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Situation Analysis of HIV/AIDS in Nepal

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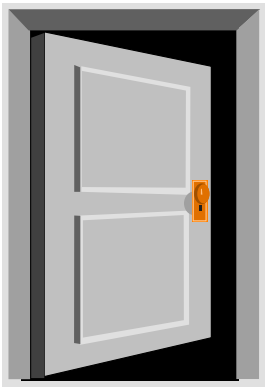

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Richoi Associates
Study Team

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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 inadequate surveillance mechanisms and poor data keeping. The discrepancy in the 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 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 offsprings, born and unborn, as well as many others, may further expand and generalize the epidemic. A lack of adequate and effective control program that specifically addresses the mobile population will only accelerate this process.

Situation Analysis has also identified other conventional groups (i.e. youths & adolescents 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 the 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 Nepal's exposure to the HIV/AIDS epidemic.

The gaps identified within each domain of this situation analysis seem to have been further exacerbated by a lack of consistency in policy, continuity in leadership and credibility in the management of National HIV/AIDS programs. Thus, advocacy programs need to be spearheaded by prominent national figures, recognized by a large majority of the population, if maximum impact and benefit are to be anticipated.

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 change.

As concluded, the situation analysis has highlighted following major aspects of HIV/AIDS prevention programs that demand 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, adolescent and youth, 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, 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 are 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 takes a generalized form.

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	• 75 Districts • 58 Municipalities, 3913 Village Development Committees • Capital: Kathmandu
Special features	• The size of the economy is small with low economic growth, low investments rate and a large informal sector. • Power alliances seem fragile with weak infrastructures, lack of human resources and development, high population mobility, etc. • Almost 80% of the total population are Hindus. Diverse ethnic and cultural background. • Diverse geographic settings -- from the highest peaks in the Northern part to the low land in Terai, within a 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 is 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, ARI and many others. • Rehabilitation, improvement and management of health services remain a key issue and a priority to MOH. • Although government health institutions do exist at the grass root levels, these institutions are at best providing minimal services due to limited human and 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 institutions.

HIV/AIDS epidemiological Situation

Background

- 1988- HIV/AIDS 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 (implemented).
- 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 found to be mostly affected with HIV, gradually spreading to the eastern and Western parts of Nepal (Suvedi-1999).

Summary of HIV/AIDS Surveillance Data

	Figures in Number	Year
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 number of orphans due to death of HIV/AIDS parents	25,00	WHO (1999)
Estimated number 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 users	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 are:

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 comprised of studies and research papers prepared by INGOs and NGOs including some government published documents. However, it must be pointed out that a majority of these documents are rather old and did not necessarily represent the current situation of HIV/AIDS in Nepal. A list of these materials is given in reference.

Round Table Discussion (RTD)

Round table discussions (RTD) were held in Kathmandu as well as in other selected areas. These areas included Biratnagar, Bharatpur (Chitwan), Nepalgunj, and Pokhara. A total of nine round table discussions were held, each lasting for more than three hours participated by eight to twelve persons and facilitated by knowledgeable and experienced professional.

These discussions helped to gather relevant information with regards to IDUs, SW, MP, PLWHA, and care and support in context of HIV/AIDS situation analysis. A number of

useful topics were discussed. Experiences and knowledge gained through studies and research were shared and exchanged among the participants. Ideas on utilizing research data and 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 refer to Appendix I for details.

Focus Group Discussion (FGD)

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

Places, where FGD were held:

1. Central Jail at Kathmandu with 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 Interaction

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 Interaction and Interview

Various personalities were contacted with seeking their views regarding the HIV/AIDS situation in Nepal as well as issues related to its prevention and control. Their views have been reflected in this report. As a matter of fact these views have also supplemented 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 quite sensitive, vital and has a national significance, 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 the allotted three months' period included two major Nepali holidays, *Dashain* and *Tihar,* which naturally cramped the parameters of the study. Secondly, 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 only limited numbers of studies conducted in this area. Most of the researches done are either very out-dated or specific only to certain geographical locations of particular groups. Furthermore, the majority of data that is currently available is inconsistent and lacks uniformity. These factors make it difficult to develop national comprehensive HIV/AIDS situation, 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 emerged 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, a 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 the discussion of the implications looming for Nepal's HIV/AIDS predicament.

Sex Workers

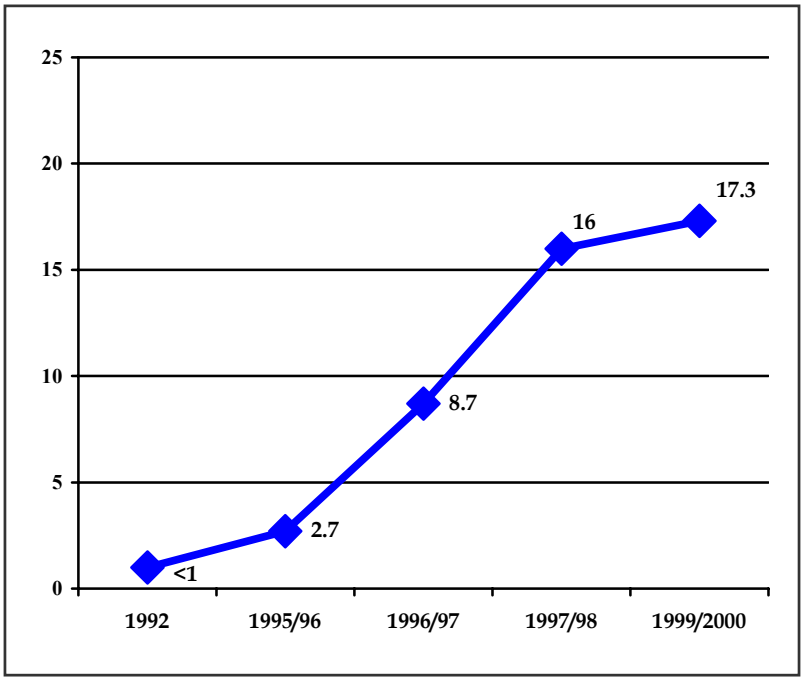
Sex work is defined here as a trade, exchange and/or selling of a sex to people seeking it. It is an inevitable avenue for economic gain to people (especially women) with limited resources or access to social institutions. In Nepal, historically and to a certain degree culturally, sex work has existed 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 demand 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, there has been an increase in both the supply and demand 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 high-risk sexual behavior, often leading 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 up. A study undertaken 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 is likely to have 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 contact further intensifies the situation. The overall situation would be even more disheartening if the clients of the sex workers are 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 situation through the various activities as stated in the objectives 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 in the age group of 15 to 28 years. According to a SACTS study conducted in Feb. 2000, in the Kathmandu valley alone, 62% of female sex workers range between 20-29 years in age. The trend of street children being exploited and involving in the sex work is also increasing in 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. Especially, 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 expbitation. Thus, further expanding risks of contracting HIV/AIDS.

Although a number of organizations such as Maiti Nepal, ABC Nepal, GWP and numerous others have done significantly appreciable and honorable work for enhancing better conditions for the sex workers, ample room, nonetheless, do exist for improvement and expansion for intervention programs targeted at them. 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 the attempts of 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. Some 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 these problems -- significant changes will not occur.

Legal Issues/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 decriminalization would provide sex workers with better social and economic security; they would also be able to form organizations and develop specific agendas 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 clients and 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 are 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 put sex workers at a very vulnerable position. Often, they develop the so-called "adverse mentality" by which they refuse to use condoms knowing they can transmit HIV/AIDS to the clients, who later on spread the infection 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, clients refusing to use condoms and yet still having sex opens avenues of research, which needs further examination. Most researches and studies show 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 #1 1
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 have 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 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 depressed 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 an unprotected sex, thus putting all parities involved at higher risk of contacting 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 are 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 envoice 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 to 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, most 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 are compelled to 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 are because a) their husbands had married another woman and b) they have been alcoholics and abusive. Although separated, most sex workers are often found having sex with their husbands. Some also have client/husbands (who are often abusive) but 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 is two months pregnant, is beaten up by her husband everyday. He kicks her on the stomach, punches her, and often even locks her up inside the room all day. Sometimes, he does not let her eat. She reported being very week and tired. On top, he has taken away all her money and the jewelry that she stole from her parents (before she ran away with him) and sold it. Once it so happened that She starved for three days and that is when she decided to engage in sex business. (Pokhara, FG)

5. Most sex workers with children are raising their children independently without any support from their husbands, including the children born out of sexual encounters with the clients.
6. Sex workers do have multiple abortions. Abortion 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 kind of drugs. However, a large percentages drink alcohol, often as an escape for them from worries.
10. Sex workers think about committing suicide frequently.
11. Significant populations of sex workers at some point of their life have tried alternative employment opportunities, but have failed to solely depend on these. Therefore, they ended up doing sex work as a side job. New ERA Study in 1998 shows 56% of female sex workers are engaged in 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 in a position 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 her footsteps. (FG Pokhara)

12. It is important to highlight that often their money is snatched away by clients after the sexual encounter takes place or they are not paid at all. The confrontation generally ends up in sex workers being physically and sexually assaulted.
13. The pattern has been that clients frequently abuse sex workers. Most of the abusive clients as pertaining to focus group in Pokhara are rowdy young men who even use alcohol and drugs (i.e. marijuana and hashish)
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 do not possess good ideas about what it is and how it is transmitted.

Implications

Certain implications of these information gathered during the focus group meeting, round table discussions and literature review have been drawn.

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 among 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 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 safe environment, minimum protection (by police or any other governing bodies) against abuse and maximum social instabilities in their lives have 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 put them at higher vulnerability level to transmit or to be transmitted with HIV/AIDS.
6. A good support system including places for their health examination, counseling centers on STDs, HIV/AIDS, building self-esteem and treatment for psychological issues, depression, violence etc is also virtually non-existent. As a result, they are not always able to protect themselves from contracting **infectious** diseases.
7 Children of sex workers are also growing up with out 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 particularly deal 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 the irresponsible sexual behavior committed by some fellow Nepali adolescents, youths 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 home as well as lack of education on having a healthy relationship with wives or lovers also affect the kind of choices they make in life (i.e. not wanting to use a condom, having multiple wives/ sexual partners), 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 as in India; people also do not tend to think that a significant number 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, most of them do visit sex workers in secrecy. In the same vein, because sex workers are highly dispersed and unstable, much of the 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 constrain their access to social services and information. The majority of institutions including the 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 organized and de-criminalised sex work would allow sex workers to protect themselves from social barriers and abuse causing better stability in their lives and further helping to mobilize their own community for common good. Furthermore, it would also help them to pinpoint the problems within their own domain and seek necessary actions to solve their problems including HIV/AIDS. However, since this is not the case, factors of instability, dispersion and lack of organizational identity of sex workers create 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 them.
- Network of extensive services around places where they are more likely to live and conduct their business.
- Commitment of proper guidance and resources for them to form organizations at the national level.
- A nationally supported and coordinated effort 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 of SACTS shows that within Kathmandu valley, only 18% of 300 sex workers 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 residing 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 reported using condoms with all their clients whereas only 21.5% of them reported 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 undertaken 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 it 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 are 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 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, rickshapullers, businessmen and policemen (pg. 14, May 2000). Like this study points out, most of the clients are 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 is that not many studies have been done on the clients. In fact, until very recently clients were not openly discussed and not perceived to be at high risk of HIV/AIDS. There is a gap between perception 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 spouse/partners 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. spouse). Moreover, it's also important to point out that clients also do bring HIV/AIDS to the sex workers not just to their partners. In this sense, it is also important to note that they are also a group with 'high-risk' behavior.

Although some clients may have access to condoms and other services, a significant numbers, however, don't. Moreover, clients as a dispersed group who are difficult to be identified, make it even more difficult 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 speck 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.
- Policy incentive is needed for organizations and social services geared toward addressing multi-sectoral issues related to HIV/AIDS and clients.

Housewives

A whole another entity of sex business, who are directly or indirectly, affected by the fatality of HIV/AIDS and are rarely discussed in the literature, are the housewives (spouse). Although never been researched on their vulnerability to HIV/AIDS, as most professionals working in the fields of HIV/AIDS point out that housewives are the most

prominent 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 reality 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 are absent having migrated to another city or 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 relation 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 affect their abilities to protect themselves from HIV infection.

Response needs

Housewives need:

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

Obstacles and opportunities

Need:	*Obstacles:*	*Opportunities:*
• Responsible sexual behavior education	▪ Low literacy rate and lack of awareness among the people who are involved in high-risk behavior and also among people who are at high risk. ▪ 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.	▪ Ministry of education and health, local bodies and non-governmental organizations favorable ▪ Precedent for HIV/AIDS messages on TV, radio and through medium of poster and pamphlets. ▪ Promotion of sexual behavior and sex education through village to village drama, folk songs, dances, etc.
• Condoms that are friendly to targeted population	• Condoms have a bad image. • Proper utilization of condom is lacking.	▪ 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 as a method of family planning and for prevention of STDs/HIV.
• Access to Condoms	▪ Accessibility to condoms is also minimal and they are not accessible when and where they are 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	▪ 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.
• Access to services	▪ 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.	▪ Creation of voluntary testing based on counseling services in various areas of Nepal ▪ Infrastructures providing services adequate (but not enough) and therefore, must be reoriented. ▪ Health institutions exist throughout the entire country ▪ A lot of "street medicine" and/or "home 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 narcotics that prevailed have dramatically changed over the period, their utilization has rather alarmingly escalated due to the criminalization of cannabis and easy availability of other cheaper substitutes 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 disclosed as 2 % of IDUs being HIV positive. Unfortunately, recent studies (1998/99) reveal that the trend of HIV positives among IDUs demonstrates sharp rise with 49% being HIV positive.

Sadly despite the efforts of government or non-government sectors to address and intervene HIV/AIDS issues related to IDUs, the number 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 of. The government's as well as other players' lack of efficiency to capitalize on such internationally appreciated effort may be causing a continuous increase in positives among IDUs throughout Nepal. Dr. Swaroop Sarkar, Technical Adviser, UNAIDS, New Delhi pointed out 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, current attempt to provide substitute drugs by mental hospital is even experiencing immense difficulty. Moreover, this has also to do with shortage of human and financial resources.

Substantial issues raised in the Round Table Discussion

An important fact that was brought up during RTD was regarding the actual number of drug users in Kathmandu Valley, and in the entire country. Manners 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 with. Thus leaving room for discussions on size of the drug users. In any event, because high percentage of IDUs are HIV positive, even the lower end of estimated drug users makes the number of HIV infected people rather high.

Although drug users particularly, IDUs claim that they do not seek sex with FSW, it has been noted that the non-injecting drug users do visit female sex workers. On one hand, data presented at Harm Reduction Workshop in June 1999 indicated that 72.2% of drug users had premarital sex with multiple partners and 64.7% of them without using condom. Thus, they (if positive) might have been categorized as in the same users as IDUs being positive. On other hand, as reflected in various studies, a recognizable percentage of IDUs do visit female sex workers. This is also 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. Among who are subsequently labeled and categorized as positive IDUs, they could have contracted HIV either from sharing needles or engaging in unprotected sexual acts.

Another serious aspect of IDU's relation to HIV is linked to deprived street children who are considered to be most vulnerable within the groups of IDUs. Drug habits are almost always the result of street children working as "go-getters" between drug dealers and users. Unfortunately as "go-getters" they are compensated in the form of drug as remuneration.

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

Findings of Round Table Discussion (Biratnagar)

Although rapid growth in drug related HIV/AIDS epidemic is realized, a lack of proper coordinated efforts seem to have created confusion, frustration, and dismay on this issue.

For as much emphasis is given and activities are being launched for drug users, questions are still being raised on whether these efforts have fallen in the right places or not. 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 have received minimal and inadequate awareness messages and are more likely to indulge in risky behavior without (proper) knowledge of HIV/AIDS and resources related.

In addition, evidence of wrong interpretation and/or ineffective awareness campaigns are also cited from time to time.

Case # 6
A person from a village in eastern Nepal was given condoms as family planning method, and was taking it orally, before realizing after twenty-four days what its proper use was!

Institutional networks including schools could also prove to be effective information dissemination mediums. Since police presence exists at least in all parts of the country, they can be encouraged to provide supportive attitude toward the programmes and organizations to implement harm reduction programs. Similarly, numbers of human resources from other multi-sectoral organization such as health workers, agriculture extension workers, village secretaries etc. can also be utilized as effective mediums for information dissemination and awareness programs.

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

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 "taboo" associated with this subject, messages disseminated often remain incomplete. The depth of expression needed to make 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. The lack of counseling services is a big void in the effectiveness of care and support to HIV/AIDS patients. It is sad to say that health care providers' attitude and manner are not encouraging in this respect. Doctors and other medical personnel have their own difficulty, as they could also be vulnerable in the absence of precautionary measures at different health institutions.

Findings of Focus Group Discussion (Biratnagar)

Although the number of drug users has increased, types of drugs being used have narrowed. It is estimated that in Biratnagar area (Dharan and Itahari included) alone, there are around 10000-15000 drug users (as mentioned in the Focus Group) and among them, a large majority comprising of IDUs . A majority of people addicted to drugs eventually resort to injecting drugs. All of them start out with lesser forms of drugs, usually pharmaceutical such as Phensedyl, and shift to injecting druges such as Tidigesic. Reasons disclosed for this particular kind are almost always due to its low cost coupled with easy accessibility. In case of areas north of Biratnagar, particularly in Damak area, people are using brown sugar intravenously.

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

Drug addiction has crossed over all kinds of boundaries. People from all family background, caste, socio-economic status or educational status have been drawn to this ill habit. People from the poorest of the poor, rickshawallahs to civil servants and medical doctors, both educated and uneducated, have fallen its prey. However, people of the lowest income level 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 other 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 area are HIV positive and are sharing needles with 4-5 people on daily basis.

Transmission through sexual contacts with sex workers, in either party being transmitted is minimal as IDUs claim that sex is the last thing in their mind while using drug.

However, there are other drug users who frequently visit sex workers. Most of the IDUs reported that they are either married or have consistent sexual partners. Condom use seems to be virtually non-existent among them. In addition, there are cases in this region where sex workers are also IDUs and 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 her husband can support his habit.

IDUs are found to be almost always in poor health conditions as addiction deteriorates their health. Seeking medical help is not a priority since money needed to visit doctors and buying medicine could support their drug habit for a longer period. Often, when medical help is sought, it is reported that these IDUs usually are overcharged or paid less attention at.

Voluntary testing, although recommended by NGOs and other organizations, is realized to be a too cumbersome 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 the lack of support from the family and the 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 these centers.

As a certain degree of awareness exists regarding transmission of HIV, some IDUs are seeking less harmful drugs such as Methadone tablet. This, according to IDUs, not only is less risky but could lead to end the habit altogether.

Findings of Focus Group at Central Jail

Along with being discarded from society and family, health care providers pay less attention to IDUs. However, the system within the jail has been found better than the outside world. Acceptance of HIV positive and peer education programs have proven fruitful in educating and informing them on HIV/AIDS. New inmates are also given training on peer education.

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

IDUs, although not at central jail, are availed drugs even in police custody, obviously at a higher cost. In one custody case, three IDUs went through with-drawal symptom and police administered drugs to all three with the same needle and syringe. One IDU was apparently a HIV Positive. Other two are also suspected to have transmitted HIV during this very episode.

Police are usually aware of drug addicts and often use them to extract money. It is reported that they also extract money from dealers on regular basis on regular basis.

Most of the drug users have gone through or are at least aware of different groups/organizations that are working in drug related HIV/AIDS sectors. 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 affected populace. The global experience should be a lesson for her.

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

Detection of HIV among IDUs and their roster is lacking. The system needs to be improved. In light of this, there is a need to focus on identified groups. The unfortunate experience in Nepal's case is that the authorities have 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 its 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 have 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 addicts are injecting in alleys and shacks (Shooting Galleries) within market place (Direct observation). The most unfortunate aspect was the total freedom in using drugs as effort from the police authorities to control seemed at best, minimal. The obvious contributing factor to such border area problems stems from Nepal's open border with India.

The scenario of drug 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 these issues.

The fact remains that there is a growing problem in regards to drug use and more importantly people involved in such behavior are vulnerable as well as play a significant role as transmitters of HIV. Thus, there is a gap that exists in addressing this issue.

Response Needs

- An elaborate national level study as a follow up study of NCASC-RAR 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 network, 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 the numbers of drug users (which eventually increases HIV positives among IDUs), it is important to point out that in absence of lack of needle exchange as part of harm reduction program, HIV infection among IDUs in Nepal is increasing day by day.

In Manipur, India where IDUs were rampant in the early 90s', their number dramatically decreased after government endorsed harm reduction program, which included needle exchange program (Nepali Times, 9-15 August). In addition, international experiences and studies reveal that there is a one-third reduction in the incidence of HIV among IDUs who are a part of the 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 issues in relation to HIV/AIDS.
- Development of human resources to handle sensitive needs and issues of drug users and HIV positives.

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 has been echoed by all involved in HIV/AIDS.

Response Needs

- Development of effective counseling system through out the country.
- Family based counseling, where family members are trained and involve in counseling 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 the rapid growth of drug users in Nepal, facilities for rehabilitation and proper treatment are insufficient. Existing centers are functioning on a limited basis due to various constraints. Since society shuns people who use drugs, programs benefiting the IDUs are almost non-existent. However, unlimited 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 reason, as indicated is not a problem since per person cost to rehabilitate a drug user is $30 in India and thus if the 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 need to be introduced by the government to establish proper rehabilitation centers.
- Encourage involvement of non-governmental sectors to establish and manage rehabilitation and treatment centers.
- Development of trained personnel at local level to address issues and handle the addicts/patients.
- 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 to as if to say that they deserve only 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 structural set up to address

their medical requirements in ways 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	• Low education level among the people in general • Access to information on drugs specific to geographical and cultural isolation • Drug use although being a serious societal ill is still not addressed with serious commitment	• 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	• Public education • 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 • Culturally specific information material • Sex as taboo topic in the society	• 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
Needle Exchange as Harm Reduction Program	• Lack of government endorsement/support • Resource constraints to widen the program coverage • Lack of advocacy packages	• Attitudes in the ministries of Home and Health are changing • Social endorsement in reducing risk
Access to needles and syringes	• Expensive to support • Not available everywhere and all	• NGOs and treatment/rehabilitation centers

	the time • Not easily available if suspected to be drug user • Difficult to monitor its appropriate use by the users	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	• Less targeted for condom use. • IDU would rather support their habit, instead of buying costly condom.	• 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	• Social disregard to drug users • Lack of sensitivity among the medical and health care service providers • Lack of one-stop service center for drug users • Cost associated with medical services	• Policy exists in the Ministry of Health • Involvement of private institutions in handling drug users • Family support favorable
Developing data base of drug users	• Information not available • Limited studies on limited areas	• Development of such programs at national level. • 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 people 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 income dispatched by 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 groups of migrant workers who are believed to be the bread winners of their families are being seen as the 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 makes them more vulnerable to HIV/AIDS.

Broadly the migration pattern may be divided 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 HIV infection.

India

According to the 1991 national census, the official number of Nepalese temporarily living 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 somewhat a 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 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 rising 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' payment 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 estimate 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 are 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 use 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 percentage of women migrating to India from the central hill districts of Nepal and 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, Lucknow, Varanasi, Agra, Kanpur, Madras and Bangalore etc.

There are a large number of Nepali women working in Mumbia 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 again. This further contributes to the HIV/AIDS epidemic.

A few NGOs have been providing some form of shelter to these women. Whether if this approach is pragmatic or not remain as a question 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 and assaulted in the Gulf states are enough to explain their vulnerability to a host of STDs and HIV/AIDS. Despite the government's discouragement, women are still going to the Gulf States sometimes via India.

Response needs

- Political commitment to arrest the traffickers 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 an 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 not only seasonal or long-term migrants but also covers people moving on short distances for short periods; for example, to attend markets, fairs festivals. This type of short-term movement between villages and cities does possess 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., with 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 financial alternatives.

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 as such 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 that most of them have migrated from the adjoining districts namely Kaverepalanchowk, Sindhupalchowk, Nuwakot, Dhading and Ramechap. These child laborers are 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 put 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, both 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 has STDs or HIV infection but what can be certainly said is that they are the 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 is 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 big but it certainly warrants caution as anecdotal information of "high class sex workers" if often reported, as "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, who 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 for study are equally vulnerable to contracting HIV/AIDS.

Another sub-group of the mobile population are the 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 on their sexual behaviour
- Sex and sexual education to promote responsible sexual behaviour
- Easy access to information on condoms and other services.

Reason and triggering factors for migration

The lack of employment opportunities within 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 illustrated that 94 % of the respondents stated

poverty and lack of employment opportunities forced their family members to seek jobs abroad. Among other various causes of migration identified by a study (Subedi et al 1993) are low agricultural production not sufficient to feed the family, lack of alternative source of to generate income except for agriculture, low economic status, family and peer pressure and free time available during winter and spring seasons.

Study conducted in Doti district (Poudel 1999) suggests that a 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 become prone to 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, adequate studies are lacking 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 causal 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 were more than 10 times among men who have drinking habits as compared to those who did 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 the 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 his/her partner or spouse through sexual contact upon returning 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 among 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
- Studies on vulnerability of migrant families.

Accessibility to Information and Health Services

The conditions, in which migrants live and work, have serious implications for wide range of diseases 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. 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#7
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 ' saririk 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
• Studies on Mobility pattern and process of migration but not limited to migrants	• Mobility in itself is a complex issue • These studies need both national and international networking which seems to be poor at the moment	• HIV/AIDS is a growing international concern, it may be possible to conduct cross-border studies related to migrant issues
• 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
• Intervention modalities addressing the needs of mobile population • Pre/Post departure counseling • Maintaining communication (letter) with family • Easy availability of Condoms	• 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	• Labor desk and local human power organizations could be used for this purpose • Local and easily available sustainable resource • Freely available in health care institutions both Govt. and NGO
• Access to health care services	• Poor response from health care workers and lack of basic infrastructure	• 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 number of these girls is 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 may be 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

Needs	Obstacles	Opportunities
• Sex/Sexuality and HIV/AIDS related education incorporated in curriculum	• 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.	• 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 streets, mostly in urban areas. These children are orphans, runways 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 and kinship ties as well as minimal access to social institutions, they suffer from starvation, illiteracy, ignorance, information and knowledge -- in process, become immune to violence, exploitation, abuse and injustice dumped by evil social forces.

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

Street children often work as "agents" (carriers) to make drug deals. This trend of being exposed to drugs and alcohol at an early age makes them vulnerable to such substances

and that puts them at high risk of HIV/AIDS. Many of the children, either boys or girls, are also exploited for sexual favors in exchange of money (and/or) accessories, which make them vulnerable to HIV/AIDS. They do not have access to services that would allow them to protect themselves.

Response needs

- Collective mobilization so that targeted intervention becomes 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
• Proper rehabilitation programs	• A lack of higher level policies and programs to address their issues • Street children highly dispersed • Resource constraint	• NGOs, INGOs favorable.

Men who have sex with men (MSM)

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

Men who have sex with men are generally perceived not to be 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, common in Nepal. Men are either voluntarily having sex with other men, or forcing little boys 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 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" or "heterosexual" acts may be exposed to general public awareness but because of stigmatization and minimal access to these institutions, they are not necessarily able to protect themselves.

Response Needs

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

Needs	Obstacles	Opportunities
• Acceptance and recognition	• Homosexuality a taboo subject • Stigmatization attached with "homosexuality"/ seen as "immoral," "sick," etc. • Male sex work generally happens "behind closed doors" and unbelieved of.	• 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 tests are not carried out regularly although 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 in Nepal 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 professionals regarding its safe use.
People involved in blood transfusion services, 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 major areas for care and support programs. At the same time, health workers find themselves in great dilemma due to technical and ethical reasons. It should be noted that it is very important for the National AIDS Program to address as many aspects of care and support stemming from these issues.

Response needs

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

Needs	***Obstacles***	***Opportunities***
• Safe blood donation/ transfusion	• Blood-donors not-informed about their HIV status • Blood donors unaware of their high risk behavior in terms of HIV • Window period	• Promotion of voluntary (non-paid) donors. • Promotion of regular donors • Initiation of "autologous blood transfusion"
• Rational use of blood	• Many doctors order for " fresh blood" for conditions like chronic anemia • Consequences of unsafe blood transfusion are not discussed in training programs	• Re-orientation to health care providers regarding safe blood transfusion and rational use of blood • Blood components available for certain conditions
• Screening before donating organ	• No lab facility available • People unaware of serious consequences of blood transfusion	• Willingness to develop facilities

Unborn / Newborn

World Health Organization emphasizes prevention of mother to child HIV transmission as a part of the comprehensive care with holistic and life span approach. However, a lack of control over their 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 the spread of HIV though the majority of them are probably infected by their partners/husbands.

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

- Screening of pregnant women has neither been included in the sentinel surveillance, nor in routine screening of pregnancy. Therefore, the real scenario of HIV infection among them is yet to be visible (FGD/RTD).
- Issues of 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 children (institutional interaction).
- Estimation that only one-third of the 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 Nepal when they are tested HIV positive abroad. This also 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 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 woman with her overall vulnerability to HIV and the responsibility to bear a child. Moreover, it should be kept in mind that they have less access to such services than male counterparts.
- Number of orphans due to HIV/AIDS might be low in Nepal. However, the issue of orphans is never one-sided and simple. Due to poor socio-economic condition in Nepal, their issues might have been masked and long term indications have not been understood or analysed.

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 obligation to continue this notion. A healthy parentship is needed for healthy future generation.
- Responsible parents will create responsible children for the country.
- Antenatal care along with provision of maternal services are very important aspects for HIV prevention and control.

Response needs
- Respect the right of child to born healthy and continue healthy life.
- Develop guidelines for screening pregnant women.
- Provide pregnant and HIV positive women with AZT.
- Promote safe delivery practices to minimize infection.

Needs	*Obstacles*	*Opportunities*
• Screening of pregnant women during regular antenatal check-up	• No guidelines available. • Availability of services in all the districts • "Window period" concept	• Maternity hospitals have initiated the activity
• Provision of AZT to HIV positive pregnant women	• AZT not available freely	• Some examples available in the country. • Private sector interest
• Care of newborn	• Not all health institution ready to conduct delivery	• 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 patients 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. Couple counseling seem to be effective in preventing STDs among couples but it surely is lacking in Nepal.

Sentinel syphilis surveillance in Nepal for the last few years has shown some decreasing trend in syphilis prevalence among STD patients among those 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.

Infection	*Prevalence among symptomatic female in 1997*	*Prevalence among FSW in 1999*	*Prevalence among Family planning service seeker in 1999*
Trichomonas vaginalis	9.3%	9.0%	6.0%
Chlamydia trachomatis	5.2%	9.3%	1.7%
Neisseria gonorrhea	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. Persons with STD are labeled “immoral” and often discriminated against. STD prevalence is higher among women although 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 for appropriate STD case management.
- Appropriate drugs available at the health institutions.
- Access to condoms.
- Wide spread access to health institutions for both genders.

Needs	***Obstacles***	***Opportunities***
• Awareness raising programs	• "Not my problem" attitude	• High number of housewives

		infected with HIV might be an advocacy tool. • Certain level of consciousness already generated for HIV
• Appropriate STD case management	• Training to all health care providers on appropriate STD case management • Provision of appropriate treatment at grass root level	• Syndrome STD case management guideline exists. • Many of the drugs for STD are included in the essential drug list. • Well accepted approach
• 4"C" (compliance, contact tracing, condom promotion and counseling) concepts to be made clear to all health care providers	• Training has not reached up to grass rot level • Many times not all "4-Cs" are adequately addressed	• 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 living with HIV. Care in relation to HIV is not limited to just treatment aspects, but also includes emotional and spiritual support, as well as support to the caretakers, families and communities.

In Nepal, an estimated 5000 PLWHA might be seeking medical care and other supports 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 does 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 for whoever infected or affected with HIV/STD. (7)*

Although there are clear policy guidelines related to care and support at the de *jure* level, its implementation is virtually non-existent. Implementation and monitoring of these policies as supposed to be practiced in various health institutions, are far from even 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 facility again (Focus Group, Pokhara).

It is assumed that a significant number of PLWHAs are from poor economic background, and can not afford expensive medical care at all. In this sense, they are far from even getting a "bad" service. A serious question that is raised out of this is that, who is to be held accountable for not providing any treatment to them 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 the 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. 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 the grass root level. Despite these flaws, some attempts have been made to understand the issues related to care and support to HIV/AIDS.

Some 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 yet to be generally available. Implementation of these findings in this respect has become a mere hope.

Few hospitals in the capital 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 tend to discriminate PLWHA to a greater degree.

Some studies (Rai C. 1993, Pyakurel N. 1993) clearly state that there is negative attitude and feeling toward 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 raise awareness among the medical practitioners. A KABP 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 speciality, they would manage them like other patients. However, in reality, this is rarely practised. 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 exception. 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. No clear program on care and support for a long-term sustainable rehabilitation has been seem. Medical care to those with symptoms is really questionable, since it is very rarely addressed.

A significant number of PLWHAs mentioned that the medical service to them is rather insufficient. Neither are there any guidelines nor instructions to carry out the services 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 contradict with the prevention messages. (Example: "AIDS is a killer disease," which kills the enthusiasm of the PLWHA to live.)
- There is no coordination between hospitals and various organizations working in the field of HIV/AIDS.
- PLWHAs do not know whether they can get required services in the country or not.
- PLWHAs in Nepal are dying because of their HIV status and other illnesses 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 in other countries and not available in the country? Who will take the initiation?"*
- *"How can one get all the needed investigations conducted 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 they are 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 especially at Dharan, Biratnagar, Nepalgunj, Bhairahawa and Dhangadhi.

Refusing to recognize the sex workers and denying service to them have 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 the 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.

Needs	***Obstacles***	***Opportunities***
• Confidentiality	• Not all health workers and health institutions confirm to the policy of confidentiality	• 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.
• Receiving appropriate care at the health institutions	• Negative experiences in the past by PLWHA • Non-availability of drugs and services at the Health Institutions	• 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
• Universal precaution and Infection control measures are inadequate	• 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	• Nepal Medical Association and many other NGOs promoting infection control measures and universal precautions • Health institutions very much receptive for universal precaution
• Cost of ART (Anti-Retroviral Therapy)	• Costly medicines • Lab facilities not available	• 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 are 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 are considered to be important in the HIV prevention and control activities. Poor service and ill-equipped care mechanism do 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 come 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.

Needs	***Obstacles***	***Opportunities***
• Appropriate information/ training/ skills to deal with HIV infection in health care set-up	• Fear of transmission • Insecurity • UP and IC measures inadequate • Very few professionals, many unskilled "care takers"	• Health workers are receptive • Some institutions have taken initiation (examples available)
• Referral for treatment	• No health institution identified for referral • The availability of services not clear	• Central hospitals willing to take care initiatives. • Guidelines exist/ human resources available
• Injection safety is a concern	• Sterilization not observed • Disposable syringes re-used	• Some guidelines exist in terms of injection safety.

	• Inappropriate disposal of syringes and needles	• National level authority and many other organizations interested in collaborating
• Safety of Health workers and care takers	• No clear supporting mechanism for the care – takers. • Addressing the issue " how to cope" if one is infected during medical intervention	• - Example exist in one hospital to follow
• Modern laboratory facilities not available to monitor progress in relation to HIV load and progress in terms of CD4 cell count	• No lab facility available	• Willingness to develop lab facilities •
• Continuum of care	• Very little effort in this respect	• Homes and communities are responding to the need.
• Involvement of social and religious institutions in psycho-social support	• No attempt has been made to explore the situation	• 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.

The total budget NCASC receives is just 0.1% of the total health budget. Keeping in view the expanding epidemic and its serious consequences in Nepal, the allocated budget seems to be extremely minimal. This might hamper the planning of effective interventions at national and grass root levels. This is further complicated by a lack of trained human resources, weak infrastructure and political as well as social commitment.

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)

Coordinated multi-sectoral response to HIV/AIDS epidemic is also lacking in Nepal. Most of the HIV/AIDS prevention programs have not been effectively and adequately coordinated with other ministries and immense opportunities seem to exist to do so.

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 root level.
- Strong commitment and functioning mechanism to run the program
- Coordinated multi-sectoral effort
- National capacity building and expansion of service delivery, including strengthening surveillance and monitoring systems.

Needs	*Obstacles*	*Opportunities*
• NAP should stand as a visible and important program	• Willingness to grow is still poor. • Heavy external financial resources	• Human resources available • Financial Resources available
• Effective Cooperation and collaboration with NGO sector	• Weakness in the cooperation mechanism	• NGO Sector responsive and willing to cooperate
• Strengthening of support programs	• Weak structure • Weak financial support system	• Blood safety: one of the successful program
• Private sector mobilization for HIV/AIDS prevention	• Minimal effort to Mobilize private sector	• Private sector is responsive
• Districts need to be strengthened t plan, monitor and coordinate prevention activities	• Low funding • Vision and strategies lacking	• Willingness of districts • Multiple partners working in the districts • DDC at chair of DACC

Overall Analysis

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

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 should be given 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 already have 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 newborn children are the general populations who are also on increasing risks 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 number of HIV infection and increasing number of HIV/AIDS survivors, it is 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, be minimized 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.

The major obstacle to immediate and effective HIV/AIDS interventions within Nepal includes a lack of information and awareness, lack of political support, flaws in education and advocacy programs and the denial of HIV/AIDs epidemic. To overcome these challenges, a stronger national commitment to HIV/AIDs is a must with coordinated multi-sectoral responses, mobilization of communities and strengthening care, support and prevention efforts as well as incorporating regional issues to HIV/AIDs advocacy programs.

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 aspects 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 number of IDUs throughout the country is increasing. In the absence of rehabilitation and counseling programs as well as affordable medical treatment, along with lack of safer and more responsible drug using methods, the number 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 are also involved 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 analysed 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 at immediate risk. Ethical and technical issues in relation to the issues of HIV in unborn/newborn are very important from policy and strategic point of view. Although still not apparently visible and hidden behind the bars of statistics, increasing numbers of AIDS orphans is a major area to be taken into account.
- A high proportion of HIV/AIDS infected males in the age group of 20-29 indicates that there is a need to assess 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 actions.

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.

The analysis clearly demonstrates that it is not until very recently that HIV/AIDS has begun to be perceived not just as health problem. Coordinating multi-sectoral response and coordinating community participation and social mobilization seem to have been major challenges in fighting the epidemic. Boundless opportunities lie to incorporate other institutions such as education, social welfare, information, etc. and countless communities to develop a stronger advocacy at political, national and grass root levels.

And, 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 the 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.

- It is recommended that there needs to be further studies on vulnerabilities of migrant families and hence, further concrete intervention programs could be implemented.

- 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 such as condom promotion

- Programs that provide a good support system including a place for their health examination, counseling centers, life-skills trainings, treatment for depression, violence and abuse is recommended.

- Although it may be difficult to collectively target clients for intervention, condom promotion and provision of advocacy related to client-sex workers compliance is recommended.

- Because sex workers children are also quite 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 should be incorporated into national education curriculum.

- Situation analysis has identified a few new groups that are at immediate risk of HIV/AIDS needing 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.

- Among high-risk groups -- sex workers, injecting drug users and clients--, promotion of peer-education program should be conducted extensively.

- Prevention: All aspects of HIV/AIDS related issues require some sort of preventive methods. All the preventive methods broadly include the following categories. It is recommended to adhere to 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-mandotary

   - ♦ Referral
   - ♦ Facilitation
   - ♦ Follow-up
   - ♦ Management

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

   - ♦ Psychological counseling
   - ♦ 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 be examined and reviewed.
  This includes

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

- There is an urgent need for stronger political advocacy to fight against HIV/AIDS in Nepal. A major advocacy effort should focus on utilizing key political figures i.e. national leaders as well as through multi-sectoral and integrated approaches to linking HIV/AIDS to issues such as education information, social welfare and development, as HIV/AIDS is not solely a health problem.

- Since advocacy at grass root level is crucial to fight against HIV/AIDS, a "bottom up approach" is felt important by which locals will influence decisions on national agenda and as such, increasing visibility will lend itself to decrease stigma and denial about the epidemic by further strengthening advocacy efforts.

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Appendix-1

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Blood Transfusion Centre, NRS	LACC	SCF, NEPAL
BNMT	LALS	SCF/US
BP MHF	Maiti Nepal	SEDA
Mahendra Morang Campus	Mary Stopes Clinic, Chitwan	Teku Hospital
Central Jail	Maternity Hospital	Tourist Police
Central Police Women Cell	Municipality Ratnanagar	Tri-Netra Nepal, Chitwan
NGOCC, Chitwan	Mental Hospital, Kathmandu	UMN Sakriya HIV/AIDS
CIAA	Ministry of Health	UNAIDS/Bangkok
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EHDAG	PLAN International	
FHI, Kathmandu	Pokhara sub-metropolis	
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Appendix-III

Structure of the National AIDS Program