5. There are limited resources (including organizations) where they can access complete and accurate information on HIV/AIDS related issues. This flaw in organizational infrastructure once again puts them at higher vulnerability level to transmit or to be transmitted with HIV/AIDS.
6. A good support system including a place for their health examinations, counseling centers on STDs, HIV/AIDS, building a self-esteem and treatment for psychological issues, depression, violence etc is also virtually non-existent.
7. Children of sex workers are also growing up with lack of education and access to information and various social institutions. They are living in filthy and unhealthy environment that promotes violence, abuse, alcoholism and drug use. In addition, lack of good role models in their lives to boost their self-esteem and confidence also triggers the conditions at which they are more prone to high risk of HIV/AIDS.
8. A large number of clients also don't have access to resources in terms of visiting or contacting organizations that particular deals with sex workers-clients related issues. Furthermore, patriarchal cultures like Nepal's, where romanticism of male domination is so persistent, encourages, excuses and often, does not question irresponsible sexual acts committed by some of fellow Nepali boys and adults. The idea of "machismo" as perfectly complimented by an old Far Western Nepali proverb "marda lai bhirangi, namarda lai luto" undoubtedly creates situations where they sometimes put themselves at high risk of HIV AIDS and often times, transmitting others with it. Lack of proper gender and sex studies at school and homes as well as a lack of education on having a healthy relationship with wives or lovers also affects the kinds of choices they make in life (i.e. not wanting to use a condom, having multiple wives). Further making them more vulnerable to HIV/AIDS.

Analysis and needs

Sex work has existed in Nepal for centuries. This is not something that government can control or eradicate. There is an overall assumption that in Nepal, there are not as many sex workers (like for example in India); people also do not tend to think that a significant numbers of husbands, brothers, fathers etc. tend to visit sex workers frequently. The situation analysis has highlighted a gap between perception and reality on these issues. In reality, they do visit sex workers, mostly secretly. In the same vein, because sex workers are highly dispersed and unstable, much of instabilities in their lives are caused by their

mobility looking for clients, without whom their economic survival is impossible. These instabilities in turn, limit and constraint their access to social services and information. The majority of institutions including police official feel (RTD, FGD) that because they are not de-criminalised and organized groups, it is hard to mobilize them with collective agenda and develop targeted intervention programs.

Keeping these gaps in mind, various professionals working in the field of HIV/AIDS express that the organizational and de-criminalised sex work would allow sex workers to protect themselves from social barriers and abuse which causes better stability in their lives and further helps to mobilize their own community by actively participating in it. Furthermore, it would also help them to pinpoint the problems within their own domain and seek necessary actions to solve the problems including HIV/AIDS. However, since this is not the case, factors of instability, dispersion and lack of organizational identity of sex workers creates situations in which they are exposed to highest prevalence of HIV/AIDS.

Response Needs

Sex workers need

- National leadership and political commitment at the highest levels to address the sex workers' status in Nepal.
- Their involvement in networking and coordination about issues related to sex workers.
- network of extensive services around places where they are more likely to live and have sexual encounters.
- Commitment of proper guidance and resources for them to form organizations at the national level.
- A nationally supported and coordinated effort is needed to raise consistent condom use in high-risk sexual settings to at least 80%-90%.

It is evident that the *condom use among the sex workers and the clients* is significantly low. A recent study done by SACTS shows that within Kathmandu valley, only 18% of sex workers out of sample size of 300 say that all their clients use condom, while 53.7% say that most of their clients use condom (SACTS, Feb. 2000). Moreover, a study done by New ERA with 196 commercial sex workers from Baitadi in the Far Western region to Jhapa in the Eastern region and 65 CSWs in India shows that only 51.3% of them were using condoms with all their clients whereas only 21.5% of them were using condoms with most of their clients. It is important to point out that 8.8% of them had never used condom, all of the informants for this working in Nepal.

According to various sources, the low rate of condom use has to do with clients not wanting to use condoms for pleasure. In the same study done by New Era, 20.4% of sex workers in Nepal reported that they could never refuse to have sex with clients even if they did not want to. The percentage of sex workers who can always and generally refuse if they did not want to have sex was significantly low of 5.6% & 9.7% respectively.

According to various individuals and studies, sex workers have less negotiating power to use condom because their clients disliked it. Another study showed that 14% of CSWs were not aware of condoms, 11% did not want to use condoms and the non-availability of condoms was questions by 14% of the SWs in Nepal (New ERA, pg. 73, 1997). All of these factors create situations that make difficult for the sex workers to protect themselves from HIV/AIDS.

Response Needs

Sex workers need

- More information about responsible sexual behavior
- Condoms marketed with them in mind
- Access to condoms and other services
- Training on handling clients and developing negotiation power.
- Non-governmental organizations and governmental institutions to play a key role in ensuring non-discrimination and respect for human rights and in sustaining progressive policies of behavior change.

Children of Sex workers

Most of the sex workers are married with children and are single parent. A vast majority of the sex workers and their children live in extremely unfavorable social environment where alcoholism, drug use, violence is persistent. Moreover, they have minimal (or no access) to various services and resources, including educational institutions. A lot of time they internalize these flaws of society and for lack of better alternatives, end up following what they have experienced and witnessed in their childhood. The crisis of proper social conditioning as propagated by lack of proper guidance to their children, absence of good role models, lacking opportunities to information and social institutions also puts the children of sex workers at vulnerable position of HIV/AIDS.

Although children of sex workers are significantly affected by the wrath of HIV/AIDS pandemic, there are only very few studies done on this area. In this sense, there is a tremendous gap in terms of information dissemination and the actuality of the problems related to this area. Thus, creating an absolute need for examining this area.

Response Need

Children of sex workers need:

- Various surveys and studies done on them to find out about the what their struggles and needs are.
- Better access to social institutions like health care and education.
- Greater attention from national level authorities to solve their problems.
- Programs and services related to boosting their self-esteem, confidence and life-skill training.

Clients of sex workers

A study done by New ERA outside of KTM valley with 410 sex workers in four study sites shows that the most frequently reported client types were transport workers (drivers and helpers), migrant workers, rickshawala, businessmen and policemen (pg. 14, May 2000). Like this study points out, most of the clients are as well highly mobile. They belong to all age groups and a majority of them tend to be married. Significant numbers of Nepali males are clients of sex workers.

The problem has been that there are not many studies done on the clients; because, until very recently clients were not openly discussed and were not perceived to be at high risk of HIV/AIDS. There is a gap between perceptions and realities about the clients. There is no denial to the fact that sex business thrives on its clients. As long as there are clients, sex work will continue. The condom use among the clients with sex workers is very low and most of the clients when engaging in sexual acts with their wives virtually never use condoms. In this sense, they play a significant role as a bridging population to transmit HIV/AIDS from the high-risk behavior groups (i.e. sex workers) to general population (i.e. housewives).

Although some clients may have access to condoms and other services, a significant numbers, however, don't. Moreover, clients as a dispersed groups who are difficult to be identified, makes it even harder to develop effective programs for HIV/AIDS prevention. All of these factors make them vulnerable to HIV/AIDS.

Response needs

Clients need:

- A study done on (and about) them to speak targeted intervention.
- Access to information about responsible sexual behavior
- Condoms marketed with them in mind
- Access to condoms and other services at times and places when it is need.
- Partner's counseling (i.e. husband-wife) on condom use, issues related to HIV/AIDS and other sexually transmitted diseases.
- An important mechanism for monitoring compliance among sex workers and clients.
- Organizations and social services geared toward addressing the issues related to HIV/AIDS and clients.

Housewives

A whole another entities of sex business, who directly or indirectly affected by the fatality of HIV/AIDS who are rarely discussed in the literatures, are the housewives (spouse). Although never researched on their vulnerability to HIV/AIDS, as most professionals working in the fields of HIV/AIDS point out that housewives are the most significant generalized population infected with HIV/AIDS and also are highly vulnerable. Generally, spouses at risk are categorized into two groups.

- a. **Spouse of clients:** These are groups of women whose husbands are frequently visiting sex workers and also having sexual encounters with their wives at home. Since clients are engaged in non-monogamous sexual relationships with multiple partners, most probably having unprotected sex, they are likely to transmit their wives with HIV/AIDS. In general, these housewives are monogamous. A study done by WHO shows that among married women with HIV positive in South Asia, 90% are monogamous and have had one sex partners throughout their lives. Studies on STDs in Nepalgunj have also pointed out that a lot of time when a housewife is infected with STDs, she is blamed for "sleeping around with other men". In actuality, a lot of time, her husband transmits her. In this sense, there is a gap again, in perception and realities on this issue. Some housewives are already infected with HIV/AIDS, others with STDs that may increase their risk of HIV infection. A vast majority of housewives are illiterate and do not have access to services that would protect them from HIV/AIDS.
- b. **Spouse of migrant workers (and/or foreign employees):** In dominant Nepali culture, married women are not supposed to engage in extramarital sexual affairs so they are believed NOT to be at high risk of HIV/AIDS. There is a gap in perceptions and realities on this issue. Recent arguments and discussions has been that there are married women (housewives) who engage in extramarital affairs, especially in communities where husbands have migrated to another city or a country for a long period of time. The lack of sexual intimacy between husband and wife because of them being separated causes instabilities in their sexual relations as well as financial status, leading housewives to 1) seek sexual pleasure from someone else and/or 2) to have sex with multiple partners as economic supplement to their needs. Sex with multiple partners and often, lack of access to information and condom affects their abilities to protect themselves from HIV infection.

Response needs

Housewives need:

- Studies on sexual behavior of housewives.
- Studies on their HIV/AIDS health status and its related areas.
- More information should be provided on how HIV/AIDS is transmitted and responsible sexual behavior
- Condoms marketed with them in mind
- Access to condoms and other treatment services
- Partner counseling and training at local and community level to enhance better relationships with their husbands (or wives) and to motivate them for condom use.

Obstacles and opportunities

<i>Need:</i>	<i>Obstacles:</i>	<i>Opportunities:</i>
<ul style="list-style-type: none"> • Responsible sexual behavior education 	<ul style="list-style-type: none"> • Low literacy rate and lack of awareness among the people who are involved in high-risk behaviors and also among people who are at high risk. 	<ul style="list-style-type: none"> • Ministry of education and health, local bodies and non-governmental organizations favorable • Precedent for HIV/AIDS messages on TV, radio and through medium of post

	<ul style="list-style-type: none"> • Absence of responsible feelings about one's actions toward danger of transmitting HIV/AIDS to other people • Access to information is very minimal and so is the seeking behavior for it on parts of sex workers, clients and/or any other vulnerable groups. 	<ul style="list-style-type: none"> ▪ and pamphlets. ▪ Promotion of sexual behavior and sex education through village to village drama, folk songs, dances, etc.
<ul style="list-style-type: none"> • Condoms that are friendly to targeted population 	<ul style="list-style-type: none"> • Condoms have a bad image. • Proper utilization of condom is lacking 	<ul style="list-style-type: none"> ▪ Interest in market from private sector firms with marketing expertise under a national supervision ▪ Health ministry, local health institutions can promote 100% condom program nation wide like in Thailand. ▪ Promoting condoms both for only as a method of family planning and for prevention for STDs/HIV.
<ul style="list-style-type: none"> • Access to Condoms 	<ul style="list-style-type: none"> ▪ Accessibility to condoms is also minimal and they are not accessible when and where it is needed. ▪ A wide range of young people (including clients, married women and men) are often denied free condoms. ▪ Police arrests if caught with carrying condoms. ▪ Open market condoms relatively expensive, low quality 	<ul style="list-style-type: none"> ▪ Private sector interest (including profit and non-profit organizations) ▪ Ministry of health favorable. ▪ Since police and other experienced workers presence exist in almost all villages, their utilization to make condoms accessible.
<ul style="list-style-type: none"> • Access to services 	<ul style="list-style-type: none"> ▪ Many sex workers, clients, housewives, etc. have undiagnosed STDs, HIV. ▪ Lack of services and resources in various towns and villages ▪ Unmarried excluded from reproductive health services and other information related to this. 	<ul style="list-style-type: none"> ▪ Creation of voluntary testing based on counseling services in various areas of Nepal ▪ Service provision infrastructure adequate (but not enough) and therefore, must be reoriented ▪ Health institutions exist throughout the entire country ▪ A lot of "street medicine" and/or "homey medicine" to self-treat HIV/AIDS. Possibility for working with street sellers to provide information on safe behavior.

Injecting Drug Users

Use of narcotic drugs in Nepal has existed for centuries from mythical era of gods and goddesses to the present day *kaliyug*. Although reasons and types of narcotic that prevailed have dramatically changed over the period, its utilization has rather alarmingly escalated due to criminalization of cannabis and easy availability of other cheaper substitutions for drugs. Furthermore, availability and increase of dependency on pharmaceutical drugs have led to induction of users from different sects of society,

different age groups, and different walks of life in urban as well as rural settings throughout Nepal.

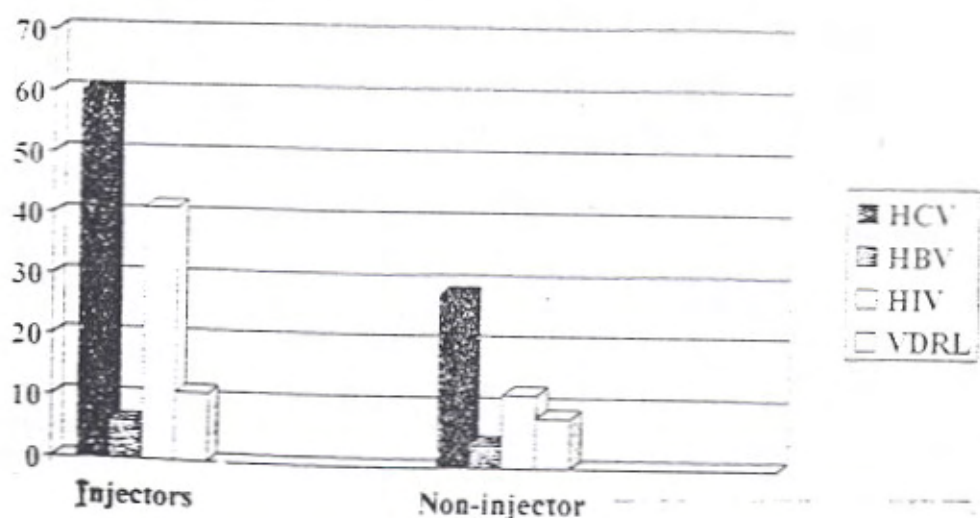
Types of Drugs currently being used:

SN	Name of Drugs	Percentage
1	Tidigesic (Buprenorphine)	65.2
2	Nitrazepam	46.1
3	Phensidyl	30.3
4	Marijuana	42.3
5	Heroin	15.9
6	Hashish	15.9
7	Tidigesic - Nitrazepam	6.9
8	Phensidyl - Nitrazepam	4.2

Source: Proceedings of the Workshop on Harm Reduction Program, NCASC, June 1999

Injecting Drug Users (IDU) with their (high) risk behavior along with people involved in the sex trade, particularly Sex Workers are identified as being most vulnerable to HIV/AIDS epidemic in Nepal. Studies from early nineties disclose that 2 % of IDUs being HIV positive. Unfortunately, recent studies (1998/99) reveal that trend of HIV positives among IDUs demonstrates sharp rise reaching to 49% being HIV positive.

Prevalence of HIV, HBV & HCV among Drug Users



Sadly, despite the efforts of government or non-government sectors to address and intervene HIV/AIDS issues related to IDUs, the numbers of IDUs still continues to rise. An effort to curb HIV cases among IDUs in Nepal, particularly as a part of needle exchange program, was globally lauded and made example. The government's as well as other players' lack of efficiency to capitalize on such internationally appreciated effort is causing a continuous increase in positives among IDUs throughout Nepal. Dr. Swaroop Sarkar, Technical Adviser, UNAIDS, New Delhi pointed out the fact that the efforts of LALS (a Nepali NGO, working with IDUs) would have probably delivered more results had the donor community not only encouraged its initiation but continued with support while the program was achieving tangible results. (Harm Reduction Workshop, Kathmandu, June 1999). Unpopularity of internationally acclaimed efforts by LALS based on a notion that harm reduction does not necessarily reduce drug habits or risky behavior, and because, usage of drug habits in itself is perceived as an illegal act, getting government's endorsement was reported to be technically difficult. Because harm reduction program in Nepal has been extremely stigmatized, attempts to provide substitute drugs by mental hospital is even experiencing immense difficulty due to shortage of human and financial resources.

Substantial issues raised in the Round Table Discussion

One important fact that was brought up was regarding the actual number of drug users in Kathmandu Valley, or in Nepal as a whole. Manner in which data is collected has possibilities of inclusion of same drug users repeatedly. This is due to data being gathered through various NGOs and treatment centers that users are associated within different form. Thus leaving room for criticism on size of the said group. In any event because of high percentage of IDUs are HIV positive, even the lower end of estimated drug users make the number of HIV infected people rather high in the context of Nepal.

Although drug users particularly IDUs, claim that they do not seek sex with FSW, non-injecting drug users do visit female sex workers. Data presented at Harm Reduction Workshop in June 1999 indicated that 72.2% of dug users had premarital sex with multiple partners and 64.7% without using condom. Thus, they (if positive) might have been categorized as in the same users as IDUs being positive. Contrary to claim, as reflected in various studies a recognizable percentage of IDUs visit the female sex workers. This is complemented by a discussion that a number of female drug users turn to commercial sex work mostly to support their habit and some are forced by their spouse to support his habit. In addition, people who are using non-injecting drugs are visiting FSW and possibly contracting HIV/AIDS through sex. Those who are subsequently labeled and categorized as positive IDUs, conforming with the fact that they might have contracted while sharing needles.

In regard to such rapid increase in drug use, specifically injecting drug, is attributed to escalation of price and unavailability of heroine in Nepal. Thus, cheaper and easier access to narcotics was gained through other readily available injecting drugs.

An another serious aspect of IDUs' relation to HIV is to economically deprived street children who are most vulnerable within the vulnerable groups of IDUs in transmitted with HIV virus. Street children's development of drug habits are almost always result of working as "go-getters" between drug dealers and users, where most of the time, they are compensated in form of drug for their work.

A proper treatment centre is a must for IDUs. Non-government sides are not always able to deliver treatment packages due to limitations in resources and policies. Unfortunately there is not any tangible effort from the government to establish either of these. Treatment center with services for pre and post rehabilitation to health care support is needed to provide the IDUs with continuous support they require.

Findings of Round Table Discussion (Biratnagar)

Although, rapid growth in HIV/AIDS epidemic is realized, a lack of proper coordinated effort seem to have created confusion leading to frustration and dismay on the issue.

As much emphasis and activities are being launched in the name of HIV/AIDS, questions are being raised whether these efforts have fallen in right places. As expressed during the Round Table Discussion, the pattern is that awareness and education effort are geared and focused on "same groups" repeatedly rather than trying to widen the base to make awareness program more successful. Grass root level population has received minimal awareness messages. Nevertheless, this population is more likely to indulge in risky behavior without (proper) knowledge of HIV/AIDS and resources related.

In addition, evidences of wrong interpretation or an ineffective awareness campaign is also cited from time to time.

Case - 6

A person from a village in eastern Nepal was given condoms as family planning method, which he took home and was taking it orally; before realizing told after twenty-four days what its proper use was'

Police and other institutional networks including schools could also prove to be effective information dissemination mediums. For example, police presence exists at least in most of VDCs of the country, messages would, without failure reach the local level. Message disseminated in this way would also be uniform. However, a training program and methods of information dissemination have to be provided to such personnel.

Furthermore, informed groups too are not demonstrating any behavioral change in regard to HIV/AIDS requiring to rethink the credibility and effectiveness of such programs. In this sense there is a need to assess the programs as well as people who provide training and people being trained. Training awareness programs are needed for the elected officials and academician at grass root/local levels where their voices are more influential and effective.

Academic institutions particularly high schools and colleges (that consist of a population who are experimental with different things), should also be targeted in awareness

campaigns. These institutions have student bodies from every corner of the region, providing opportunity for wider coverage of messages.

Unfortunately, due to the "taboo" associated with this subject, messages disseminated are often incomplete. The depth of expression needed to make it a complete information is lacking. Thus, misinterpretation of information occurs.

There is a general need to enhance a greater availability of care and attention to HIV/AIDS patient. Proper counseling is an absolute necessity whether before or after taking test for HIV. Lack of counseling is a big void in effectiveness of care and support to HIV/AIDS patients. Sadly, health care providers' attitude and manner in which they provide care has shown discouraging picture. Doctors and other medical personnel have their own difficulty, as they are extremely vulnerable in absence of precautionary measures.

Findings of Focus Group Discussion (Biratnagar)

Although drug users have increased, types of drugs used have narrowed. It is estimated that in Biratnagar area (Dharan and Itahari included) there are around 10-15000 drug users (as mentioned in the Focus Group) and mostly comprising of IDUs. Majority of people addicted to drugs eventually resort to injecting drugs. All start out with lesser form of drugs, usually pharmaceutical such as Phensedyl, and shift to injecting drug such as Tidigestic. Reasons disclosed for this particular kind are almost always due to its low cost coupled with easy accessibility.

In Jogbani, a bordering town in India, various drugs are readily available in almost all pharmacies and *pan pasals*. Furthermore, police authorities overlook drug-uses and it has made the use of drugs much easier. Reasons cited for drug addiction are: a) peer pressure where they start out by just wanting to find out about it b) family reasons and c) as go-getters and runners for the dealers.

Drug addiction has crossed over all kinds of boundaries. People from all family backgrounds, caste, socio-economic status or educational status have been drawn to this ill habit. People from poorest of the poor, uneducated, rickshawallahs to civil servants and medical doctors have fallen prey. However, people of lowest level income bracket are more vulnerable to HIV/AIDS transmission due to their wider practice of needle sharing as they can not afford new needles every time. However, this does not rule out people with affordability to escape from the risk as "moment of need" overlooks money or any reasoning. Thus even people who are informed about possible harm are resorting to risky behavior through needle sharing and unsafe sex practices.

According to participants in the Focus Group in Biratnagar, 80-90% of the drug users in that areas are HIV positive and these positives are sharing needles with 4-5 people on daily basis.

Transmission through sexual contacts with sex workers, in either party being transmitted in minimal as IDUs claim that sex is last thing in their mind while using drug. However, there are other drug users who frequently visit sex workers or most of the IDUs are either married or have a sexual partners. Condom use seems to be virtually non-existent. In addition, there are cases in this region where sex workers are also IDUs usually access drugs by sexual favors as well. Furthermore, there is a reported case where a spouse is forced to have sex with others so husband can support his habit.

Health conditions of IDUs are almost always in poor state as the habit deteriorates their health. Seeking medical help is not the priority since money needed to visit doctor and medicine supports their drug habit for longer period. Sadly, when medical help is sought, they usually are overcharged or given less attention.

Voluntary testing, although recommended by NGOs and other organizations, is realized to be too cumbersome of a process and is expensive. Provision for free testing would probably allow or draw more people for testing.

Even people who want to kick the habit fall back into it due to lack of support from the family and society, and also due to absence of proper rehabilitation programs. Centers in India, particularly in Bihar, have proven to be meaningless as drugs are availed even within the center. It is just waste of money and time.

As a certain degree of awareness exists regarding transmission of HIV, some IDUs are seeking less harmful drugs such as Methadone tablets. This, according to IDUs, not only is less risky but could lead to end the habit altogether. In case of areas north of Biratnagar, particularly in Damak area, people are using brown sugar intravenously.

Findings of Focus Group at Central Jail

Care and support, counseling, and rehabilitation center's need were expressed. Along with society and family discard, health care providers pay less attention to IDUs. However, the system within jail was better than outside world. Acceptance of HIV positive and peer education programs have proven fruitful in educating and informing about HIV AIDS. New inmates are also given training on peer education.

Inmates are tested after symptoms of certain infection on repeated basis. Voluntary testing is not done for the cost factor. In case of diagnosed HIV infection or AIDS they are treated symptomatically.

IDUs, although not at central jail, are availed drugs even in police custody, obviously at a higher cost. In one HIV positive's case, while in custody with two other drug users, they went through with-drawl symptom and police administered drugs to all three with the same needle and syringe. They are suspected to have transmitted HIV during this very episode.

Police usually are aware of drug addicts and often use them to extract money. They also extract money from dealers of different areas on regular basis.

Effectiveness of awareness campaigns and messages are overshadowed and their effects diluted when people from certain 'advocacy groups' themselves indulge in drugs. Thus, confining the recipients of these messages.

Most of the drug users have gone through or at least are aware of different groups/organization that are working in drug in HIV/AIDS sector. Some have used their services.

Institutional and Personal Interactions

Institutional and personal contacts were instrumental to indicate whether the study was in conformity with the existing status of HIV/AIDS in Nepal. HIV/AIDS epidemic is still in a concentrated form in Nepal. However, the country has to brace itself for generalized form which could engulf Nepal in coming years. Depending on strategies developed and adopted, the duration it would take to transform from concentrated to generalized epidemic may vary. The system should be developed to face the generalized epidemic, while not getting stuck and worried about the number of effected populous. The global experience should be a learning experience.

Out of all the drug users in Nepal, 50% of the IDUs are HIV positive in Kathmandu valley, and likewise, in other parts of the country, it ranges from 20-50% (RTD).

Detection of HIV among IDUs and their roster are lacking. The system needs to be improved. In light of this, there is a need to focus on identified groups. Unfortunate experience in Nepal's case was that the authorities missed to effectively address the issue. Despite knowing 2% of the IDUs being HIV positives in the early '90s, it shot up to 50% in a span of less than a decade. Opportunities like this should not be missed again. The government needs to work with national non-governmental organizations/agencies to ensure national coverage of identified groups and their clients for prevention activities. Similarly, outreach program should cover not less than 70-80% of the general population to prove effective impact.

Analysis and Needs

Intensity of Drug use in Nepal

In recent years due to limited availability and control over various forms of drugs, injecting drugs and its usage has climbed up. These intravenous drugs are also readily available from *pan pasals* to pharmacies. In Jogbani (India), across from Biratnagar, it is evident how readily these drugs are available and that addicts are injecting in alleys and shacks (Shooting Galleries) within market place (Direct observation). Unfortunate aspect was the total freedom in using drugs as effort from police authorities to control seemed at best, minimal.

The scenarios of drugs availability is similar in cases of other border areas as well (Ministry of Home, Workshop on Harm Reduction, June 1999). Drugs and HIV awareness education must be included in medium to high school curriculums as well as teachers should be trained to address the issue.

The fact remains that there is a growing problem in regards to drug use and more importantly these people being vulnerable as well as transmitter of HIV. Thus, there is a gap that exists in addressing this issue.

The obvious contributing factor to such border area problems stems from Nepal's open border situation with India.

Response Needs

- An elaborate national level study on drugs, drug users, drug types and various aspects related to drugs.
- Education and awareness on broader meaning of drugs to everyone in society including responsible members, government networks political leaders and academic institutions.
- Strong and nationally recognized figure on advocacy on drug related issues.
- Education on drug use in relation to HIV/AIDS and its socio-economic impact.
- Programs to address issues specifically relating to drug use.

Needle Exchange Program as part of Harm Reduction

Contrary to the notion that needle exchange program contributes to increase in the numbers of drug users (which eventually increases HIV positives among IDUs), it is important to point out that because of lack of needle exchange as part of harm reduction program, HIV infection among IDUs in Nepal is further increasing.

Manipur, India where IDUs were rampant in early 90s' dramatically decreased after government endorsed harm reduction program, which included needle exchange program (Nepali Times, 9-15 August). Furthermore, international experiences and studies reveal that there is a reduction of one third in the incidence of HIV among IDUs who are a part of needle exchange program. Furthermore, the US government study reveals that needle exchange programs reduced vulnerability to HIV without increasing drug use. In addition, by taking Harm Reduction to another level through provision of substitute drugs such as Methadone, heroin injecting has significantly declined. Even in Kathmandu about 70% of the methadone clients have stopped injecting practice (Harm Reduction Workshop, Kathmandu, June 1999).

Response Needs

- More information on drugs and types, and 'responsible' drug use particularly among IDUs.
- Access to needle exchange services available to and at IDUs convenience/ease.

- Programs to address needle sharing issue in relation to HIV/AIDS.
- Development of human resources to handle sensitive needs and issues of drug users and HIV positives among them.

Counseling

As mentioned earlier, counseling aspect is crucial in addressing HIV/AIDS issue in Nepal. There is a need to provide counseling services to drug users and more importantly, in context of HIV/AIDS. Urgency to establish counseling system is echoed by all involved in HIV/AIDS from the outcome of our Round Table, Focus Group and Personnel contacts.

Response Needs

- Developments of effective counseling system through out the country.
- Family based counseling, where family members are trained and involve in counseling to addicts as well as positives.
- HIV/AIDS has to be an integral part of counseling to IDUs.
- Access to information about counseling has to be easy for the needy.
- Access to counseling itself has to be efficient
- Support for counseling by all the concerned authorities, including development partners

Rehabilitation/Treatment Center

In light of rapid growth of drug users in Nepal, rehabilitation and proper treatment are surely insufficient. Existing centers are functioning on limited basis due to various constraints, and still much to be desired from their effectiveness. Since society shuns people who use drugs, programs benefiting the IDUs are almost virtually non-existent. However, boundless opportunities also do exist since guardians and families of IDUs are requesting authorities to rehabilitate their children involved in drug uses. Capitalizing these resources would be advantageous to address HIV AIDS issues related to IDUs.

Financial reasons alone could not be the reason any more as per person cost to rehabilitate a drug user is \$30 in India and thus if same cost is true for Nepal for less than one million dollar could rehabilitate 30,000 drug users. Considering the long run implications, this amount is nominal (Nepali Times, 9-15 August 2000) and outcome can be extremely beneficial for the society as a whole.

Response Needs

- Appropriate policy incentives needs to be introduced from the government to establish proper rehabilitation centers.
- Encourage involvement of non-governmental sectors to establish and manage rehabilitation and treatment centers.
- A development of trained professionals at local level to address issues and to handle addicts/patients at their set up.
- Capitalize and prioritize guardians options and needs.

Medical Attention

People who are affected by drug using habits are shunned and looked down upon by the society. Their needs are paid less attention as if to say that they deserve what they get because they indulge in habits that are repudiated by appropriate social norms. However, the truth remains that drug users do have healthcare needs, and that they too are prone to wide spectrum of diseases. The gap remains in structure to address their medical requirements in a manner where they get their medical help without insensitivity and with sincerity since this is a serious societal issue.

Drug users have various medical problems ranging from variety of infections, viral diseases to psychiatric disorders. Some of them develop sexual problems; risk of overdose and surgical conditions are also persistent. All these health related issues further increase their vulnerability to HIV/AIDS. Deaths due to these reasons are also commonly heard of. All these require special service and care.

Response Needs

- Need to have medical facilities where spectrum of illnesses can be consistently examined.
- Trained professionals to provide care and support
- Availability of these facilities throughout the country.
- Counseling for medical professional
- Protocol of treatment and follow-up to be developed and health workers need to be trained.

Obstacles and Opportunities:

Need	Obstacles	Opportunities
• Education on drugs and drug use	<ul style="list-style-type: none">• Low education level among the people in general• Access to information on drugs specific to geographical and cultural isolation• Drugs although being a serious societal ill is thus not addressed with serious commitment	<ul style="list-style-type: none">• Ministries of Education, Home, Social Welfare and Health are favorable• Culture, ethnicity focused promotional activities through mass media, or other forms of campaigns• People are receptive
• Education level on drug use in relation to HIV/AIDS transmission	<ul style="list-style-type: none">• Education of the general population.• Educational level of the high risk behavior groups• Absence of responsible behavior of drug users (using intravenous drugs) and their sexual behavior• Access to information on drugs, sexual behavior, and implication on HIV transmission	<ul style="list-style-type: none">• Ministries of Education, Home, Social Welfare and Health more favorable• High profile personalities to address the issue focussing on particular groups• Approaches to reduce risky behavior related to drug use and HIV/AIDS• Concerns also expressed by communities

	<ul style="list-style-type: none"> • Culturally specific information material • Sex as taboo topic in the society 	
Needle Exchange as Harm Reduction Program	<ul style="list-style-type: none"> • Lack of government endorsement/support • Resources constraints to widen the program coverage • Lack of advocacy packages 	<ul style="list-style-type: none"> • Attitudes in the ministries of Home and Health are changing • Society's endorsement in reducing risk
Access to needles and syringes	<ul style="list-style-type: none"> • Expensive to support • Not available everywhere and all the time • Not easily available if suspected to be drug user • Difficult to monitor its appropriate use by the users 	<ul style="list-style-type: none"> • NGOs and treatment/rehabilitation centers to avail needles at subsidized rates • Drop in centers could not only provide clean needles but be data base and information center • Donor agencies favorable
Access to condoms	<ul style="list-style-type: none"> • Less targeted for condom use. • IDU would rather support their habit, instead of buying costly condom. 	<ul style="list-style-type: none"> • Ministry of Health through its network favorable in disseminating information and services • INGOs/NGOs working in reproductive health and contraceptive promotion as well as HIV/AIDS include and address IDUs' concern in their programs
Health care	<ul style="list-style-type: none"> • Society's disregard to drug users • Lack of sensitivity in medical and health care service providers • Lack of one-stop service center for drug users • Cost associated with medical services 	<ul style="list-style-type: none"> • Policy exists in the Ministry of Health • Involvement of private institutions in handling drug users • Family support are favorable
Developing data base of drug users	<ul style="list-style-type: none"> • Information not available • Limited studies on limited areas 	<ul style="list-style-type: none"> • Development of such programs at national levels • Government and families more favorable • NGO's involvement favorable

Mobile population

The history of foreign (labour) migration in Nepal dates back to early 19th century when Nepali men first travelled to India to be enrolled in the British Army. For the past 200 years, many families in Nepal have more or less relied on the money dispatched by these migrant workers.

Over the years the dimensions of migration has changed both in quality and quantity and at the dawn of the 21st century, these same group of migrant workers who are believed to

be the bread winners of their families are being seen as vectors of HIV/AIDS. However, examining the factors in migration will show that the migrant workers are not the problem rather the realities in it is that migration process itself creates problems and make them more vulnerable to HIV/AIDS.

Broadly the migration pattern may be divide into two categories: External migration and internal migration.

External Migration

The emigration of Nepali people, predominantly for employment, has increased rapidly over the years. According to the National census of 1991, emigrants have increased by about 63% compared to 1981. Emigration outside Nepal takes places in four major destinations. (Seddon 2000), namely India, East and South East Asia, The Gulf States and the West. These emigrants are predominantly young males living without their spouse which automatically puts them at a risk for indulging in extra-marital or pre-marital sex. Thus they are at an increased risk for acquiring the HIV infection.

India

According to the 1991 national census, the official number of Nepalese temporarily abroad in 1981 was 400,000; this rose to a 660,000 in 1991 and a majority (89%) of them went to India. A recent survey done (KC et al 1997) shows a somewhat similar picture.

Largely due to the open Indo-Nepal border it is not possible to predict a fairly reliable number of Nepali migrants to India. However, about a million Nepalese are believed to be working in India (Seddon 2000). Most of these people are employed in low paying jobs as restaurant 'boys', watchman, domestic helpers, factory workers etc.

Proportion of foreign migrants going overseas, as opposed to India has gradually increased over the years - in fact, it may have doubled over the last two decades. (7% in 1981 vs. 15% in 1997).

The Gulf States

The number of Nepali labor migrants in the Gulf States (Saudi Arabia, United Arab Emirates, Bahrain, Oman, Kuwait and Iraq) is raising rather dramatically (40,000 in 1997 vs. 90,000 in 1999). This increase may be explained by the fact that the nature of work in the Gulf States is mainly heavy manual labor in construction sites or road works which does not demand much educational qualification. Further substantial 'up-front' payments unlike other countries in the Southeast Asia and the west is usually not needed. Hence, the number of emigrants to the Gulf States is likely to increase in the future.

East and South East Asia (except India)

A total of some 44,000 Nepali migrants are thought to be working in this region; either legally or illegally (this is just a conservative estimate as many as 25000 Nepalese are thought to be in Hong Kong alone. One fourth of them are in Japan and others in South Korea, Saipan, Taiwan, Thailand, Malaysia, Philippines, Maldives etc,

The west- the Americas and Europe

The smallest numbers of migrants are in this region, conservative estimates for 1997 suggests a total of about 12,500 Nepalese working in Europe and about 2500 in North America. A large proportion of these (permanent) migrants are professionals (not labour migrants) living with their families. Presumably their contribution to the HIV/AIDS epidemic in Nepal would be minimal. The largest number in any one country is Great Britain with 3600 officially registered and 8000 unofficial workers in Britain.

Newer Destinations

In the 1980s and well up to the mid 1990s the number of people going to Hong Kong and Bangkok for business purposes (*jhiti gunta*) is rather well known. The volume of people going to this sector may have abated now but newer destinations have emerged. As trade between Nepal and Tibet flourishes cross-border activities is certain to rise. News reports suggest that many of those visiting the border towns of Tibet are already or are more likely to visit the local sex market for entertainment. This may add a new dimension to Nepal's HIV/AIDS epidemic.

Response needs

- Studies on sexual behaviour of this group
- Studies on destination and the nature of work undertaken at destination
- Studies on the needs and obstacles of the emigrants moreover those that might predispose them to STDs. HIV/AIDS need to be identified
- Pre and Post-departure counselling regarding STDs, HIV/AIDS and safe sex
- Encouragement on condom with sex partners at destination and with spouses on returning home
- Cross-border partnership between Governments and NGOs to effectively address the needs of migrants and others

Women migrants (internal and external)

Studies conducted so far fail to reliably estimate the total number of Nepali women migrants in Nepal, India and beyond. However, indirect estimates (based on the dispatched remittances) suggest that out of all the migrants, 11% could be women. A majority of female migrants work within Nepal. Although there is very scanty information on the pattern of their migration and employment, it is believed that most of the women tend to work in the manufacturing industry (e.g., carpet industry, garment factories). It is widely believed that women working in these institutions are often subject to sexual abuse by their employers and male co-workers thus rendering them vulnerable to HIV infection. Further, these carpet and garment factories are also thought to serve as a base for trafficking women to India (Round table discussions).

A very high proportion of women migrating to India from the central hill districts of Nepal, eventually become involved in the sex trade. (Seddon, D 1998). Estimates show up to 150,000 Nepali women to be working as commercial sex workers in various cities of India mainly Mumbai, Calcutta, Delhi as well Lucknow, Varanasi, Agra, Kanpur, Madras and Bangalore etc.

There are a large number of Nepali women working in Mumbai as sex workers. It has been observed that upon disclosure of the sex workers' positive HIV sero-status, they lose their jobs and are sent back home after rigorous suffering at remand homes. However, even upon returning home, the fate of these women remains largely the same. Lack of social acceptance and adequate rehabilitation program causes high mobility among them, often compelling them to resort to prostitution once more. This further contributes to the HIV/AIDS epidemic.

Some NGOs have been providing some form of shelter to these women although if this approach is a pragmatic, should a large number of sex workers with a positive HIV sero-status start returning home, is still a question.

Women migrants, although numerically small compared to those going to India, are also seeking jobs elsewhere as domestic helpers. Time and again stories of these women being physically and sexually abused in the Gulf states is enough to explain their vulnerability to a host of STDs and HIV/AIDS. Despite the governments' discouragement, women are still going to the Gulf States sometimes via India.

Response needs

- Political commitment to arrest the trafficker of women/girl children to India and beyond needs further intensified.
- Knowledge on STDs, HIV/AIDS and safe sex needs to be disseminated through / in institutions where women are working e.g., carpet / garment factories.
- Easy accessibility of condoms, including female condoms
- Institutional counselling services preferably for partners/spouses
- Proper rehabilitation of the returnees

Internal Migration

Much attention has been paid to cross-border migrants but the number of these migrants are much small compared to the number of people moving within borders of any country (Skeldon, R 2000). In 1991, in Nepal alone the volume of internal migrants was about 1.2 million, which is 6.6% of the total population. This volume is almost twice that of external migrants (Nepal Population Report, 2000)

As most studies point out that policy makers and scholars tend to focus more on the cross-border migrants to India and beyond while the composition and flow of migrants within Nepal awaits to be (systematically) scrutinized.

Existing work has focused on only a isolated part of the total mobility system, mainly the land transport workers, and has ignored many of the real mechanism through which HIV/AIDS is diffused. There are volumes of study on the vulnerability of land transport workers to HIV/AIDS.

Mobility also covers people moving on short distances for short periods; for example, to attend markets, fairs festivals and not only seasonal or long-term migrants. This type of short-term movement between villages and cities do possess the potential to propagate the Virus.

Short-term development projects can and do increase the incidence of HIV/AIDS (Skeldon, R 2000). Construction of dams and roads often aggregate a substantial number of male labourers at least until the duration of the project. Obviously the demand for sex would rise and the local women could be exploited. For example the construction of a dam in Ghana inundated farmland and left women with little alternative activity but to enter local sex work (Decosas 1996). Albeit anecdotal analogies can be drawn from our context - the Kaligandaki project. It is widely believed that once the project started there was a sharp increase in the consumption of alcohol and condoms in that area

Another group of people constantly on the move inside the country (sometimes outside the country e.g., the UN peacekeeping force) is the armed forces. It is believed that military personnel have a high risk of exposure to STDs, including HIV. In peace time the STD infection rate among armed forces are generally 2 to 5 time higher than in a comparable civilian population. (UNAIDS, 1998). In times of conflict the difference can be 50 times higher or more. Typically the factors that put members of the armed forces at risk of acquiring the infection are: lengthy periods spent from home, the risk-taking behaviour, their sexually active age and relatively more money in their pockets (e.g., those sent to peace keeping missions). Empirically these facts would be true for our armed force personnel but further evidence needs to be generated through more studies. Importantly the prevalence of STDs and HIV as well as the knowledge, attitude, and behaviour needs to be known for effective control programs.

Social justice to the deprived is an integral part and process of a democratic and developing society. An effort to rehabilitate the deprived and exploited population is

always laudable. The *Badi* communities, traditionally involved in sex work, were to benefit from such schemes. However the lack of proper or sustainable rehabilitation program has been a hindrance in attaining this goal. Similarly the recently liberated *Kamaiyas* may be in jeopardy should rehabilitation programs fail to give them adequate economic support.

Response needs

- Studies on the composition and flow of in-migrants
- Studies on their needs and obstacles at destination
- Easy accessibility of condoms, moreover its use at destination and with spouses upon returning home
- Education on responsible sexual behavior

Workplaces, such as but not limited to construction projects and factories, need to have information packages and counseling services regarding STDs, HIV/AIDS and safe sex for their workers

Child Migrants

Much cannot be said about the cross-border migration of children. However migration of children to urban areas from both rural and small urban areas is considerable in Nepal. Most of these child migrants are also child laborers and their number has exceeded 80,000 (ILO, 1995). Majorities of these children are male and come from the adjoining districts. A recent survey conducted in Kathmandu (CWIN 2000) reveals most of them have migrated from the adjoining districts namely Kaverepalanchowk, Sindhupalchowk, Nuwakot, Dhading and Ramechhap. These child laborers working as carpet weavers, domestic servants, shoe shiners, porters, tempo khalssis etc. Child labor predisposes a child to abuse especially if it is a girl child. Girl child workers have been exploited either through under pay or through sexual harassment and exploitation which again puts them at an increased risk of HIV infection (CWIN 2000). Girl children constitute a large part of the carpet labor force in Nepal.

Coupled with the internationalization of sex tourism and a false notion held by many that there is less danger of infection from young partners makes children more vulnerable to HIV infection. This situation is further worsened by the existing network of pedophiles whose targets are both boys and girls of different age groups.

Response needs

- Networks exploiting children, physically and sexually, need to be identified
- Proper rehabilitation programs.
- Access to health, education and other needs of these children
- Strict adherence of law-to protect the right of children

Foreign immigrants

The contribution of foreign migrants to the HIV/AIDS epidemic is yet another area to contemplate. The number of immigrants to Nepal from other countries, mainly India,

continues to rise. A majority of these immigrants are males in the age group of 20-44 years living without their families often involved in petty jobs from construction workers, barbers to vegetable vendors. It is not known what proportion of these migrants have STDs or HIV infection but what can be certainly said is that they are potential clients of the local sex workers.

Response needs

- Studies on their mobility pattern and sexual behavior
- Easy condom accessibility
- Education on HIV/AIDS and safe sexual behavior

Tourists

Thailand has a classic example of how tourism contributes to sex trade and eventually to the HIV/AIDS epidemic. The bulk of sex industry and tourism in Nepal may not be as big but it certainly warrants caution as anecdotal information of "high class sex workers" if often reported, who are "not identified". Reports of tourists being involved in pedophilia already exists and to say that they may be involved in both hetero- and homosexual activities would not be mere accusations. However, studies regarding the behavior and the prevalence of STDs and HIV are lacking.

Response needs

- Studies on the sexual behavior of tourists and their entertainment
- Proper awareness programs for people working in the tourism industry
- Condom accessibility to both the clients and sex providers.

Refugees

When talking about mobile population, refugees should also be considered. There are currently about a hundred thousand Bhutanese refugees in Nepal. Often the conditions surrounding the refugees exacerbate the spread of disease including HIV/AIDS, notably to women and young girls. Sentinel surveillance for HIV infection has not been done in the Bhutanese refugee camps but the incidence of STDs is rapidly raising. This indirectly explains the vulnerability of the refugees to HIV/AIDS. In addition to the Bhutanese refugees there are Tibetan refugees, albeit, in transition they may take advantage of this time and indulge in risk behavior for HIV transmission.

Response needs

- Sentinel surveillance of HIV/AIDS in the refugee camps
- Studies on the sexual behavior of refugees
- Easy condom accessibility
- Safe sex education

Students

Students contribute to both internal and external mobility. Students within Nepal, coming from rural area to the urban area are reported to visit FSWs rather frequently. The

likelihood of female students indulging in sex work is high. This may be a mechanism to cope with the economic hardships of life in urban areas. Similarly, students going abroad to study are equally vulnerable of contracting HIV/AIDS.

Another sub-group of the mobile population are sportsmen often travelling within and outside the country - be it for training or participating in various tournaments. The boom in sex industry in Sydney during the year 2000 Olympics may explain this.

Response needs

- Studies done on their sexual behaviour
- Sex and sexual education to promote responsible sexual behaviour
- Easy access to information condoms and other services.

Reason and triggering factors for migration

The lack of employment opportunities within in Nepal is said to have encouraged people to migrate especially to India (Jha 1995). A study done in one selected district of Nepal (Poudel 1999) with a high migration rate, it is illustrated that 94 % of the respondents stated poverty and lack of employment opportunities forced their family members to seek jobs abroad. that Among other various causes of migration identified by a study (Subedi et al 1993) are low agricultural production not sufficient to feed the family, no alternative to generate income except for agriculture, low economic status, family and peer pressure and free time available during winter and spring.

Study conducted in Doti districts (Poudel 1999) suggests that vast majority (82%) of migrants belong to sexually active age group (14-45 years). A majority of them are married and are not accompanied by their spouses. These characteristics of the migrants put them at an increased risk of extra or pre-marital sex and thus STDs and HIV infection. While the spouses are away for an extended period the remaining spouse at home may also indulge in extra-marital sex. This is believed to be especially so among spouses of military personnel working abroad (RTD). Thus married migrants and their spouses are at a dual risk of HIV infection.

Sexual Behavior of Migrants and Families

As people migrate, the rules of sex culture changes (Herdt 1997). However, there have not been enough studies in Nepal to ascertain the sexual behaviour of mobile population. It can only be grossly said that cut off from their families and social support system, a mobile person may engage in unprotected casual or commercial sex rendering themselves to STDs and HIV infection. A study aimed at understanding the sexual behaviour of non-resident men in Nepal (Puri et al 1998) states that 28% of the men had casual sex with non-regular partner and only one third of them used condoms.

Another study (Subedi et al 1993) states that 49 % of male and 40 % of female migrants had either premarital or extramarital sexual relationship during seasonal migration. About 70 % of these migrants had no knowledge on HIV/AIDS and about 83% had no

knowledge on condom use. Obviously this puts migrant workers at a greater risk of HIV transmission.

A large percentage of these men who indulge in sexual intercourse with non-regular partners did not perceive themselves at a risk of contacting HIV/AIDS. The study further states that the odds of being promiscuous was more than 10 times among men who have drinking habits as compared to those who do not. This finding is consistent with the findings of a study done in Kenya (Kiraju et al 1993). Thus labour migrants who have a drinking habit are at an increased risk of HIV infection.

The sexual encounters of mobile population is also said to be rather 'impromptu' (FGD). Sexual acts often take place at odd hours and at odd places often outdoors and without condoms.

It can be noted from earlier arguments that migrant workers and their families are, without doubts, vulnerable to HIV/AIDS. If a migrant worker contracts STDs or HIV infection, he or she can easily pass on the disease to their partner or spouse through sexual contact when they return home. In the same way it is also possible that in the absence of the migrant worker his or her partner may engage in casual or extra-marital relationships. Therefore migrants and their families are at dual risk of infection.

This is further aggravated by the incidence of low condom use with wives on returning home (FGD) and the tendency of the spouses not to disclose their sexual infidelities.

Another reason why migrant especially labour migrants are vulnerable to infection is their lack of knowledge on either the transmission or the prevention of STDs and HIV/AIDS. In one study (SACTS 1996) about 30 % of the migrants did not know about condoms and those who did only 35 % knew about the protective value of condoms against STDs and HIV infection.

Response needs

- Studies on the sexual behaviour of the mobile population at destination and at home with their partners or spouses

Accessibility to Information and Health Services

The conditions, in which migrants live and work, have serious implications for a wide range of disease including HIV infection. However much of the migrants from developing countries have restricted access to medical care, this is especially true for non-documented or illegal migrants. (Sawada 2000). In some cases this may be deliberate on the employers part. Thus, migrants may not be able to afford the health care cost at the destination. This is explained by the number of migrants returning home when they are suffering from various diseases (other than HIV infection) e.g. tuberculosis. Alternately those having access too may not seek health care for the fear of losing their job as migrants are invariably deported should they test positive for STDs or HIV infection.

The health-seeking behavior of the Nepali migrant workers has not been studied. However it might not be different from what has been said above. However, medical services are available to migrants within Nepal (FGD) although they have a preference for private health facilities or local pharmacies.

Information about HIV/AIDS and STDs are available to most migrant workers through public radios and other mass media. Lack of institutional subscription to information services withholds migrants from clarifying misconceptions about the diseases should they have any.

Case=
 Messages from radios and TV are often brief. These may not be understood completely by consumers. Hence misconceptions may arise e.g. It is often said in HIV/AIDS prevention message that it is transmitted by 'sarrik samparka' (literally meaning physical contact). How consumers take this message may vary. The message implies sexual intercourse but illiterate and ignorant people may consider this merely as physically touching. Hence in the absence of institutional subscription to information, such misconceptions could easily arise.

Response needs

- Knowledge on the health seeking behavior of mobile population
- Easy and affordable health and counseling services at destination and origin
- Confidentiality at health care and counseling center
- Dissemination of customized information package

Needs	Obstacles	Opportunities
<ul style="list-style-type: none"> • Studies on Mobility pattern and process of the population but not limited to migrants 	<ul style="list-style-type: none"> • Mobility in itself is a complex issue • These studies need both national and international networking which seems to be poor at the moment 	<ul style="list-style-type: none"> • HIV/AIDS is a growing international concern, it may be possible to conduct cross-border studies related to migrant issues
<ul style="list-style-type: none"> • Studies on Knowledge, attitude, behavior and Practices of mobile population 	<ul style="list-style-type: none"> • Mobile population and the sub-groups within not identified. 	<ul style="list-style-type: none"> • Academic institutes and NGOs are already doing some studies so it will may not be very difficult to focus on these issues
<ul style="list-style-type: none"> • Intervention modalities addressing the needs of mobile population • Pre Post departure counseling • Maintaining communication (letter) with family • Easy availability of Condoms 	<ul style="list-style-type: none"> • Lack of trained human resource for counseling • Low literacy rate, unreliable postal service • Despite the availability of condoms, there is no guarantee it will be used 	<ul style="list-style-type: none"> • Labor desk and the local manpower organizations could be used for this purpose • Local and easily available and sustainable resource • Freely available in health care institutions both Govt and NGO
<ul style="list-style-type: none"> • Access to health care services 	<ul style="list-style-type: none"> • Poor response from health care workers and lack of basic infrastructure 	<ul style="list-style-type: none"> • Appropriate training could change the attitude of health care workers

Adolescents and Youth

Adolescents and youths, a substantial group representing 20% of the total population, by age and physical status, are at a state where they are perceived to be fragile in various fronts. Adolescents carry boundless energy with infinite curiosities and opportunities to experiment and realize different aspects of human life, such as, sex, relationships, sexuality, etc.

Traditionally, Nepali adolescents are thought not to be sexually promiscuous before marriage. However, study conducted in Palpa reveals that 44% of 13-15 year olds and 56% of 16-18 year olds said that they have had sex before marriage (Prasai, Adolescent Sexuality). It could be assumed to be true in national context as well. Although early marriages are widely practiced in Nepal, where average age of marriage for girls is 18.1 years, a significant numbers of these girls are sexually active even before marriage (National Adolescent Reproductive Health Strategy, 2000- Draft). The same pattern is also seen among boys.

In reality Nepali youth are having premarital sex on a regular basis and are prone to HIV infection. Some young people are already infected with HIV, others with other STDs that may increase their risk of HIV infection. This is especially true to people who drop out of school early. While youths are exposed to general public information campaigns about HIV, they may not have access to information and services that would allow them to protect themselves.

Response Needs

- More information about sex and drugs at early stage in school so people who drop out are not excluded
- Condoms marketed to them in mind
- Access to condoms and other services
- Reproductive Health need

Adolescent

Needs	Obstacles	Opportunities
<ul style="list-style-type: none">• Sex/Sexuality and HIV/AIDS related education incorporated in curriculum	<ul style="list-style-type: none">• Lack of policies in regard to adolescent health• Cultural values and norms• Denied access to condoms and other services• Generation gap in terms of information sharing• Undiagnosed STD and HIV excluded from reproductive health services	<ul style="list-style-type: none">• Ministries of Health, Education and Sports, Social Welfare and Youth favorable• Policies concerning adolescents' health status is under preparation.• Popular advocacy• Private sector interest

Street Children

There are thousands of children in Nepal who survive on the street, mostly in urban areas. These children are orphans, runaways and children forced on the street due to economic and social constraints. These children are by far the most vulnerable group in facing social evils on a daily basis. Growing up with lack of a good social network, kinship ties and minimal access to social institutions, they suffer from starvation, illiteracy, information and knowledge in process, become immune to violence, exploitation, abuse and injustice dumped by evil social forces.

A lot of discussions and professionals point out that a significant number of street children are vulnerable to HIV/AIDS. Among street children, girl child worker in particular have been exploited either through under pay or through sexual harassment and exploitation which makes them vulnerable to HIV/AIDS (Far Away from Home, CWIN, pg. 7)

The dialogue has been that often, street children work as "middle men" (Inkmen) to make drug deals. This trend of being exposed to drugs and alcohol at an early age makes them vulnerable to try such substances and that puts them at high risk of HIV/AIDS. A lot of children, either boys or girls are also exploited for sexual favors in exchange of money (and/or) accessories, which makes them vulnerable to HIV/AIDS. Furthermore, they do not have access to services that would allow to protect themselves.

Respond needs

- Collective mobilization so that targeted intervention becomes more possible.
- Access to institutions, social services and information
- Alternatives for income generating activities
- Training on life skill courses
- Better and inexpensive access to condoms
- Access to other services
- Basic health/sex related educational information

Needs	Obstacles	Opportunities
<ul style="list-style-type: none">• Proper rehabilitation programs	<ul style="list-style-type: none">• A lack of higher level policies and programs to address their issues• Street children highly dispersed• Resource constraint	<ul style="list-style-type: none">• NGOs, INGOs favorable

Men who have sex with men (MSM)

Although homosexuality is said to have existed for centuries in worldly cultures, its open acceptance is still lacking. "Nepal may not be an exception to this phenomenon." People of various backgrounds are engaging in same sex relationships in Nepal, most particularly males as noted by various professionals. Some are voluntarily engaging in same sex relationships and committing to sexual acts while others, specifically young boys (i.e. street children) are forced into it.

Men who have sex with men are generally perceived to be not at a high risk because there are social sanctions against homosexuality. Situation analysis has highlighted a gap between perception and reality in this issue. Homosexuality is, as stated above, persistent in Nepal. Men are either voluntarily having sex with other men, or forcing little boys (or men) to provide them sexual pleasure (FG, FV). Some are already infected with HIV/AIDS, others with STDs and along with these factors, their sexual behavior with multiple partners or bi-sexual relationships puts them at a risk of HIV infection.

Male sex workers

Male sex workers are generally unheard of in Nepali popular culture. There is a general disbelief that they do exist. There is a gap in perception and reality on this issue. There are increasing numbers of male sex workers committing to sexual acts with multiple partners, both women and men. This undoubtedly makes them prone to HIV infection. While all of these men engaging in some form of exploited "homosexual" acts may be exposed to general public awareness but because of stigmatization and minimal access to other institutions, they are not necessarily able to protect themselves.

Response Needs

- More studies/research done in issues of homosexuality as well as male sex workers
- Condoms/ preventive methods development with them in mind

Needs	Obstacles	Opportunities
<ul style="list-style-type: none"> • Acceptance and recognition 	<ul style="list-style-type: none"> • Homosexuality a taboo subject • Stigmatization attached with "homosexuality"/ seen as "immoral," "sick," etc. • Male sex work generally happens "behind closed doors" and unbelieved of. 	<ul style="list-style-type: none"> • Private sector interest • For male sex workers, NGOs and INGOs favorable.

Blood Recipients / Organ Transplant Recipients

In Nepal to date only one case of HIV transmission through blood transfusion has been reported officially. Similarly, one case of acquiring HIV after organ transplantation is also in the record (NCASC).

The policy on HIV/AIDS and STD mentions

- *HMG will adopt a policy of transfusing blood only after screening the blood.*
- *The result of blood tests will be kept confidential as per government policy.*

In Nepal, major organ transplantation needing human Leukocyte Antigen compatibility tests are not carried out regularly but corneal transplantation is relatively frequent. However, there are many people who have received organ transplant abroad, especially kidney transplant. The issue of "safe" (in terms of HIV) organ transplantation so far remains a silent issue. Unofficial information mentions that at least three persons might have contracted HIV after organ transplantation abroad. They were found to be HIV positive few weeks after the said operation.

Blood transfusion service (BTS) of NRCS is the only institution allowed to collect blood from donors for medical purpose and supply of it to medical institutions. Blood donation by HIV positive persons has been a serious issue for BTS as these people have repeatedly donated blood. It is not clear from the guidelines of NCASC whether the BTS should inform the HIV positive donors about their HIV positive status. "If the answer is yes, how should BTS proceed and what approach should it take?" Similarly, there is no system of referral from periphery as well as from one hospital to another for getting appropriate services for HIV positive persons if they are detected after blood donation.

Findings of RTD/ FGD and institutional interactions

Safety of blood transfusion has raised certain issues among medical professional regarding its safe use.

People involved in blood transfusion service, health care and HIV/AIDS raised the following issues in relation to blood transfusion and organ transplantation.

- Safety of donated blood: is it completely safe to be transfused with blood
- Issue of window period: is it completely safe?
- HIV testing prior to blood donation and its implications: Is it appropriate to test a donor before blood transfusion?
- HIV positives among health care workers: what care/support the health worker gets if s/he is found HIV positive?

Implications

Blood transfusion service and organ transplant services should be considered a major area for care and support programs. At the same time health workers find themselves in great dilemma due to technical and ethical reasons. This is very important for the National AIDS Program to address as many aspects of care and support stems from this.

Response needs

- Clear guidelines on blood transfusion and organ transplant.
- Support to be made for safe blood transfusion program.
- Training of health workers for rational use of blood.
- IEC activities for the safe organ transplant.
- Information and services to people donating or accepting blood about related possible consequences.

<i>Needs</i>	<i>Obstacles</i>	<i>Opportunities</i>
<ul style="list-style-type: none"> • Safe blood donation/transfusion 	<ul style="list-style-type: none"> • Blood-donors not-informed about their HIV status • Blood donors unaware of their high risk behavior in terms of HIV • Window period 	<ul style="list-style-type: none"> • Promotion of voluntary (non-paid) donors. • Promotion of regular donors • Initiation of "autologous blood transfusion"
<ul style="list-style-type: none"> • Rational use of blood 	<ul style="list-style-type: none"> • Many doctors order for "fresh blood" for conditions like chronic anemia <p>Consequences of blood transfusion are not discussed in training programs</p>	<ul style="list-style-type: none"> • Re-orientation to health care providers regarding safe blood transfusion and rational use of blood • Blood components available for certain conditions
<ul style="list-style-type: none"> • Screening before donating organ 	<ul style="list-style-type: none"> • No lab facility available • People unaware of serious consequences of blood transfusion 	<ul style="list-style-type: none"> • Willingness to develop facilities

Unborn / Newborn

World Health Organization emphasizes prevention of mother to child HIV transmission as a part of the comprehensive care - holistic and life span approach. However, lack of control over own sexuality and sexual relationship puts serious threat to the issue of HIV prevention among women, not to speak of the coerced sex. In Nepal's context, often women are blamed for spread of HIV, though the majority of them are probably infected by their only partner/husband.

The reported figures from NCASC show that the rate of housewives infected with HIV as of September 30, 2000 is on the rise. The number of children being infected is also climbing up obviously, most of it being vertical transmission. It is estimated that some 1000 children might be infected each year in Nepal. (UNAIDS, June 2000 data.)

Prevention of transmission of HIV from an infected woman to her unborn newborn child has been an open debate all over the world. Though this is still a least-debated issue in Nepali context, it is likely to raise many issues in near future due to following reasons:

- Screening of pregnant women has neither been included in the sentinel surveillance, nor in routine screening of pregnant women. So, the real scenario is yet to be visible (FGD/RTD).
- The women are less addressed in terms of HIV/AIDS issue. Even the UNAIDS seems to estimate the prevalence of HIV among women in Nepal at about 1/3 of the total estimated HIV infections, this in turn might have influence over the low estimation of HIV among unborn/Newborn (institutional interaction).
- Estimation that only one-third women might have been infected with HIV in Nepal in itself casts doubt over the reliability of the data/ source/ estimation, as there are no compelling evidences to believe that Nepal is different in terms of HIV transmission. Every available report / research/ study mentions that because Nepal is predominantly a patriarchal heterosexual culture, women are more vulnerable (biologically/anatomically) to HIV than males. Similarly, many trafficked women are forced to

return to Nepal when they are found HIV positive abroad. This gives ample evidence that the estimation of HIV positive women is not less in Nepal, if more than the males in reality. This in turn casts shadow in the low estimation among the unborn/newborn as well (institutional interaction).

- Although it has been reported that the women seek medical care less than the males, it does not however mean that they are not infected/affected and do not need addressing for HIV prevention. Addressing such issues becomes more important in the total context of being a Nepali women with her overall vulnerability to HIV and the responsibility to bear a child.
- Number of orphans due to HIV/AIDS might be low in Nepal. However, the issue of the orphans is never one-sided and simple. Due to poor socio-economic condition in Nepal the issue might be masked, but the long-term implications have not been really analyzed.

Implications

- Every child has a right to live healthy as other children and every parent wishes to have a healthy child. The entire philosophy of perpetuity of life stands here and the society has the obligation to continue this notion however, a healthy parenthood is needed for healthy future generation.
- Responsible parents will make responsible children for the country.
- Antenatal care along with provision of maternal services is very important aspects in terms of HIV prevention and control.

Response needs

- Respect the right of child to born healthy and continue healthy life.
- Develop guidelines for screening of pregnant women.
- Make provision for AZT to women who are pregnant and HIV positive.
- Promote safe delivery practices to minimize infection.

<i>Needs</i>	<i>Obstacles</i>	<i>Opportunities</i>
<ul style="list-style-type: none"> • Screening of pregnant women during regular antenatal check-up 	<ul style="list-style-type: none"> • No guidelines available. • Availability of services in all the districts • "Window period" concept 	<ul style="list-style-type: none"> • Maternity hospitals has initiated the activity
<ul style="list-style-type: none"> • Provision of AZT to HIV positive pregnant women 	<ul style="list-style-type: none"> • AZT not available freely 	<ul style="list-style-type: none"> • some examples available in the country.
<ul style="list-style-type: none"> • Care of newborn 	<ul style="list-style-type: none"> • Not all health institution ready to conduct delivery 	<ul style="list-style-type: none"> • Some health institutions are good examples

Sexually Transmitted Diseases

STDs are considered to be one of the most common diseases in the world, ranking among the top five diseases for which health care is sought. Up to 70 percent of STD patients in Africa and up to 30 percent STD patients in Thailand are reported to have HIV (NMA Guidebook on HIV/AIDS, 2000). Chances of acquiring HIV infection through sex among STD patients are 4.5 to 9 times higher than for a person without STD. All these

factors show that for HIV/AIDS prevention program, STDs occupy a major area for intervention.

HIV is predominantly transmitted through sex, as do STDs. Over 1030 of the reported HIV cases in Nepal are under the category of STD/Clients of Sex workers (NCASC). In Kaski district alone, there are 14,000 STDs patient actively taking medicine (RTD Pokhara). In refugee camps and other areas of the country, the rate of STDs is on significant rise. Both can be prevented by safer sexual practices including condom use. Various organizations have been performing village to village drama, folksongs/ dances, etc in various places in order to create awareness about HIV/AIDS and to promote condom use. However, they rarely raise the issues of STDs. Furthermore, these programs are not always successful as they are one-time activity and spouses presence are not adequate. One of the reasons is the lack of couple counseling.

Sentinel syphilis surveillance in Nepal for last few years has shown some decreasing trend in syphilis prevalence among STD patients, who seek medical care.

Year	Number tested	RPR positive	%
1994	1542	113	7.3
1995	1995	23	4.5
1996	724	38	5.3
1997	980	34	3.5

However, other STDs are shown to be widespread among various population groups.

<i>Infection</i>	<i>Prevalence among symptomatic female in 1997</i>	<i>Prevalence among FSW in 1999</i>	<i>Prevalence among Family planning service seeker in 1999</i>
Trichomonas vaginalis	9.3%	9.0%	6.0%
Chlamydia trachomatis	5.2%	9.3%	1.7%
Neisseria gonorrhoea	1.9%	9.0%	1.7%

Source: UOH/STD HIV Project

These figures indicate that there might be significant number of STD infected persons in the country with higher chances of acquiring HIV.

Implications

These figures are important in terms of HIV prevention activities, as the implication of the infections would jeopardize the life of women in Nepali socio-cultural context. Person with STD are labeled as "immoral" and often discriminated against. However, it is more so with the women while treatment is widely available for bacterial infection and

often at affordable costs. Discrimination might play a negative role in prevention activities.

Response needs

- Awareness raising programs targeted on STDs.
- Training for widely available STD case management.
- Wide use of components of appropriate STD case management.
- Appropriate drugs available at the health institutions.
- Access to condoms.

<i>Needs</i>	<i>Obstacles</i>	<i>Opportunities</i>
<ul style="list-style-type: none"> • Awareness raising programs 	<ul style="list-style-type: none"> • "Not my problem" attitude 	<ul style="list-style-type: none"> • High number of housewives infected with HIV might be an advocacy tool • Certain level of consciousness already generated for HIV
<ul style="list-style-type: none"> • Appropriate STD case management 	<ul style="list-style-type: none"> • Training to all health care providers on appropriate STD case management • Provision of appropriate treatment at grass root level 	<ul style="list-style-type: none"> • Syndrome STD case management guideline exists. • Many of the drugs for STD are included in the essential drug list. • Well accepted approach
<ul style="list-style-type: none"> • 4"C" (compliance, contact tracing, condom promotion and counseling) concepts to be made clear to all health care providers 	<ul style="list-style-type: none"> • Training has not reached up to grass root level • Many times not all "4-Cs" are adequately addressed 	<ul style="list-style-type: none"> • Training program on HIV/AIDS can incorporate easily • Condoms easily available in health institutions

Care and Support

It has been well accepted that good care can greatly improve the quality and length of life of people with HIV. Care in relation to HIV is not limited to the treatment, but also includes emotional and spiritual support, as well as and support to the caretakers, families and communities.

In Nepal, an estimated 5000 PLWHA might be seeking medical care and other support in year 2000 and some 2500 deaths might have occurred in 1999 due to HIV/AIDS (UNAIDS). In contrary to the UNAIDS' estimation, the latest report of NCASC reveals that a total of 1,703 persons having symptoms of HIV (AIDS) with 140 deaths as of September 30, 2000. Although NCASC estimation of death toll due to HIV/AIDS is low, there are frequent anecdotal reporting cited in local newspapers some 15 deaths in one VDC due to AIDS in one district of Nepal, which do not constitute part of the reporting system.

Care and support for HIV/AIDS in Nepal has been an issue of debate since the very beginning of the pandemic reported in Nepal (Gurubacharya, Bhatta and Vadies, JNMA-1991). Few studies carried out later have shown that the pattern of presentation of AIDS

in Nepal is similar as elsewhere. (Suvedi, Rana, Gurubacharya- 1994, Suvedi – 1998). A few articles have been published in relation to the symptomatic HIV persons in Nepal. (Suvedi- 1995 and 1998). Tuberculosis has been increasingly coupled with HIV positive status. However, clear guideline is yet to be chalked out in this respect and many other issues.

In relation to HIV/AIDS and care and support, the policy guideline states that:

- a) *HMG will provide counseling and other services to those who are infected and affected. (policy- 10)*
- b) *HMG will adopt a policy to prevent and provide service through both government and non- government level. (11)*
- c) *HMG will adopt a policy of non-discrimination, whoever is infected or affected with HIV STD. (7)*

Although there are clear policy guidelines related to care and support at the *de jure* level, the care and support part is virtually non-existent at implementation level. Implementation and monitoring of these policy as is supposed to be practiced in various health institutions are not far from being interpreted and enforced. In reality, PLWHA are facing tremendous stigmatization, isolations and neglect from various health institutions. As reported in a health facility in Pokhara, a HIV positive patient was denied service and asked not to come back to that to facility again (Focus Group, Pokhara).

It is assumed that a significant number of PLWHAs are from poor economic backgrounds, and can not afford expensive medical care at all. In this sense they are far from even getting a "bad" service. A serious issue that is raised out of this is that who is held accountable for them not getting any treatment at all. The policies (a) and (b) mentioned above, in this case, again are not really adopted and/or initiated at local, regional, national health institutions due to lack of skilled human resources and appropriate infrastructure.

Until very recently counseling services in Nepal included a narrow meaning of explaining the client about how HIV/AIDS is transmitted. Though there is a whole arena of counseling services in regard to psychological needs, that is vital to examine. In Nepal, this kind of psychology counseling service is virtually non-existence. Whatever the counseling services may be, it is worsened by a lack of an effective network, collaboration, and referral system. Most of all it lacks skilled human resources and management from the highest level to grass root levels. Despite these flaws few attempts have been made to understand the issues related to care and support to HIV/AIDS.

Few training on home-based care of AIDS to health workers and NGO staff have been carried out by NCASC. Similarly, NCASC is reported to have conducted a study on the needs of people living with HIV/AIDS and their caretakers in 1997. Unfortunately, the report is still to be generally available. Implementation of the findings in this respect was insignificant.

Few hospitals in the capital city have started taking care of symptomatic HIV positive persons. The scenario within Kathmandu valley and outside is significantly different. Due to limited resources and information/counseling services outside of Kathmandu regarding HIV/AIDS, general population tends to discriminate PLWHA to a greater degree.

Few studies (Rai C. 1993, Pyakurel N. 1993) clearly mention that there is negative attitude and feeling towards PLWHA. Discrimination, breach of confidentiality and non-availability of required service were major issues raised by FGD and RTD participants.

The medical community is responsive to the medical needs of PLWHA (Bhattarai, Karki, Naing-1999). In this context, many articles have been published in the medical journals of the country to aware medical practitioners. A KAP survey on medical professionals of Nepal regarding HIV/AIDS care and prevention shows that although 92% of the participants responded that if an HIV positive person comes to them with a medical problem of their specialty, they would manage themselves like other patients. However, in reality, this is rarely seen. Nepal Medical Association has recently published a guidebook on HIV/AIDS for medical professionals; however, its wide use by the medical community at the grass root level is yet to be seen.

Most PLWHAs are not receiving any support except for a few exceptions. NGOs like ABC Nepal, WOREC and Maiti Nepal are reported to provide some degree of care and support to HIV positive female sex workers returning from Indian brothels. This is being done in a temporary basis and is extremely limited due to various constraints at all level. There does not seem to be any clear program on care and support for a long-term sustainable rehabilitation. Medical care to those with symptoms is really a question, which is very rarely addressed.

A significant Numbers of PLWAHA mentioned that the medical service to them is rather insufficient. Neither are there any guidelines nor instructions to carry out the service by the medical professionals as well as the caretakers.

- The PLWHAs are left without serious attention in terms of care and support issues.
- IEC messages in terms of care and support contradicts with the prevention messages. (Example: AIDS is a killer disease, which kills the enthusiasm of the PLWHA to live.)
- There is no coordination between hospital and various organizations working in the field of HIV/AIDS.
- PLWHA do not know whether they can get required services in the country.
- PLWHA in Nepal are dying because of their HIV status and other illness related to it and not because of AIDS.
- Those who know about HIV/AIDS fear of dying but those who do not know about HIV/AIDS hope that they will be cured.

The issues raised by the PLWHAs are summarized as follows:

- *As the issue of confidentiality is very important to the PLWHAs, it is not always possible for them to expose their identity or the HIV status to the attending medical person.*

- "What is the use of exposing the HIV positive status if one is not going to get any required service?"
- "What about making those medicines available are available in other countries and not available in the country? Who will take the initiation?"
- "How can one get all the needed investigations done here in Nepal?"
- Can anybody take responsibility for the transmission (save it for health institution)?

Injecting drug users have also been in difficult position in receiving appropriate care. Many NGOs, mainly based in Kathmandu are taking care of them, but it is more or less confined to providing primary care of minor illnesses. Outside Kathmandu, the issues of IDUs are rarely addressed although these issues are becoming severe throughout the country (Dharan, Biratnagar, Nepalgunj, Bhairahawa and Dhangadhi).

Refusing acknowledgement of sex workers and denying service to them has also led to constraints in providing care for STD and HIV prevention activities (Nepalgunj).

Implications

Holistic approach stresses that care and support to PLWHA are important aspects in prevention activities. Involvement of PLWHA in planning of care and support program gives impetus to the successful implementation of program. In this respect it is very important that the care and support activities are seriously considered by the program to achieve the goal.

Response needs

- Maintaining confidentiality at the health care set up.
- Strengthening universal precaution and Infection control measures at the health care set up.
- Availability of appropriate care in selected health institutions
- Availability, accessibility and affordability of testing facility and anti-retroviral therapies.
- Provision of trained care treatment providers at all levels.
- Capacity of NGOs and others to be strengthened.

<i>Needs</i>	<i>Obstacles</i>	<i>Opportunities</i>
<ul style="list-style-type: none"> • Confidentiality 	<ul style="list-style-type: none"> • Not all health workers and health institutions confirm to the policy of confidentiality 	<ul style="list-style-type: none"> • Clear policy exists in the country in terms of confidentiality. • Implementation of policies is possible • Training on confidentiality to NGO/INGO and all related sectors.
<ul style="list-style-type: none"> • Receiving appropriate care at the health institutions 	<ul style="list-style-type: none"> • Negative experiences in the past by PLWHA • Non-availability of drugs and services at the Health Institutions 	<ul style="list-style-type: none"> • Many hospitals are receptive and developing care programs • AZT has been introduced among HIV positive pregnant women to reduce vertical transmission • Exploring possibility to provide Anti-Retroviral Therapy

<ul style="list-style-type: none"> • Universal precaution and Infection control measures are inadequate 	<ul style="list-style-type: none"> • No clear guidelines and "safety measures" to the health workers. • No "strict" measures to follow the safe injection practices. • Management of HI reluctant / unaware of UP and IC 	<ul style="list-style-type: none"> • Nepal Medical Association and many other NGO promoting infection control measures and universal precautions • Health institutions very much receptive for universal precaution
<ul style="list-style-type: none"> • Cost of ART (Anti-Retroviral Therapy) 	<ul style="list-style-type: none"> • Costly medicines • Lab facilities not available 	<ul style="list-style-type: none"> • Medicines available in the market • Potential for developing lab. Facilities

Care Providers

A few hospitals (namely Teku Hospital, Bir Hospital, Patan Hospital and Teaching Hospital) in Kathmandu are providing care to symptomatic PLWHAs. However issues of PLWHA are not being addressed adequately and appropriately. There is only a degree of willingness to cope with the demands and only a room to provide "quality" care.

Case=8

Do you suggest me to go to a hospital and expose my HIV status? What if they take it otherwise breaching my confidentiality?

Since health care issues related to PLWHA in the context of Nepal's total health care system is a new dimension in itself, health workers in this area are not prepared. HIV/AIDS and care itself is a new paradigm to Nepal. Credible protocol, clear guidelines and policies are still lacking from the government's side which in reality is supposed to regulate and maintain the services in all the health institutions.

Health workers and care providers are very much concerned with the "minimum level" of universal precaution (infection control) measures in the health institutions. The overall concern is injection safety to the health personnel and its appropriate management in case a health worker contracts HIV through injecting equipment during his/her working environment.

From the point of view of care providers, it has been noticed that the care of HIV positive persons encompasses lots of issues. The concerns expressed are as follows:

- *Where to refer, if one encounters some undiagnosed situation?*
- *Can the person afford the cost of treatment?*
- *How can the care providers protect themselves with so little protection measures given to the health care providers?*
- *How long can the health institution keep a person with symptomatic HIV without any person to look after him/her?*
- *As the Anti-retroviral drugs are very expensive, how can one provide services?*
- *Availability of facility to monitor the retroviral load in a PLWHA?*
- *How can the health worker be protected: provided services in case they acquire HIV during their professional work?*

- *Counseling is a major area, but is Nepal prepared for this? Can the health institutions afford all this?*

Few NGOs are providing care to PLWHA. However, it is often limited to "primary services". Whenever a PLWHA needs referral from NGO, there is no appropriate "recognized institution" for all the needed care and the NGO health personnel are rarely informed of the available services or the continuation of care. The gap in "continuum of care" is distinct in this respect, especially pertaining to infections like tuberculosis, skin conditions and multiple infections observed in PLWHA.

Continuum of care from health care facilities to home/community is a major issue for the PLWHA. Basically family members are the main caretakers at home. However, their level of knowledge on HIV transmission and appropriate precaution to be taken is non-existent. Moreover, there are significant numbers of PLWHA who do not have homes. In this sense, who is responsible for their care?

Role of religious institutions is considered important in providing psychosocial care (example from Thailand). However, these institutions are not active in Nepal (RTD/FGD). That's another area that requires further examination and could definitely be useful.

Implications

Care and support is considered to be one of the important part in the HIV prevention and control activities. Poor service and care mechanism does not help in the prevention and control activities. This also has negative impact on the program as the infected and affected people do not receive any type of needed and desired attention.

Response needs

- Introduction of behavioral modalities to over stigmatization toward PLWHA.
- Availability of measures for strict observance of universal precautions in the health care set up.
- Wide availability of materials for infection control measures in the health care set up (example: gloves, syringes, needles etc)
- Identification of health institutions and development of referral mechanisms for those in need
- Availability of upgraded laboratory facilities to monitor the progress.
- Clinical training to the care providers regarding management of HIV/AIDS.

<i>Needs</i>	<i>Obstacles</i>	<i>Opportunities</i>
<ul style="list-style-type: none"> • Appropriate information/ training/ skills to deal with HIV infection in health care set-up 	<ul style="list-style-type: none"> • Fear of transmission • Insecurity • UP and IC measures inadequate • Very few professionals, many unskilled "care takers" 	<ul style="list-style-type: none"> • Health workers are receptive • Some institutions have taken initiation (examples available)
<ul style="list-style-type: none"> • Referral for treatment 	<ul style="list-style-type: none"> • No health institution identified for referral 	<ul style="list-style-type: none"> • Central hospitals willing to take care initiatives.

knowledge on condom use. Obviously this puts migrant workers at a greater risk of HIV transmission.

A large percentage of these men who indulge in sexual intercourse with non-regular partners did not perceive themselves at a risk of contacting HIV/AIDS. The study further states that the odds of being promiscuous was more than 10 times among men who have drinking habits as compared to those who do not. This finding is consistent with the findings of a study done in Kenya (Kiraju et al 1993). Thus labour migrants who have a drinking habit are at an increased risk of HIV infection.

The sexual encounters of mobile population is also said to be rather 'impromptu' (FGD). Sexual acts often take place at odd hours and at odd places often outdoors and without condoms.

It can be noted from earlier arguments that migrant workers and their families are, without doubts, vulnerable to HIV/AIDS. If a migrant worker contracts STDs or HIV infection, he or she can easily pass on the disease to their partner or spouse through sexual contact when they return home. In the same way it is also possible that in the absence of the migrant worker his or her partner may engage in casual or extra-marital relationships. Therefore migrants and their families are at dual risk of infection.

This is further aggravated by the incidence of low condom use with wives on returning home (FGD) and the tendency of the spouses not to disclose their sexual infidelities.

Another reason why migrant especially labour migrants are vulnerable to infection is their lack of knowledge on either the transmission or the prevention of STDs and HIV/AIDS. In one study (SACTS 1996) about 30 % of the migrants did not know about condoms and those who did only 35 % knew about the protective value of condoms against STDs and HIV infection.

Response needs

- Studies on the sexual behaviour of the mobile population at destination and at home with their partners or spouses

Accessibility to Information and Health Services

The conditions, in which migrants live and work, have serious implications for a wide range of disease including HIV infection. However much of the migrants from developing countries have restricted access to medical care, this is especially true for non-documented or illegal migrants. (Sawada 2000). In some cases this may be deliberate on the employers part. Thus, migrants may not be able to afford the health care cost at the destination. This is explained by the number of migrants returning home when they are suffering from various diseases (other than HIV infection) e.g. tuberculosis. Alternately those having access too may not seek health care for the fear of losing their job as migrants are invariably deported should they test positive for STDs or HIV infection.

The health-seeking behavior of the Nepali migrant workers has not been studied. However it might not be different from what has been said above. However, medical services are available to migrants within Nepal (FGD) although they have a preference for private health facilities or local pharmacies.

Information about HIV/AIDS and STDs are available to most migrant workers through public radios and other mass media. Lack of institutional subscription to information services withholds migrants from clarifying misconceptions about the diseases should they have any.

Case-
 Messages from radios and TV are often brief. These may not be understood completely by consumers. Hence misconceptions may arise e.g. It is often said in HIV/AIDS prevention message that it is transmitted by 'sarrik samparka' (literally meaning physical contact). How consumers take this message may vary. The message implies sexual intercourse but illiterate and ignorant people may consider this merely as physically touching. Hence in the absence of institutional subscription to information, such misconceptions could easily arise.

Response needs

- Knowledge on the health seeking behavior of mobile population
- Easy and affordable health and counseling services at destination and origin
- Confidentiality at health care and counseling center
- Dissemination of customized information package

Needs	Obstacles	Opportunities
<ul style="list-style-type: none"> • Studies on Mobility pattern and process of the population but not limited to migrants 	<ul style="list-style-type: none"> • Mobility in itself is a complex issue • These studies need both national and international networking which seems to be poor at the moment 	<ul style="list-style-type: none"> • HIV/AIDS is a growing international concern, it may be possible to conduct cross-border studies related to migrant issues
<ul style="list-style-type: none"> • Studies on Knowledge, attitude, behavior and Practices of mobile population 	Mobile population and the sub-groups within not identified.	Academic institutes and NGOs are already doing some studies so it will may not be very difficult to focus on these issues
<ul style="list-style-type: none"> • Intervention modalities addressing the needs of mobile population • Pre Post departure counseling • Maintaining communication (letter) with family • Easy availability of Condoms 	<ul style="list-style-type: none"> • Lack of trained human resource for counseling • Low literacy rate, unreliable postal service • Despite the availability of condoms, there is no guarantee it will be used 	<ul style="list-style-type: none"> • Labor desk and the local manpower organizations could be used for this purpose • Local and easily available and sustainable resource • Freely available in health care institutions both Govt and NGO
<ul style="list-style-type: none"> • Access to health care services 	<ul style="list-style-type: none"> • Poor response from health care workers and lack of basic infrastructure 	<ul style="list-style-type: none"> • Appropriate training could change the attitude of health care workers

Adolescents and Youth

Adolescents and youths, a substantial group representing 20% of the total population, by age and physical status, are at a state where they are perceived to be fragile in various fronts. Adolescents carry boundless energy with infinite curiosities and opportunities to experiment and realize different aspects of human life, such as, sex, relationships, sexuality, etc.

Traditionally, Nepali adolescents are thought not to be sexually promiscuous before marriage. However, study conducted in Palpa reveals that 44% of 13-15 year olds and 56% of 16-18 year olds said that they have had sex before marriage (Prasai, Adolescent Sexuality). It could be assumed to be true in national context as well. Although early marriages are widely practiced in Nepal, where average age of marriage for girls is 18.1 years, a significant numbers of these girls are sexually active even before marriage (National Adolescent Reproductive Health Strategy, 2000- Draft). The same pattern is also seen among boys.

In reality Nepali youth are having premarital sex on a regular basis and are prone to HIV infection. Some young people are already infected with HIV, others with other STDs that may increase their risk of HIV infection. This is especially true to people who drop out of school early. While youths are exposed to general public information campaigns about HIV, they may not have access to information and services that would allow them to protect themselves.

Response Needs

- More information about sex and drugs at early stage in school so people who drop out are not excluded
- Condoms marketed to them in mind
- Access to condoms and other services
- Reproductive Health need

Adolescent

Needs	Obstacles	Opportunities
<ul style="list-style-type: none">• Sex/Sexuality and HIV/AIDS related education incorporated in curriculum	<ul style="list-style-type: none">• Lack of policies in regard to adolescent health• Cultural values and norms• Denied access to condoms and other services• Generation gap in terms of information sharing• Undiagnosed STD and HIV excluded from reproductive health services	<ul style="list-style-type: none">• Ministries of Health, Education and Sports, Social Welfare and Youth favorable• Policies concerning adolescents' health status is under preparation.• Popular advocacy• Private sector interest

Street Children

There are thousands of children in Nepal who survive on the street, mostly in urban areas. These children are orphans, runaways and children forced on the street due to economic and social constraints. These children are by far the most vulnerable group in facing social evils on a daily basis. Growing up with lack of a good social network, kinship ties and minimal access to social institutions, they suffer from starvation, illiteracy, information and knowledge in process, become immune to violence, exploitation, abuse and injustice dumped by evil social forces.

A lot of discussions and professionals point out that a significant number of street children are vulnerable to HIV/AIDS. Among street children, girl child worker in particular have been exploited either through under pay or through sexual harassment and exploitation which makes them vulnerable to HIV/AIDS (Far Away from Home, CWIN, pg. 7)

The dialogue has been that often, street children work as "middle men" (Inkmen) to make drug deals. This trend of being exposed to drugs and alcohol at an early age makes them vulnerable to try such substances and that puts them at high risk of HIV/AIDS. A lot of children, either boys or girls are also exploited for sexual favors in exchange of money (and/or) accessories, which makes them vulnerable to HIV/AIDS. Furthermore, they do not have access to services that would allow to protect themselves.

Respond needs

- Collective mobilization so that targeted intervention becomes more possible.
- Access to institutions, social services and information
- Alternatives for income generating activities
- Training on life skill courses
- Better and inexpensive access to condoms
- Access to other services
- Basic health/sex related educational information

Needs	Obstacles	Opportunities
<ul style="list-style-type: none">• Proper rehabilitation programs	<ul style="list-style-type: none">• A lack of higher level policies and programs to address their issues• Street children highly dispersed• Resource constraint	<ul style="list-style-type: none">• NGOs, INGOs favorable

Men who have sex with men (MSM)

Although homosexuality is said to have existed for centuries in worldly cultures, its open acceptance is still lacking. "Nepal may not be an exception to this phenomenon." People of various backgrounds are engaging in same sex relationships in Nepal, most particularly males as noted by various professionals. Some are voluntarily engaging in same sex relationships and committing to sexual acts while others, specifically young boys (i.e. street children) are forced into it.

Men who have sex with men are generally perceived to be not at a high risk because there are social sanctions against homosexuality. Situation analysis has highlighted a gap between perception and reality in this issue. Homosexuality is, as stated above, persistent in Nepal. Men are either voluntarily having sex with other men, or forcing little boys (or men) to provide them sexual pleasure (FG, FV). Some are already infected with HIV/AIDS, others with STDs and along with these factors, their sexual behavior with multiple partners or bi-sexual relationships puts them at a risk of HIV infection.

Male sex workers

Male sex workers are generally unheard of in Nepali popular culture. There is a general disbelief that they do exist. There is a gap in perception and reality on this issue. There are increasing numbers of male sex workers committing to sexual acts with multiple partners, both women and men. This undoubtedly makes them prone to HIV infection. While all of these men engaging in some form of exploited "homosexual" acts may be exposed to general public awareness but because of stigmatization and minimal access to other institutions, they are not necessarily able to protect themselves.

Response Needs

- More studies/research done in issues of homosexuality as well as male sex workers
- Condoms/ preventive methods development with them in mind

Needs	Obstacles	Opportunities
<ul style="list-style-type: none"> • Acceptance and recognition 	<ul style="list-style-type: none"> • Homosexuality a taboo subject • Stigmatization attached with "homosexuality"/ seen as "immoral," "sick," etc. • Male sex work generally happens "behind closed doors" and unbelieved of. 	<ul style="list-style-type: none"> • Private sector interest • For male sex workers, NGOs and INGOs favorable.

Blood Recipients / Organ Transplant Recipients

In Nepal to date only one case of HIV transmission through blood transfusion has been reported officially. Similarly, one case of acquiring HIV after organ transplantation is also in the record (NCASC).

The policy on HIV/AIDS and STD mentions

- *HMG will adopt a policy of transfusing blood only after screening the blood.*
- *The result of blood tests will be kept confidential as per government policy.*

In Nepal, major organ transplantation needing human Leukocyte Antigen compatibility tests are not carried out regularly but corneal transplantation is relatively frequent. However, there are many people who have received organ transplant abroad, especially kidney transplant. The issue of "safe" (in terms of HIV) organ transplantation so far remains a silent issue. Unofficial information mentions that at least three persons might have contracted HIV after organ transplantation abroad. They were found to be HIV positive few weeks after the said operation.

Blood transfusion service (BTS) of NRCS is the only institution allowed to collect blood from donors for medical purpose and supply of it to medical institutions. Blood donation by HIV positive persons has been a serious issue for BTS as these people have repeatedly donated blood. It is not clear from the guidelines of NCASC whether the BTS should inform the HIV positive donors about their HIV positive status. "If the answer is yes, how should BTS proceed and what approach should it take?" Similarly, there is no system of referral from periphery as well as from one hospital to another for getting appropriate services for HIV positive persons if they are detected after blood donation.

Findings of RTD/ FGD and institutional interactions

Safety of blood transfusion has raised certain issues among medical professional regarding its safe use.

People involved in blood transfusion service, health care and HIV/AIDS raised the following issues in relation to blood transfusion and organ transplantation.

- Safety of donated blood: is it completely safe to be transfused with blood
- Issue of window period: is it completely safe?
- HIV testing prior to blood donation and its implications: Is it appropriate to test a donor before blood transfusion?
- HIV positives among health care workers: what care/support the health worker gets if s/he is found HIV positive?

Implications

Blood transfusion service and organ transplant services should be considered a major area for care and support programs. At the same time health workers find themselves in great dilemma due to technical and ethical reasons. This is very important for the National AIDS Program to address as many aspects of care and support stems from this.

Response needs

- Clear guidelines on blood transfusion and organ transplant.
- Support to be made for safe blood transfusion program.
- Training of health workers for rational use of blood.
- IEC activities for the safe organ transplant.
- Information and services to people donating or accepting blood about related possible consequences.

<i>Needs</i>	<i>Obstacles</i>	<i>Opportunities</i>
<ul style="list-style-type: none"> • Safe blood donation/transfusion 	<ul style="list-style-type: none"> • Blood-donors not-informed about their HIV status • Blood donors unaware of their high risk behavior in terms of HIV • Window period 	<ul style="list-style-type: none"> • Promotion of voluntary (non-paid) donors. • Promotion of regular donors • Initiation of "autologous blood transfusion"
<ul style="list-style-type: none"> • Rational use of blood 	<ul style="list-style-type: none"> • Many doctors order for "fresh blood" for conditions like chronic anemia <p>Consequences of blood transfusion are not discussed in training programs</p>	<ul style="list-style-type: none"> • Re-orientation to health care providers regarding safe blood transfusion and rational use of blood • Blood components available for certain conditions
<ul style="list-style-type: none"> • Screening before donating organ 	<ul style="list-style-type: none"> • No lab facility available • People unaware of serious consequences of blood transfusion 	<ul style="list-style-type: none"> • Willingness to develop facilities

Unborn / Newborn

World Health Organization emphasizes prevention of mother to child HIV transmission as a part of the comprehensive care - holistic and life span approach. However, lack of control over own sexuality and sexual relationship puts serious threat to the issue of HIV prevention among women, not to speak of the coerced sex. In Nepal's context, often women are blamed for spread of HIV, though the majority of them are probably infected by their only partner/husband.

The reported figures from NCASC show that the rate of housewives infected with HIV as of September 30, 2000 is on the rise. The number of children being infected is also climbing up obviously, most of it being vertical transmission. It is estimated that some 1000 children might be infected each year in Nepal. (UNAIDS, June 2000 data.)

Prevention of transmission of HIV from an infected woman to her unborn newborn child has been an open debate all over the world. Though this is still a least-debated issue in Nepali context, it is likely to raise many issues in near future due to following reasons:

- Screening of pregnant women has neither been included in the sentinel surveillance, nor in routine screening of pregnant women. So, the real scenario is yet to be visible (FGD/RTD).
- The women are less addressed in terms of HIV/AIDS issue. Even the UNAIDS seems to estimate the prevalence of HIV among women in Nepal at about 1/3 of the total estimated HIV infections, this in turn might have influence over the low estimation of HIV among unborn/Newborn (institutional interaction).
- Estimation that only one-third women might have been infected with HIV in Nepal in itself casts doubt over the reliability of the data/ source/ estimation, as there are no compelling evidences to believe that Nepal is different in terms of HIV transmission. Every available report / research/ study mentions that because Nepal is predominantly a patriarchal heterosexual culture, women are more vulnerable (biologically/ anatomically) to HIV than males. Similarly, many trafficked women are forced to

return to Nepal when they are found HIV positive abroad. This gives ample evidence that the estimation of HIV positive women is not less in Nepal, if more than the males in reality. This in turn casts shadow in the low estimation among the unborn/newborn as well (institutional interaction).

- Although it has been reported that the women seek medical care less than the males, it does not however mean that they are not infected/affected and do not need addressing for HIV prevention. Addressing such issues becomes more important in the total context of being a Nepali women with her overall vulnerability to HIV and the responsibility to bear a child.
- Number of orphans due to HIV/AIDS might be low in Nepal. However, the issue of the orphans is never one-sided and simple. Due to poor socio-economic condition in Nepal the issue might be masked, but the long-term implications have not been really analyzed.

Implications

- Every child has a right to live healthy as other children and every parent wishes to have a healthy child. The entire philosophy of perpetuity of life stands here and the society has the obligation to continue this notion however, a healthy parenthood is needed for healthy future generation.
- Responsible parents will make responsible children for the country.
- Antenatal care along with provision of maternal services is very important aspects in terms of HIV prevention and control.

Response needs

- Respect the right of child to born healthy and continue healthy life.
- Develop guidelines for screening of pregnant women.
- Make provision for AZT to women who are pregnant and HIV positive.
- Promote safe delivery practices to minimize infection.

<i>Needs</i>	<i>Obstacles</i>	<i>Opportunities</i>
<ul style="list-style-type: none"> • Screening of pregnant women during regular antenatal check-up 	<ul style="list-style-type: none"> • No guidelines available. • Availability of services in all the districts • "Window period" concept 	<ul style="list-style-type: none"> • Maternity hospitals has initiated the activity
<ul style="list-style-type: none"> • Provision of AZT to HIV positive pregnant women 	<ul style="list-style-type: none"> • AZT not available freely 	<ul style="list-style-type: none"> • some examples available in the country.
<ul style="list-style-type: none"> • Care of newborn 	<ul style="list-style-type: none"> • Not all health institution ready to conduct delivery 	<ul style="list-style-type: none"> • Some health institutions are good examples

Sexually Transmitted Diseases

STDs are considered to be one of the most common diseases in the world, ranking among the top five diseases for which health care is sought. Up to 70 percent of STD patients in Africa and up to 30 percent STD patients in Thailand are reported to have HIV (NMA Guidebook on HIV/AIDS, 2000). Chances of acquiring HIV infection through sex among STD patients are 4.5 to 9 times higher than for a person without STD. All these

factors show that for HIV/AIDS prevention program, STDs occupy a major area for intervention.

HIV is predominantly transmitted through sex, as do STDs. Over 1030 of the reported HIV cases in Nepal are under the category of STD/Clients of Sex workers (NCASC). In Kaski district alone, there are 14,000 STDs patient actively taking medicine (RTD Pokhara). In refugee camps and other areas of the country, the rate of STDs is on significant rise. Both can be prevented by safer sexual practices including condom use. Various organizations have been performing village to village drama, folksongs/ dances, etc in various places in order to create awareness about HIV/AIDS and to promote condom use. However, they rarely raise the issues of STDs. Furthermore, these programs are not always successful as they are one-time activity and spouses presence are not adequate. One of the reasons is the lack of couple counseling.

Sentinel syphilis surveillance in Nepal for last few years has shown some decreasing trend in syphilis prevalence among STD patients, who seek medical care.

Year	Number tested	RPR positive	%
1994	1542	113	7.3
1995	1995	23	4.5
1996	724	38	5.3
1997	980	34	3.5

However, other STDs are shown to be widespread among various population groups.

<i>Infection</i>	<i>Prevalence among symptomatic female in 1997</i>	<i>Prevalence among FSW in 1999</i>	<i>Prevalence among Family planning service seeker in 1999</i>
Trichomonas vaginalis	9.3%	9.0%	6.0%
Chlamydia trachomatis	5.2%	9.3%	1.7%
Neisseria gonorrhoea	1.9%	9.0%	1.7%

Source: UOH/STD HIV Project

These figures indicate that there might be significant number of STD infected persons in the country with higher chances of acquiring HIV.

Implications

These figures are important in terms of HIV prevention activities, as the implication of the infections would jeopardize the life of women in Nepali socio-cultural context. Person with STD are labeled as "immoral" and often discriminated against. However, it is more so with the women while treatment is widely available for bacterial infection and

often at affordable costs. Discrimination might play a negative role in prevention activities.

Response needs

- Awareness raising programs targeted on STDs.
- Training for widely available STD case management.
- Wide use of components of appropriate STD case management.
- Appropriate drugs available at the health institutions.
- Access to condoms.

<i>Needs</i>	<i>Obstacles</i>	<i>Opportunities</i>
<ul style="list-style-type: none"> • Awareness raising programs 	<ul style="list-style-type: none"> • "Not my problem" attitude 	<ul style="list-style-type: none"> • High number of housewives infected with HIV might be an advocacy tool • Certain level of consciousness already generated for HIV
<ul style="list-style-type: none"> • Appropriate STD case management 	<ul style="list-style-type: none"> • Training to all health care providers on appropriate STD case management • Provision of appropriate treatment at grass root level 	<ul style="list-style-type: none"> • Syndrome STD case management guideline exists. • Many of the drugs for STD are included in the essential drug list. • Well accepted approach
<ul style="list-style-type: none"> • 4"C" (compliance, contact tracing, condom promotion and counseling) concepts to be made clear to all health care providers 	<ul style="list-style-type: none"> • Training has not reached up to grass root level • Many times not all "4-Cs" are adequately addressed 	<ul style="list-style-type: none"> • Training program on HIV/AIDS can incorporate easily • Condoms easily available in health institutions

Care and Support

It has been well accepted that good care can greatly improve the quality and length of life of people with HIV. Care in relation to HIV is not limited to the treatment, but also includes emotional and spiritual support, as well as and support to the caretakers, families and communities.

In Nepal, an estimated 5000 PLWHA might be seeking medical care and other support in year 2000 and some 2500 deaths might have occurred in 1999 due to HIV/AIDS (UNAIDS). In contrary to the UNAIDS' estimation, the latest report of NCASC reveals that a total of 1,703 persons having symptoms of HIV (AIDS) with 140 deaths as of September 30, 2000. Although NCASC estimation of death toll due to HIV/AIDS is low, there are frequent anecdotal reporting cited in local newspapers some 15 deaths in one VDC due to AIDS in one district of Nepal, which do not constitute part of the reporting system.

Care and support for HIV/AIDS in Nepal has been an issue of debate since the very beginning of the pandemic reported in Nepal (Gurubacharya, Bhatta and Vadies, JNMA-1991). Few studies carried out later have shown that the pattern of presentation of AIDS

in Nepal is similar as elsewhere. (Suvedi, Rana, Gurubacharya- 1994, Suvedi – 1998). A few articles have been published in relation to the symptomatic HIV persons in Nepal. (Suvedi- 1995 and 1998). Tuberculosis has been increasingly coupled with HIV positive status. However, clear guideline is yet to be chalked out in this respect and many other issues.

In relation to HIV/AIDS and care and support, the policy guideline states that:

- a) *HMG will provide counseling and other services to those who are infected and affected. (policy- 10)*
- b) *HMG will adopt a policy to prevent and provide service through both government and non- government level. (11)*
- c) *HMG will adopt a policy of non-discrimination, whoever is infected or affected with HIV STD. (7)*

Although there are clear policy guidelines related to care and support at the *de jure* level, the care and support part is virtually non-existent at implementation level. Implementation and monitoring of these policy as is supposed to be practiced in various health institutions are not far from being interpreted and enforced. In reality, PLWHA are facing tremendous stigmatization, isolations and neglect from various health institutions. As reported in a health facility in Pokhara, a HIV positive patient was denied service and asked not to come back to that to facility again (Focus Group, Pokhara).

It is assumed that a significant number of PLWHAs are from poor economic backgrounds, and can not afford expensive medical care at all. In this sense they are far from even getting a "bad" service. A serious issue that is raised out of this is that who is held accountable for them not getting any treatment at all. The policies (a) and (b) mentioned above, in this case, again are not really adopted and/or initiated at local, regional, national health institutions due to lack of skilled human resources and appropriate infrastructure.

Until very recently counseling services in Nepal included a narrow meaning of explaining the client about how HIV AIDS is transmitted. Though there is a whole arena of counseling services in regard to psychological needs, that is vital to examine. In Nepal, this kind of psychology counseling service is virtually non-existence. Whatever the counseling services may be, it is worsened by a lack of an effective network, collaboration, and referral system. Most of all it lacks skilled human resources and management from the highest level to grass root levels. Despite these flaws few attempts have been made to understand the issues related to care and support to HIV/AIDS.

Few training on home-based care of AIDS to health workers and NGO staff have been carried out by NCASC. Similarly, NCASC is reported to have conducted a study on the needs of people living with HIV/AIDS and their caretakers in 1997. Unfortunately, the report is still to be generally available. Implementation of the findings in this respect was insignificant.

Few hospitals in the capital city have started taking care of symptomatic HIV positive persons. The scenario within Kathmandu valley and outside is significantly different. Due to limited resources and information/counseling services outside of Kathmandu regarding HIV/AIDS, general population tends to discriminate PLWHA to a greater degree.

Few studies (Rai C. 1993, Pyakurel N. 1993) clearly mention that there is negative attitude and feeling towards PLWHA. Discrimination, breach of confidentiality and non-availability of required service were major issues raised by FGD and RTD participants.

The medical community is responsive to the medical needs of PLWHA (Bhattarai, Karki, Naing-1999). In this context, many articles have been published in the medical journals of the country to aware medical practitioners. A KAP survey on medical professionals of Nepal regarding HIV/AIDS care and prevention shows that although 92% of the participants responded that if an HIV positive person comes to them with a medical problem of their specialty, they would manage themselves like other patients. However, in reality, this is rarely seen. Nepal Medical Association has recently published a guidebook on HIV/AIDS for medical professionals; however, its wide use by the medical community at the grass root level is yet to be seen.

Most PLWHAs are not receiving any support except for a few exceptions. NGOs like ABC Nepal, WOREC and Maiti Nepal are reported to provide some degree of care and support to HIV positive female sex workers returning from Indian brothels. This is being done in a temporary basis and is extremely limited due to various constraints at all level. There does not seem to be any clear program on care and support for a long-term sustainable rehabilitation. Medical care to those with symptoms is really a question, which is very rarely addressed.

A significant Numbers of PLWAHA mentioned that the medical service to them is rather insufficient. Neither are there any guidelines nor instructions to carry out the service by the medical professionals as well as the caretakers.

- The PLWHAs are left without serious attention in terms of care and support issues.
- IEC messages in terms of care and support contradicts with the prevention messages. (Example: AIDS is a killer disease, which kills the enthusiasm of the PLWHA to live.)
- There is no coordination between hospital and various organizations working in the field of HIV/AIDS.
- PLWHA do not know whether they can get required services in the country.
- PLWHA in Nepal are dying because of their HIV status and other illness related to it and not because of AIDS.
- Those who know about HIV/AIDS fear of dying but those who do not know about HIV/AIDS hope that they will be cured.

The issues raised by the PLWHAs are summarized as follows:

- *As the issue of confidentiality is very important to the PLWHAs, it is not always possible for them to expose their identity or the HIV status to the attending medical person.*

- "What is the use of exposing the HIV positive status if one is not going to get any required service?"
- "What about making those medicines available are available in other countries and not available in the country? Who will take the initiation?"
- "How can one get all the needed investigations done here in Nepal?"
- Can anybody take responsibility for the transmission (save it for health institution)?

Injecting drug users have also been in difficult position in receiving appropriate care. Many NGOs, mainly based in Kathmandu are taking care of them, but it is more or less confined to providing primary care of minor illnesses. Outside Kathmandu, the issues of IDUs are rarely addressed although these issues are becoming severe throughout the country (Dharan, Biratnagar, Nepalgunj, Bhairahawa and Dhangadhi).

Refusing acknowledgement of sex workers and denying service to them has also led to constraints in providing care for STD and HIV prevention activities (Nepalgunj).

Implications

Holistic approach stresses that care and support to PLWHA are important aspects in prevention activities. Involvement of PLWHA in planning of care and support program gives impetus to the successful implementation of program. In this respect it is very important that the care and support activities are seriously considered by the program to achieve the goal.

Response needs

- Maintaining confidentiality at the health care set up.
- Strengthening universal precaution and Infection control measures at the health care set up.
- Availability of appropriate care in selected health institutions
- Availability, accessibility and affordability of testing facility and anti-retroviral therapies.
- Provision of trained care treatment providers at all levels.
- Capacity of NGOs and others to be strengthened.

<i>Needs</i>	<i>Obstacles</i>	<i>Opportunities</i>
<ul style="list-style-type: none"> • Confidentiality 	<ul style="list-style-type: none"> • Not all health workers and health institutions conform to the policy of confidentiality 	<ul style="list-style-type: none"> • Clear policy exists in the country in terms of confidentiality. • Implementation of policies is possible • Training on confidentiality to NGO/TNGO and all related sectors.
<ul style="list-style-type: none"> • Receiving appropriate care at the health institutions 	<ul style="list-style-type: none"> • Negative experiences in the past by PLWHA • Non-availability of drugs and services at the Health Institutions 	<ul style="list-style-type: none"> • Many hospitals are receptive and developing care programs • AZT has been introduced among HIV positive pregnant women to reduce vertical transmission • Exploring possibility to provide Anti-Retroviral Therapy

<ul style="list-style-type: none"> • Universal precaution and infection control measures are inadequate 	<ul style="list-style-type: none"> • No clear guidelines and "safety measures" to the health workers. • No "strict" measures to follow the safe injection practices. • Management of HI reluctant / unaware of UP and IC 	<ul style="list-style-type: none"> • Nepal Medical Association and many other NGO promoting infection control measures and universal precautions • Health institutions very much receptive for universal precaution
<ul style="list-style-type: none"> • Cost of ART (Anti-Retroviral Therapy) 	<ul style="list-style-type: none"> • Costly medicines • Lab facilities not available 	<ul style="list-style-type: none"> • Medicines available in the market • Potential for developing lab. Facilities

Care Providers

A few hospitals (namely Teku Hospital, Bir Hospital, Patan Hospital and Teaching Hospital) in Kathmandu are providing care to symptomatic PLWHAs. However issues of PLWHA are not being addressed adequately and appropriately. There is only a degree of willingness to cope with the demands and only a room to provide "quality" care.

Case=8

Do you suggest me to go to a hospital and expose my HIV status? What if they take it otherwise breaching my confidentiality?

Since health care issues related to PLWHA in the context of Nepal's total health care system is a new dimension in itself, health workers in this area are not prepared. HIV/AIDS and care itself is a new paradigm to Nepal. Credible protocol, clear guidelines and policies are still lacking from the government's side which in reality is supposed to regulate and maintain the services in all the health institutions.

Health workers and care providers are very much concerned with the "minimum level" of universal precaution (infection control) measures in the health institutions. The overall concern is injection safety to the health personnel and its appropriate management in case a health worker contracts HIV through injecting equipment during his/her working environment.

From the point of view of care providers, it has been noticed that the care of HIV positive persons encompasses lots of issues. The concerns expressed are as follows:

- *Where to refer, if one encounters some undiagnosed situation?*
- *Can the person afford the cost of treatment?*
- *How can the care providers protect themselves with so little protection measures given to the health care providers?*
- *How long can the health institution keep a person with symptomatic HIV without any person to look after him/her?*
- *As the Anti-retroviral drugs are very expensive, how can one provide services?*
- *Availability of facility to monitor the retroviral load in a PLWHA?*
- *How can the health worker be protected/ provided services in case they acquire HIV during their professional work?*

- *Counseling is a major area, but is Nepal prepared for this? Can the health institutions afford all this?*

Few NGOs are providing care to PLWHA. However, it is often limited to "primary services". Whenever a PLWHA needs referral from NGO, there is no appropriate "recognized institution" for all the needed care and the NGO health personnel are rarely informed of the available services or the continuation of care. The gap in "continuum of care" is distinct in this respect, especially pertaining to infections like tuberculosis, skin conditions and multiple infections observed in PLWHA.

Continuum of care from health care facilities to home/community is a major issue for the PLWHA. Basically family members are the main caretakers at home. However, their level of knowledge on HIV transmission and appropriate precaution to be taken is non-existent. Moreover, there are significant numbers of PLWHA who do not have homes. In this sense, who is responsible for their care?

Role of religious institutions is considered important in providing psychosocial care (example from Thailand). However, these institutions are not active in Nepal (RTD/FGD). That's another area that requires further examination and could definitely be useful.

Implications

Care and support is considered to be one of the important part in the HIV prevention and control activities. Poor service and care mechanism does not help in the prevention and control activities. This also has negative impact on the program as the infected and affected people do not receive any type of needed and desired attention.

Response needs

- Introduction of behavioral modalities to over stigmatization toward PLWHA.
- Availability of measures for strict observance of universal precautions in the health care set up.
- Wide availability of materials for infection control measures in the health care set up (example: gloves, syringes, needles etc)
- Identification of health institutions and development of referral mechanisms for those in need
- Availability of upgraded laboratory facilities to monitor the progress.
- Clinical training to the care providers regarding management of HIV/AIDS.

<i>Needs</i>	<i>Obstacles</i>	<i>Opportunities</i>
<ul style="list-style-type: none"> • Appropriate information/ training/ skills to deal with HIV infection in health care set-up 	<ul style="list-style-type: none"> • Fear of transmission • Insecurity • UP and IC measures inadequate • Very few professionals, many unskilled "care takers" 	<ul style="list-style-type: none"> • Health workers are receptive • Some institutions have taken initiation (examples available)
<ul style="list-style-type: none"> • Referral for treatment 	<ul style="list-style-type: none"> • No health institution identified for referral 	<ul style="list-style-type: none"> • Central hospitals willing to take care initiatives.

	<ul style="list-style-type: none"> The availability of services not clear 	<ul style="list-style-type: none"> Guidelines exist/ human resources available
<ul style="list-style-type: none"> Injection safety is a concern 	<ul style="list-style-type: none"> Sterilization not observed Disposable syringes re-used Inappropriate disposal of syringes and needles 	<ul style="list-style-type: none"> Some guidelines exist in terms of injection safety. National level authority and many other organizations interested in collaborating
<ul style="list-style-type: none"> Safety of Health workers and care takers 	<ul style="list-style-type: none"> No clear supporting mechanism for the care – takers. Addressing the issue “ how to cope” if one is infected during medical intervention 	<ul style="list-style-type: none"> - Example exist in one hospital to follow
<ul style="list-style-type: none"> Modern laboratory facilities not available to monitor progress in relation to HIV load and progress in terms of CD4 cell count 	<ul style="list-style-type: none"> No lab facility available 	<ul style="list-style-type: none"> Willingness to develop lab facilities
<ul style="list-style-type: none"> Continuum of care 	<ul style="list-style-type: none"> Very little effort in this respect 	<ul style="list-style-type: none"> Homes and community are responding to the need
<ul style="list-style-type: none"> Involvement of social and religious institutions in psycho-social support 	<ul style="list-style-type: none"> No attempt have been made to explore the situation 	<ul style="list-style-type: none"> Example from other countries

Program Management

During desk review, RTD, FGD, Institutional and individual interactions, it was often stated that current National HIV/AIDS program is not paying enough attention to various issues related with HIV prevention and care. This included weak coordination/collaboration with partner agencies at the central level and virtually nil networking with the partner agencies at the community level. Similarly, the community level health institutions are not clear about their role in HIV/AIDS/STD prevention activities.

Findings from Institutional Interaction:

- “The line of authority from center to grass root level health institutions almost does not exist.”*
- “We organize world AIDS day every year and that is what we do for HIV AIDS prevention in this district.”*

Even district health offices (DHO) are not found to be clear on their role in HIV/AIDS prevention and control. NGOs were found to be very much responsive to address the issue but clear understanding on how DHO should deal with the issue and program planning, monitoring and evaluation is missing. Many NGOs and CBOs were found to be working in various districts but DHOs were not aware of these activities. The district health offices do not receive any fund from NCASC to run any related activities other than the World AIDS Day.

Lack of effective networking, collaboration and coordination often is leading to repetition of programs within the same group via same approaches. Moreover, absence of good monitoring and evaluation also further hampers success of programs.

Technical capacity is very weak at the National AIDS program (NAP). Sentinel surveillance, STD management counseling care and support activities come under NCASC's supervision and guidance. However, these areas are poorly addressed. Even the willingness to get support for these activities is very low. (RTD, FV)

Implications

A strong program guides the future momentum of HIV/AIDS situation in Nepal. Partners in the field would appreciate responsive program. However, cooperation and collaboration are crucial for the success of any program. The corner stone for this is good planning, monitoring and evaluation. And only then the impact will be seen at the grass root level. Otherwise the program will be labeled as “superfluous” and will have little impact on the prevalence and prevention activities.

Response needs

- Strong leadership
- Cooperation and coordination with partner agencies
- Responding to the needs
- Structure that reaches the grass roots level.
- Strong commitment and functioning mechanism to run the program

<i>Needs</i>	<i>Obstacles</i>	<i>Opportunities</i>
<ul style="list-style-type: none">• NAP should stand as a visible and important program	<ul style="list-style-type: none">• Willingness to grow is still poor.• Heavy external financial resources	<ul style="list-style-type: none">• Human resources available• Financial Resources available
<ul style="list-style-type: none">• Effective Cooperation and collaboration with NGO sector	<ul style="list-style-type: none">• Weakness in the cooperation mechanism	<ul style="list-style-type: none">• NGO Sector responsive and willing to cooperate
<ul style="list-style-type: none">• Strengthening of support programs	<ul style="list-style-type: none">• Weak structure• Weak financial support system	<ul style="list-style-type: none">• Blood safety: one of the successful program
<ul style="list-style-type: none">• Private sector mobilization for HIV/AIDS prevention	<ul style="list-style-type: none">• Minimal effort to Mobilize private sector	<ul style="list-style-type: none">• Private sector is responsive

Overall Analysis

Much of discussion on HIV/AIDS seems to have been debated and argued around the numbers of infection, survivors, deaths, etc. There are variations among these numbers in almost every study. The uniformity and consistency is surely lacking. However, the situation analysis has not emphasized on the variations of these numbers. Despite whatever the numbers may be, the magnitude of problems is alarmingly increasing. Within the next decade, HIV/AIDS will be a major "disease burden" in Nepal, becoming the leading cause of deaths.

The HIV infection in Nepal is increasing and so is the numbers of tragic deaths caused due to its infection and HIV/AIDS related issues. The highest prevalence of HIV/AIDS is among sex workers and injecting drug users. This means that *serious* and *immediate* priority is needed to address the issues facing these two groups.

Another area that also demands an immediate examination and intervention is the mobile population. They are serving as a bridging population to transmit HIV/AIDS from concentrated to generalized population. A large number of people fall into this group and perhaps, a significant percent of them may have already been infected. Situation analysis highlights that although adequate studies are lacking to reveal the realities of HIV infection among mobile population, it can be predicted that vulnerability is severe. They must be seriously considered for intervention programs if the HIV/AIDS problem in Nepal is to be properly unperturbed.

Spouse, students, youths and adolescents, unborn and newborns are general populations who are also on increasing vulnerability to contracting HIV/AIDS. Because they are the future stars of Nepal's development, it is vital to examine their HIV status and develop intervention programs.

With increasing vulnerability to HIV/AIDS, increasing numbers of HIV infections and increasing numbers of HIV/AIDS survivors, it is also important to develop effective care and support programs. The situation analysis highlights that there is a lack of technical guidelines and protocols for care and support of HIV/AIDS in Nepal. Because care and support program in itself is a part of intervention programs, effective guidelines and protocols are needed to be developed, implemented, enforced and monitored at various levels of health institutions.

Everyday more people are being infected with HIV. Only a small number of these people are likely to get tested for HIV/AIDS. A large percent will probably never find out about their HIV status and continue on having unprotected sex and sharing needles with multiple partners. The intensity of transmission is beyond imagination in this sense. However, in Nepal, the epidemic is still concentrated among sex workers and injecting drug users. If Nepal is able to develop specific targeted intervention programs immediately for these groups, the epidemic will, to a certain degree, reduce among the greater population. In this case, timely and immediate *priority* intervention programs are must for these groups. Simultaneously, other programs need to be introduced to address

the issues facing groups vulnerable to HIV/AIDS. In other words, future attention is needed on developing intervention programs for more conventional groups (i.e. youths) and clients (i.e. some mobile population) to control the further spread of HIV/AIDS among greater population. The concern should focus more on developing targeted intervention programs geared toward most vulnerable groups rather than trying to eliminate the impossibility (i.e. sex work, or drug use) or arguing over the numbers of infections, and deaths.

Conclusion

Although Nepal may not be perceived as a country with a major HIV/AIDS threat, the factors for its propagation are yet rampant.

The prevalence of HIV infection among sex workers and IDUs has significantly increased, demonstrating a shift from a low-level epidemic to concentrated epidemic.

The numbers of sex workers in Nepal are increasing. The situation analysis has illustrated that they are vulnerable to HIV/AIDS NOT only because of high-risk sexual behavior but also because of other systematic barriers of oppression facing their lives. One of the most important aspect being a lack of social and legal protection minimal access to social as well as health services and other resources (including proper rehabilitation, care and support etc).

The numbers of IDUs throughout the country is increasing. In absence of rehabilitation and counseling programs as well as affordable medical treatment, along with lack of safer and more responsible drug using methods, the numbers of infection will continue to rise.

Situation analysis reveals that in addition to high HIV prevalence due to injecting methods, their high risk-sexual behavior also contributes to overall increase in HIV infection among drug users. Female and male injecting drug users also involve in sexual acts with drug users and/or other clients, sex partners, etc. Thus, rendering everyone involved into further HIV/AIDS epidemic.

The mobile population, least addressed by research as well as by targeted activities serves as a bridging population to transmit HIV/AIDS from concentrated population (more specifically sex workers) to generalized population (i.e. housewives).

In the process of identifying the generalized population, the situation analysis has new groups who are immensely vulnerable to HIV/AIDS and needs to be set as a priority group for targeted intervention.

- Housewives are one of the groups who, due to limited access to information, resources and various constraining gender dynamics as well as due to lack of decision making and negotiating powers are transmitted with HIV/AIDS.
- Another population that is also at high risk is infants and children. This also includes the new born and unborn. Due to various dynamics affecting their lives, they are identified as immediate risk. Ethical and technical issues in relation to the issues of HIV in unborn/newborn are very important from the policy and strategic point of view. Although still not apparently visible and behind the bars of statistics, increasing numbers of AIDS orphans is a major area to take into account.
- A high proportion of HIV/AIDS infected males in the group 20-29 indicates that there is a need to access and examine their sexual behavior and other possible factors that may be contributing to HIV infection.

Provision of care and support to people living with HIV/AIDS is minimal at present. PLWHA concerns about confidentiality and provisions of care are unarguable. Similarly, health workers' concerns on poor state of universal precaution and infection control are not negligible. Issues regarding safe blood transfusion and organ transplantation are serious and demand appropriate action.

Population movement is an integral part of development, intervention to control the epidemic of HIV/AIDS through the control of human movement is unlikely to succeed. Rather programs to control the incidence of HIV/AIDS need to be incorporated into overall development program.

As pertaining to analysis done in each of these particular areas, situation analysis has again and again highlighted a major gap in terms of management of national AIDS program. There are numerous problems within the programs in terms of coordination, monitoring, information sharing and resources regarding HIV/AIDS within central, regional and local levels. Moreover, the flaw in capacity building including utilizing and motivating human resources to feel committed to the intensity of the problems itself further stretches the gaps. Inadequate and incomplete information dissemination, unavailability and inaccessibility of resources have partly to do with lack of a good management within health institutions. In this sense, a strong advocacy and commitment from a high profile figure is a must.

Despite the horrendous scenario of HIV/AIDS situation in Nepal, there are still myriad ways of working effectively to prevent its current traumatic spread. Many successful methods and targeted interventions programs can be developed in context of Nepal by utilizing boundless successful activities undertaken in other developing countries.

Recommendations

- The dynamics of mobility, both within and outside the country needs to be understood in national context. Studies and interventions should focus on the total mobility system rather than just migrants or specific sub-groups.
- Clientele abuses of sex workers seem to be very persistent. It is recommended that there should be specific laws and policies geared toward safety of sex workers. These policies should be thoroughly followed by the police and other authorities. In this aspect, there is a need for a good monitoring and evaluation system to see whether their rights have been protected or not.
- Although Nepal does not have necessarily officially recognized red light areas, there is still generally a good idea of where most sex work happens throughout the country. Targeted intervention is recommended in these specific locations.
- Because sex workers children are also very vulnerable to HIV/AIDS, it is recommended to develop effective programs and provide them with free and easy access to various institutions, resources and information.
- To incorporate sex/sexuality and HIV/AIDS studies into national education curriculum.
- Situation analysis has identified few new groups that are at immediate risk of HIV/AIDS and needs further national attention. In this sense, targeted intervention programs should be developed with them in mind.
- Government endorsement and wider practice of harm reduction programs particularly needle exchange along with methadone tablets, as substitute drugs have to be made available.
- Prevention: All aspects of HIV/AIDS related issues require some sort of preventive methods. All the preventive methods broadly include follow categories. It is recommended to adhere by these measures for accomplishing fully effective preventive programs.
 - Basic sex/sexuality education promotion
 - HIV/AIDS awareness
 - a. debunk myths
 - b. appropriate messages
 - c. gender sensitivity
 - Condom Promotion
 - Proper Access to Services
 - Customize accordingly to specific local needs
- Care/Support: Care and support is an integral part of addressing the issues related to HIV/AIDS epidemic. It is recommended to consider the multiple facets of

care/support related issues that are crucial to create successful intervention programs.

-Counseling

a. Development of counseling infrastructure

- ◆ Referral
- ◆ Facilitation
- ◆ Follow-up
- ◆ Management

b. Different between counseling and advising and develop clear guidelines.

b. Psychological counseling mandatory

c. Promotion of family based counseling

- Rehabilitation

a. Resource mobilization and proper utilization for long term benefits

b. Promotion of self-reliance through income generating activities and life-skill training.

- Medical Care providers/institutions

a. Promotion of issues related to HIV/AIDS

b. Development, implementation and monitoring of proper guidelines to be abided.

c. Provide proper resources to create a safe environment for HIV/AIDS patients and care takers themselves.

- Program Management: National infrastructure within the country has to be strengthened. This accommodates various aspects of (i.e., human, financial managerial) that are vital to examining and reviewed.

This includes

- Capacity building
- Coordinating
- Collaborating
- Planning
- Monitoring and Evaluation

References

- A Base line study of Commercial sex workers and Sex clients on the land transportation route from Naubise to Janakpur and Birgunj. 1995. AIDSCAP. New Era. Kathmandu, Nepal.
- A situation of Knowledge Analysis of Sex work and Trafficking in Nepal with reference to Children. 1997. New Era, Kathmandu, Nepal.
- Adhikari, H. 2057. Rastriya sima ra sikshya chetena le pani rokna nasakeko HIV/AIDS. Gorkhapatra, Bhadra 17, Kathmandu Nepal.
- AIDS and the military. 1998. UNAIDS Best Practice Collection.
- AIDS Epidemic update. 1999. UNAIDS/WHO. Geneva, Switzerland.
- AIDS. Some Questions and Answers. 1998. WHO, New Delhi, India
- Amit et al. 2000. Present situation of HIV/AIDS. The Kathmandu Post August 6.
- An evaluation of interventions targeted to commercial sex workers and sex clients on the land transportation routes from Janakpur and Birgunj to Naubise. 1997. New ERA, Kathmandu Nepal.
- Analysis of Budget and Aid Restructuring in Nepal for monitoring 20/20 Compact. 1998. Institute for Sustainable Development, Kathmandu, Nepal.
- Assessment of Knowledge, Attitude and Practice concerning HIV/AIDS and STD among Youth in Dang, Kailali and Surkhet. 1998. Karmic Society, Kathmandu Nepal.
- Behavioral Surveillance Study on the Highway Route of Nepal. Round # 2 and Kathmandu FSWs Seroprevalance study. 2000. New Era and SACTCS, Kathmandu Nepal.
- Bhatta, P et al. 1993. Commercial Sex Workers in the Kathmandu Nepal. 1993. AIDS and STD prevention Group. Valley Research Group. Kathmandu Nepal.
- Chameli: A film about girl trafficking in Nepal. An Impact assessment 2000. Reel Images, Kathmandu, Nepal.
- Chin J. 1994. Consultant report on HIV/AIDS surveillance findings and estimation projection of HIV/AIDS in Nepal. World Bank.
- Chin J. 1999. A reassessment of the HIV/AIDS situation in Nepal. FHI, Kathmandu, Nepal
- Country Report. The World Summit for Social Development, 1995. Rural Reconstruction Nepal, Kathmandu, Nepal
- CWIN 2000. Far away from home. Survey study on child migrant workers in Kathmandu valley. CWIN, Kathmandu Nepal
- Decosas, J. 1996. HIV and Development. AIDS vol. 10(supplement): S69-S74
- Education and Health Sectors Assistance Strategy Study. 1996. National Planning Commission. His Majesty's Government of Nepal and Asian Development Bank. Kathmandu Nepal.
- Erpelding, A. Assessment of Knowledge, attitude and behavior concerning STD/HIV among Army recruits. Report of a study from Trisuli in collaboration with WICOM. NCASC, Kathmandu, Nepal.

Ghimire, D. Sex industry and woman Trafficking. ABC Nepal, Kathmandu Nepal.

Guide to Technical Support available to HIV/AIDS projects in developing countries. 1995. UK NGO AIDS Consortium. London, UK.

Hertd, G. 1997. Sexual cultures and population movement implications for AIDS/STD. Oxford University press, 1997

ILO. 1995. Child labours in Nepal. ILO/IPEC, Kathmandu, Nepal.

Internal and International Migration in Nepal. 1983. Summary and recommendation of the Task force on migration.

Into the Valley of AIDS. 2000 Nepali times (August 9-15) Kathmandu Nepal

Inventory of HIV/AIDS Information sources in the Asia Pacific Region. 1999. UNAIDS, Bangkok Thailand

Investing in Health. 1993. World Development Report. World Bank, Washington DC, USA.

Jenkins J.B. 1999. 2nd Global Conference on Drug Abuse Primary Prevention. 8-12 Nov, Bangkok, Thailand

Jha. H.B. 1995. Nepal-India border relations. Centre for Economic and Technical Studies.

KC, B.K. 1997. Migration situation in Nepal. Central Department of Population Studies. Tribhuvan University, Kathmandu, Nepal.

Kyelem, D. 1999. Young People's Access to Sexual and reproductive Health Services in Kathmandu, Nepal.

National Policy for AIDS and STD control 2052 NCASC, Kathmandu Nepal.

Nepal Population Report. 2000. HMG Ministry of Population and Environment, Singha Durbar, Kathmandu, Nepal.

O'dea, P. 1993. Gender Exploitation and Violence. UNICEF, Paris, France.

Parajuli, B.L. 1996. Knowledge, Attitude and practice study on HIV/AIDS and sexual Behavior among students in Pokhara. NCASC, Kathmandu, Nepal.

Peak, A. 1993. A study on the Knowledge, Behavior and HIV-1 prevalence among injecting drug users in Nepal. WAVE 2. LALS, Kathmandu, Nepal.

Peak, A. 1993. A study on the Knowledge, Behavior and HIV-1 prevalence among injecting drug users in Nepal. WAVE 3. LALS, Kathmandu, Nepal.

Population Projections for Nepal. 1998. HMG, Ministry of Population and Environment. Kathmandu, Nepal

Poudel, K.C. 1999. Migration Pattern of Doti. Participatory Planning and Management of HIV/AIDS

Prasai, D.P. 1998. Adolescent Sexuality. Knowledge, Attitude, Beliefs and Practices of Unmarried Adolescents. A school based study in Palpa District of Nepal. FPAN, Kathmandu Nepal.

- Prison and AIDS. 1997. UNAIDS Best Practice Collection. UNAIDS Geneva, Switzerland.
- Proceedings of the workshop on Harm Reduction Program Planning. 1999. NCASC, Kathmandu, Nepal
- Progress in Health Development in the Southeast Asia Region. 2000. WHO, New Delhi, India.
- Puri, M. 1998. Sexual Behaviour and Risk perceptions of STDs/AIDS among non-resident men in Nepal. CREHPA, Jawalakhel, Kathmandu, Nepal
- Rapid Qualitative Assessment of AIDSCAP effect on Behavior changes among commercial sex workers and their clients. 1996. New Era, Kathmandu Nepal.
- Report on the global HIV/AIDS epidemic. 2000. UNAIDS Geneva, Switzerland.
- SACTS Report 1996. Baseline study to access the Knowledge attitude on STDs/AIDS among migrant workers, young traveller and house wives
- Seddon, D. 1998. Missing Girls. Quarterly Development Review.
- Seddon, D. 2000. Foreign Labor Migration and the remittance economy of Nepal. Final Report to DFID. Overseas Development Group, University of Anglia, Norwich
- Shrestha H. 2000. Adolescent health in Nepal. The Kathmandu Post. October 22
- Skeldon, R. 2000. Population mobility and HIV vulnerability in Southeast Asia: An assessment and analysis. UNDP
- STD and HIV Prevalence Survey among female sex workers and truckers on the highway routes in the Terai, Nepal. 2000. New era and SACTS, Kathmandu Nepal.
- STD/HIV/AIDS Intervention in Military and Police in Nepal A case study. 1999. WICOM, Kathmandu Nepal.
- Strategic Plan for HIV/AIDS in Nepal 1997-2001. NCASC, Kathmandu Nepal.
- Subedi, B. K. 1993. Seasonal Migration in western Nepal and its relation to HIV Transmission.
- Suvedi, B. K. 1995. HIV/AIDS in Nepal: an update. J. Inst. Med. Kathmandu
- Suvedi, B. K. 2000. Mapping the Trend of HIV/AIDS in Nepal. J. Inst. Med. Kathmandu
- Subedi, Rana T. Gurubacharya VL. 1993. Presentation of HIV/AIDS in Nepal. JNMA. Kathmandu.
- The World Health Report 2000 Health Systems: Improving Performance. WHO, Geneva, Switzerland

We would like to thank all the following individuals for their contribution to this study.

Achut Raj Mishra	Ganesh Kumar Jha	Phanindra Gautam
Amar Ghale	Ganesh Magar	Prachanda Shrestha
Amir Khati	Ganesh Sanpan	Prasant Lamichhane
Asha Basnyat	Ganesh Shrestha	Punya Prasad Paudel
Armina lama	Geeta Rai	Purna Shrestha
Binod Gyawali,	Gita Dhakal	Radha Dahal
Bir Bahadur Tamang	Gita Koirala	Raj Kumar Dhakal
Bir Bahadur Tamang	Gokul Dev Acharya	Rajendra Adhikari
Birendra Parajuli	Gopal Gartaula,	Rajiv Kafle
Bishnu Ghimire	Indira Karki	Ram Bahadur Shrestha
Bishnu Sharma,	Inspector D.B. Kanwar-	Ramesh Adhikari
Bisho Khadka	Jagadish Lohani	Ramesh Neupane
Chandra Gurung	Jagannath Neupane	RamHari Neupane
Dainji Sherpa	Jagdish Aryal,	Ramji Thapa
Digambar Piya	Janardan Shrestha	Ranjan K. Aryal
Dilli Ram Baral	Jeevan Ratna Bajracharya	Rishi Ojha
David Bridger	John Dickinson	Rishikesh Silwal
Dr. Buddhi B. Thapa	K.B. Thapa,	Rohit Chhetri
Dr. Chandra Kumar Sen	K.P. Bista	Roshan Kattel
Dr Gynendra Giri	Kedar Khadka	Sabitri Phuyal
Dr. G.R. Shakya	Khadga B. Basnet,	Sambhu Bahadur Shrestha
Dr. J. Chandy	Krishna Kandel	Samjhana B. Karki
Dr. James Ross	Krishna Kumar Subedi	Santa Khadgi
Dr. L.B. Thapa	Krishna Prasad Shigdel	Shanta Thapalia
Dr. L.R. Pathak	Krishna Rajbhandari	Shib Hari Maharjan
Dr. M. Shamsuddin	Krishna Yadav	Shree Prabha Sharma
Dr. M.D. Bhattarai	Krishna B. Thapa	SI. Amar Gopal Shrestha
Dr. Madhuri Adhikari	Kushum Shakya	Sitram Bhatta
Dr. N.M. Shrestha	Laxmi Pokharel	Steve Mills
Dr. Nirmal Jha	Lila Devi Roy	Sub. Inspector Suma Karki.
Dr. Rajendra Bhadra	Loknath Kandel	Subodh Kumar Singh-
Dr. Savitri Pahari	Madhu Sudhan Koirala	Sulochana Pokhrel
Dr. Shyam P. Bhattarai	Mahesh Dev Bhattarai	Sunita S. Mallia
Dr. Sudha Sharma	Mahesh Sharma	Surya Koirala
Dr. Upendra Koirala,	Mani Aryal -	Tara Chettry
Dr. Swasti Bajracharya	Meena Neupane	Tara Devi Rijal
Dr.V.L. Gurbacharya	Mohammad Alam Khan	Usha Bhurtel Koirala,
Dr. Wiwat Rojanapithayakorn	Mukul Ghimire	Yamuna Koirala
DSP Hemanta Malla	Narayan Ban	Yam Prasad Pandey
DSP. Parbati Thapa	Om Raj Paudel	

We are thankful to all the following institutions for supporting our study by making information readily available and by providing us with important human resources.

ABC Nepal	HAMS	Red Cross, Chitwan
Amnesty International	HELP, Biratnagar	Richmond Fellowship
Bheri Zonal Hospital	Indreni Jagaran Manch,	SACTS
Bir Hospital	Morang	Save the Children, US
Birendra Army Hospital	INF	SCF(UK)
Blood Transfusion Centre, NRS	Koshi Zonal Hospital	SCF, NEPAL
BNMT	LACC	SCF/US
BP MHF	LALS	SEDA
Mahendra Morang Campus	Maiti Nepal	Teku Hospital
Central Jail	Mary Stopes Clinic, Chitwan	Tourist Police
Central Police Women Cell	Maternity Hospital	Tri-Netra Nepal, Chitwan
NGOCC, Chitwan	Municipality Ratnanagar	UMN Sakriya HIV/AIDS
CLAA	Mental Hospital, Kathmandu	UNAIDS/Bangkok
Daan's Care Nursing Home	Ministry of Health	UNDP HIV/AIDS, Nepal
DDC-AIDS Program Cell, Morang	Ministry of Home	UNHCR, Nepal
Department of Health Services	Ministry of Law & Justice	UNICEF, Pokhara
District Administration Office, Chitwan, Morang & Kaski	MOH STD/HIV Project	University of Heidelberg
District Police Office, Kaski, Chitwan and Morang	NCASC	STD/Control project
District Development Committee, Morang, Kaski and Chitwan	NDCLEU	Western Regional Hospital
District Education Office Morang, Chitwan	Nepal STD and AIDS	Youth Power, Nepal
DPHO, Kaski, Kathmandu, Chitwan, Morang	Research Center, Nepalgunj	Youth Vision, Kathmandu
EHDAG	Nepal Red Cross Society,	
FHI, Kathmandu	Kathmandu, Morang, and	
FHI, Regional Office, Bangkok	Chitwan	
FPAN, Kathmandu and Chitwan	Nursing Campus	
General Welfare Pratisthan, Kathmandu	PLAN International	
	Pokhara sub-metropolis	
	Prerana/ APN	
	Pro Public	
	Program Officer, DDC	
	Punarbiban Sarokar Kendra	

Structure of the National AIDS Program