KNOWLEDGE, BEHAVIOR AND ATTITUDE OF STREET VENDORS TOWARDS HIV AND AIDS:

A Case Study of Chabahil Area in Kathmandu District

A Dissertation Submitted to the Central Department

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Arts in Anthropology

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LETTER OF RECOMMENDATION

This dissertation entitled **"Knowledge, Behavior and Attitude of Street Vendors Towards HIV and AIDS: A Case Study of Chabahil Area in Kathmandu District"** has been completed by **Ms. Pooja Niroula** under my guidance and supervision. I, therefore, recommend this dissertation for final approval and acceptance.

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LETTER OF ACCEPTANCE

This dissertation entitled **"Knowledge, Behavior and Attitude of Street Vendors Towards HIV and AIDS: A Case Study of Chabahil Area in Kathmandu District"** submitted by **Ms. Pooja Niroula** has been accepted as the partial fulfillment of the requirements for the degree of Master of Arts in Anthropology.

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LIST OF ACRONYMS

AIDS	=	Acquired Immune Deficiency Syndrome
CBS	=	Central Bureau of Statistics
CIUD	=	Center for Integrated Urban Development
ELISA	=	Enzyme Linked Sorbent Assay
FGD	=	Focus Group Discussion
FSWs	=	Female Sex Workers
GDP	=	Gross Domestic Product
GEFONT	=	General Federation of Nepalese Trade Union
GNP	=	Gross National Product
ILO	=	International Labor Organization
IDUs	=	Injecting Drug Users
MoHP	=	Ministry of Health and Population

MSM	=	Men having Sex with Men
PLHA	=	People Living with HIV/AIDS
PRA	=	Participatory Rural Appraisal
PWIDs	=	People Who Inject Drugs
UNAIDS	=	United Nations Program on HIV/AIDS
UNRISD	=	United Nations Research Institute For Social Development

CHAPTER I
INTRODUCTION

1.1 Background of the Study

Street vendors are small business people who struggle to make ends meet by selling goods, commodities or products in the open air rather than in a shop, store or any closed setting. Street vendors are also known as peddlers, Hawkers etc. depending upon the place and terminology used for them. The goods, commodities or products involved in street vending can be of different kinds. It can be vegetables and fruits, food stuff, snacks and refreshment, clothes, toys, newspapers, souvenirs or any kind of items for household use, personal use or official use. Normally the vendor has a small stand to display the items, makes use of a cart or even utilizes a bicycle with baskets to sell the commodities. These stands and carts are stored in a corner of the street at the end of the day or when not in use or either taken along with the vendor. Street vending is often found in metropolitan areas where they work long hours under harsh conditions, asking for nothing more than a chance to sell their goods on the public streets, sidewalk or so called footpaths.

The global demand of modernization, low socio-economic conditions, lack of appropriate opportunities within the rural settings has compelled the rural population to migrate to urban settings in search of better opportunities and livelihoods.

Urban centres are the attractions for unemployed and under employed population. In many Asian cities, with the growth of urban centres, the size of informal sector is growing, perhaps in much faster pace. Kathmandu is also not an exception. Because of the economic backwardness in rural areas coupled with the insurgency in the country, massive influx of population -- largely to most of the Terai urban centres and in Kathmandu – is apparent. This urban population is not fully integrated to the formal economy in the absence of specific policies towards migrant population; therefore, the informal sector has become the only rescue boat for the endurance of this population. These informal activities are reflected in informal markets: in streets and open spaces. With the advantage of being affordable and easy reach to the

customers, informal sector has become part of the city culture in Asia including Nepal (Care Nepal, 2008: 1).

Street vending is a common phenomenon and can be seen all over the urban settings of Nepal. Street vendors always occupy strategic locations where potential buyers pass through. The strategic locations can be like unused public or private lands, encroaching public spaces, the side walk of the streets, street corners, busy lanes or outlets of residential areas. These vendors survive on these public spaces for decades with ever growing numbers. Women are no exception – like the involvement in any other sector, women's involvement in this informal occupation is tremendously rising. Women street vendors carrying children at their backs, breast feeding them on the streets are becoming common. Vulnerabilities are even higher for these children. They are regularly exposed to the polluted environment of the streets, are at higher risks for road accidents, are compelled to follow the economical responsibilities of their parents and above all are losing their childhood.

Women Street vendors have dual responsibilities. They need to take care of their children and families and also run the vending business. While carrying out their responsibilities they face more problems than their male counterparts and yet the numbers are increasing day by day. In a study conducted by Center for Integrated Urban Development (CIUD) in 2006, it showed almost equal involvement of men and women in the vending business.

Street vending and migration go hand in hand. Lack of educational skills, unemployment, poverty stricken families and the difficult lifestyles in the rural areas of Nepal have compelled the habitants to move to urban areas in search of better opportunities and improved livelihoods. However, their situations even in the urban areas do not change because they lack the necessary skills required for a formal work environment.

Lack of gainful employment coupled with poverty in rural areas has pushed people out of their villages in search of a better existence in the cities of developing countries. These migrants do not possess the skills or the education to enable them to find good paid, secure employment in the formal sector, and they have to settle for work in the informal sector. In Nepal, there is another section of the population too, which is compelled to join the informal sector. They are conflict affected people, who

have migrated to urban centres for safe living and secure subsistence livelihoods. At present these types of migrants are decreasing but have not stopped yet. Literature explores that low skilled rural migrants live in all countries of Asia, but they are more prevalent in the poorer countries such as Nepal, India, Bangladesh, Cambodia, Vietnam and others (Timalsina, 2012).

Estimates of internal and external migration for seasonal and long-term labor range from 1.5 to 2 million people. It is necessary for the economic survival of many households in both rural and urban areas. Removal from traditional social structures can promote unsafe sexual practices, such as having multiple sexual partners and buying sex. A 2002 study suggests that HIV prevalence is nearly 8 percent in migrants returning from Mumbai. As of 2011, the male labor migrants comprise of 27% of total estimated HIV infections in Nepal (The World Bank, 2012)

HIV (Human Immunodeficiency Virus) is the virus that causes AIDS. This virus is passed from one person to another through blood-to-blood and sexual contact. In addition, infected pregnant women can pass HIV to their baby during pregnancy or delivery, as well as through breast-feeding. People with HIV have what is called HIV infection. Without appropriate therapy, most of these people will develop AIDS as a result of their HIV infection. HIV is transmitted from one person to the other through the following body fluids:

- blood
- semen
- vaginal fluid
- breast milk
- other body fluids containing blood

The Human Immunodeficiency Virus (HIV) causes AIDS (Acquired Immune Deficiency Syndrome) at the later stages of the infection. The syndrome, or pattern of illness was first identified and described in the United States in 1981, but the virus that causes the immune deficiency was not discovered until 1983. AIDS is caused by HIV, initially identified in 1984. It has been found in blood, semen, vaginal secretions, mucous membranes, cerebrospinal fluid, breast milk and amniotic fluid (Community Action on HIV, 2001).

AIDS is a condition that prevents the body's immune system from effectively fighting disease. Persons with AIDS are more susceptible to opportunistic illness such as severe infectious diseases and certain cancers which can be fatal. Less severe AIDS related illness include fever, swollen glands, tiredness, weight loss, and diarrhea. HIV infected individuals usually develop HIV antibodies within 6-12 weeks following infection. Beginning about 12 weeks after infection, HIV is detectable by blood test: Enzyme-Linked Immune Sorbent Assay (ELISA). A positive EIA means that the individual has been infected and can transmit the virus (Pokharel, 2003). The HIV infected individual will not necessarily develop AIDS or AIDS –related illness.

Key mechanisms of HIV transmission:

1. Having unprotected sex with HIV infected person (without the use of condom)
2. Direct contact with infected bold or blood products
3. Sharing of used and unsterilized needles, blades, razors or any skin piercing equipments
4. Transmission from infected mothers to their infants, in uteri at birth or through breast feeding.

AIDS is a major concern in both developed and developing countries. As of mid 1993 about fourth-fifth of all persons ever infected with HIV lived in developing countries where the infection was being transmitted mainly through heterosexual intercourse and the number of cases was rising most rapidly among women. In 1985, 50 percent of all the AIDS patients were in developing countries whereas by 1992 this has been increased to 66 percent and by 2000 AD, 75 percent. In the world at the end of 2004, 7, 49,00,000 people infected in 23 years. 3, 94, 00,000 are People Living with AIDS (PLHA) , 1,32,00,000 orphans by HIV and AIDS (Sakriya Sewa Samaj, 2005) In the year 2004, 3.1 million people have died from AIDS, 4.9 million new HIV cases. AIDS is a late stage of infection with HIV. AIDS is caused by HIV that attacks and destroys certain white blood cells, which are essential for the body's immune defense system.

According to UNAIDs as of 2000, an estimated 36 million adult and children around the world were living with human immune deficiency virus. According to UNAIDs and WHO estimates, there may be 33,532 HIV positive persons in Nepal, Women

living with HIV and AIDS are 10,272 and children under 15 living with the epidemic are 926. Though it seems that the number of reported HIV infection is low, the condition exists for its last transmission. This will lead to a serious socio-economic impact to the country, which is not visible now. But the potential impact will be varying obvious (UNAIDS Country Report, 2000).

1.2 Statement of the Problem

As in other developing countries internal migration is rapid in Nepal. People migrate from the rural to the urban setting in search of better opportunities. But due to lack of required skills, lack of education, lack of employment opportunities majority of the migrated population is limited to the informal work sector. Among the different kinds of work in the informal sector, street vending is one of them. People tend to choose street vending for several reasons like, low capital investment, easy to begin, less skills required, benefiting direct profit etc. Street Vending has not only attracted men but has attracted huge numbers of women too. Literature and reports reveal that almost 50% of vendors in every society are women and the numbers are growing day by day.

The trend of internal migration has been increasing in Nepal. In 1971 445,128 people migrated within the country, which accounted for 3.9 per cent of the total population. It increased to 929,585 in 1981, comprising 6.2 per cent of total population. Hence, in the decade the volume of migration increased by 108.8 per cent. In 1991, volume of internal migration increased by 32.1 per cent as compared to a decade back, to make the number of migrants to 1,228,356, which is 6.6 perent of total population. In 2001, the number of migrants within the country was 1,727, 350 which was 7.46 percent of the total population, which was an increase by 40.6 percent compared to 1991 census. (Nepal Population Report, CBS, 2011:44)

A large proportion of Nepal's workforce, whether self-employed or wage employed, is totally reliant on the informal economy for their subsistence. Workers in the informal economy face a much higher vulnerability and more intensive risks, and for the majority insecurity is a way of life. Insecurity and high risks are exacerbated by the social and economic exclusion confronting the most vulnerable groups in

Nepalese society. Caste or ethnically based social exclusion is mainly visible in the case of 'untouchables' and Dalits. Conditional social exclusion and discrimination confronts many groups of disabled people, trafficked women and prostitutes, as well as persons victimized by leprosy and HIV/AIDS (Care Nepal, 2008)

It is important to note that the risk of HIV/AIDS adds to the vulnerability of all these groups. HIV/AIDS can affect workers in the prime of their productive age. Mobile and migrant workers, female sex workers, IDUs users and, increasingly, child labors are high-risk groups. People living with HIV/AIDS are vulnerable to social and economic exclusion, and are often confronted by ignorance of their condition and negative attitudes. The ILO Code of Practice, 'HIV/AIDS and the World of Work', states that that governments, employers and workers' organizations should take all necessary steps to ensure that workers with HIV/AIDS and their families are not excluded from the full benefits and levels of protection offered by social security programs, or other occupational schemes.

Street vending is a major source of livelihoods for the informal sector in Nepal. It is estimated that over 100,000 people are engaged as street vendors; almost half of them are women. Despite the fact that street vending contributes to an important portion of household income, working conditions are largely unregulated and characterized by poor health and safety conditions. Street vendors are vulnerable to HIV and TB due to high mobility and displacement. They lack a sense of community and social reinforcements for monogamous sexual relationships. Sharing the same physical space with sex workers, they engage in unprotected sex (ILO, 2010).

Anthropology mainly focuses its study on the cultural variations among human and on various cultural traits and processes. Anthropology has continuously studied HIV and AIDS, migrant and migration, formal and informal work sector, street vendors and their livelihoods. It often focuses its studies on how such issues and groups of people get infected with HIV, it basically focuses on migrant workers and their infection rates of HIV. There are few or very nominal studies that focus on street vendors and their knowledge, attitude and behavior towards HIV and AIDS. Therefore, the main concept of this research is to identify, describe and explain the existing knowledge, behavior and attitude towards HIV and AIDS among the street vendors in Chabahil, Kathmandu.

Based on these assumptions, this study is expected to answer the following basic research questions:

I. What is the socio-economic and demographic background of street vendors ?
II. What is the existing knowledge, behavior and attitude of street vendors towards HIV and AIDS
III. How do the street vendors prevent themselves from HIV infection

Hence, being a student of Anthropology is concerned about the socio-economic backgrounds of street vendors and their risks in transmitting HIV. As anthropology is concerned about knowledge, behavior and attitude of human society, this study will provide answers to the knowledge, behavior and attitude of street vendors towards HIV and AIDS. Being a student of Anthropology, I am concerned about this neglected group who belongs to the informal work sector, spends their entire lives on the streets, are the citizens of our country and yet remain marginalized and neglected.

1.3 Objectives of the Study

The general objective of the study is to analyze and explicate the knowledge and attitude and behavior of street vendors towards HIV and AIDS. In order to accomplish this goal a set of specific objective are identified as follows:

I. To study the socio-economic situation of street vendors in Chabahil, Kathmandu
II. To study the existing knowledge, behavior and attitude of street vendors towards HIV and AIDS
III. To examine the knowledge on HIV prevention among Street Vendors

1.4 Rationale of the Study

This study keeps very important meaning and academic value in anthropological studies. Many scholars have disclosed that street vendors hold a huge percentage of population in the informal work sector, they are regarded as migrated population for improved livelihoods. They are the center of attraction in every urban setting. Studies

have been conducted on their livelihood patterns. However, their vulnerability towards HIV transmission is yet to be analyzed. On this regard, this research that is based on Medical Anthropology and empirical study would be a contribution to the Medical Anthropology. Similarly, this study would provide information to anyone interested to know about the vulnerability towards HIV among street vendors in Chabahil, Kathmandu. This study provides substantive facts to the anthropological study of behavior and attitude towards HIV and AIDS among street vendors. Likewise, this study also works as a good source for understanding to the world the issues and situations of street vendor's attitude towards HIV and AIDS in developing countries like Nepal.

1.5 Organization of the Study

Following this introduction chapter, the second chapter is the review of literature related to this thesis. The third chapter presents all the research methods and materials used for the preparation of the thesis. Socio-demographic and Economical situation of the street vendors in Chabahil area are organized in chapter four. Chapter five reflects the knowledge, behavior and attitude of street vendors towards HIV and AIDS. Likewise, chapter six presents the knowledge on HIV prevention among street vendors. Lastly chapter eight presents the summary of the thesis and conclusions developed from the findings.

CHAPTER II

REVIEW OF LITERATURE

This chapter is divided into four parts. The first part consists of the review of the Informal sector economy and gives a picture of it in the global context. The second chapter deals with the review of HIV and AIDS. Similarly, the third chapter looks into HIV and AIDS and street vending in the informal sector economy around the world. Lastly, the fourth chapter review street vending and HIV and AIDS issues in the Nepalese context.

2.1 Informal Sector Economy

The informal sector represents an important part of the economy and the labor market in many countries, especially in developing countries, plays a major role in employment creation, production, and income generation. The informal sector as defined in the resolution of the 15th International Conference of Labor Statisticians held in January 1993 refers to economic activities, that is, production and distribution of goods and services by the operating units of the households, which essentially differ from the formal sector in terms of technology, economies of scale, use of labor-intensive processes, and virtual absence of well-maintained accounts. A variety of terms have been in vogue within the administrative setup and statistical systems of countries to describe enterprises satisfying one or more similar characteristics, such as “unregistered”, “unorganized”, micro-enterprises etc (Adhikari, 2011:1).

The informal sector or informal economy is that part of an economy that is not taxed, monitored by any form of government or included in any Gross National Product (GNP), unlike the formal economy (The Informal Economy, 2011). The original use of the term ‘informal sector’ is attributed to the economic development model put forward by W. Arthur Lewis, used to describe employment or livelihood generation primarily within the developing world. It was used to describe a type of employment that was viewed as falling outside of the modern industrial sector (William, 1995)

The informal economy under any governing system is diverse and includes small-scaled, occasional members (often street vendors and garbage recyclers) as well as

larger, regular enterprises (including transit systems such as that of Lima, Peru). Informal economies include garment workers working from their homes, as well as informally employed personnel of formal enterprises. Employees working in the informal sector can be classified as wage workers, non-wage workers, or a combination of both (Carr, Marlyn and Martha, 2001)

Statistics on the informal economy are unreliable by virtue of the subject, yet they can provide a tentative picture of its relevance: For example, informal employment makes up 48% of non-agricultural employment in North Africa, 51% in Latin America, 65% in Asia, and 72% in sub-Saharan Africa. If agricultural employment is included, the percentages rise, in some countries like India and many sub-Saharan African countries beyond 90%. Estimates for developed countries are around 15%.(Men and Women In The Informal Economy, ILO, 2002)

In developing countries, the largest part of informal work, around 70%, is self-employed. Wage employment predominates. The majority of informal economy workers are women. Policies and developments affecting the informal economy have thus a distinctly gendered effect.

Women tend to make up the greatest portion of the informal sector, often ending up in the most erratic and corrupt segments of the sector (UNRISD, 2010). Sixty percent of female workers in developing countries are employed by the informal sector (Beneria, 2006). The reasoning behind why women make up majority of the informal sector is two-fold. Firstly, it could be attributed to the fact that employment in the informal sector is the source of employment that is most readily available to women. Secondly, a vast majority of women are employed from their homes (most likely due to the large number of women who are involved in care work) or are street vendors, which both are classified in the informal sector(Chen, 2001) Furthermore, men tend to be overrepresented in the top segment of the sector and women overpopulate the bottom segment (UNRISD, 2010) For example, very few women are employers who hire others and more women are likely to be involved in smaller scale operations Labor markets, household decisions, and states all propagate this gender inequality (Carr, Marlyn and Martha,2001). The gender gap in terms of wage is even higher in the informal sector than the formal sector (UNRISD, 2010).

Workers in the informal sector typically earn less income, have unstable income, and don't have access to basic protections and services (UNRISD,2010).

Informal businesses also lack the potential for growth, trapping employees in menial jobs indefinitely. On the other hand the informal sector can allow a large proportion of the population to escape extreme poverty and earn an income that is satisfactory for survival. Also, in developed countries, some people who are formally employed may choose to perform part of their work outside of the formal economy, exactly because it delivers them more advantages. This is called 'moonlighting'. They derive social protection, pension and child benefits and the like, from their formal employment, and at the same time have tax and other advantages from working on the side.

From the viewpoint of governments, the informal sector can create a vicious cycle. Being unable to collect taxes from the informal sector, the government may be hindered in financing public services, which in turn makes the sector more attractive. Conversely, some governments view informality as a benefit, enabling excess labor to be absorbed, mitigating unemployment issues (Gracia, 2006)

Women street traders tend to be restricted by their lack of education, access to resources and bargaining power compared to men. Therefore they remain, often permanently, at the survivalist level. Their enterprises generate little income (often less than the minimum standard), and have limited capital input and potential for growth11. Street trading environments also generally have poor occupational health and safety standards. Due to these poor conditions and their multiple responsibilities of domestic and productive work, women street traders face greater exposure to work-related risks including the heightened risk of ill-health. Health services are often inaccessible or unavailable in street trading environments, and women are generally restricted by the opportunity costs (lost earnings) of seeking treatment. Street traders are also excluded from the protection of labor legislation and are often unable to access formal social protection measures (for example, insurance, disability, maternity and unemployment benefits), which depend on a defined employment relationship.

2.2 HIV and AIDS

The difficulties women face in street trading are often compounded by policy and legislation. In Uganda, over-regulation and criminalization of street trading has severely restricted women's livelihood options, and compromised their personal

security and safety. Oppressive bylaws have forced women into invisible, insecure locations where they are potentially exposed to violence, harassment and sexual exploitation13. In South Africa, some city level policies have de-regulated street trading, recognizing its role in local economic development. However, local authorities still have the power to restrict trading through bylaws, which have had negative implications for women. For instance, in Durban de-regulation has not benefited men and women equally. Men, who generally have a larger resource base and more economic power, have been able to consolidate the benefits of increased access to markets, and improvements in infrastructure, facilities and services at the expense of more marginalized traders, who are predominantly women14. These institutional, social and economic factors re-enforce the situation of poverty and gender inequality, which creates a foundation for the spread of HIV/AIDS (Lee, 2004: 3).

Globally, 34.0 million [31.4 million–35.9 million] people were living with HIV at the end of 2011. An estimated 0.8% of adults aged 15-49 years worldwide are living with HIV, although the burden of the epidemic continues to vary considerably between countries and regions. Sub-Saharan Africa remains most severely affected, with nearly 1 in every 20 adults (4.9%) living with HIV and accounting for 69% of the people living with HIV worldwide. Although the regional prevalence of HIV infection is nearly 25 times higher in sub-Saharan Africa than in Asia, almost 5 million people are living with HIV in South, South-East and East Asia combined. After sub-Saharan Africa, the regions most heavily affected are the Caribbean and Eastern Europe and Central Asia, where 1.0% of adults were living with HIV in 2011. (UNAIDS, 2012: 9)

According to the Global Report on HIV and AIDS by UNAIDS, 2012, worldwide, the number of people newly infected continues to fall: the number of people (adults and children) acquiring HIV infection in 2011 (2.5 million [2.2 million–2.8 million]) was 20% lower than in 2001. Here, too, variation is apparent. The sharpest declines in the numbers of people acquiring HIV infection since 2001 have occurred in the Caribbean (42%) and sub-Saharan Africa (25%).

The pandemic of HIV/AIDS has its serious negative bearing on human development. It has adversely affected the average life expectancy, access to education and the growth and equitable distribution of per capita income, all being the indices of human development. Therefore, the pandemic of HIV/AIDS has been taken not only as a

health problem but also a development problem. More specifically, it has its negative bearing on population (by lowering life expectancy), women and children (by making women widows, making them the principal bread earners in the absence of economically productive males, adding all the household responsibilities on their shoulders and being discriminated in the families and the communities if they are infected with HIV/AIDS and making the children care takers of the sick parents, and depriving them of the access to the education), income (due to the treatment and care of sick, etc), agriculture and rural development (due to the absence of productive working hands and possibility of the hunger), education (by depriving the children of the access to education due to the deteriorating economic condition, suffering from the HIV/AIDS, loss of teaching manpower due to HIV/AOIDS like in Kenya, Uganda, Swaziland, Zambia and Zimbabwe etc.), health (need of more resource and manpower for medical services for treating people with HIV/AIDS) and industry (due to the loss of productive labor force. (Uprety, 2006, pp 1-2)

The Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) epidemic came to the attention of the world during the early 1980s and debates as to its origins continue to this day. This retroviral disease has cost the lives of millions across the globe both in Western and 'developing' societies. However the worst affected region in the world today is sub-Saharan Africa, with countries such as Zambia, Malawi and Uganda containing around 60% of the world's sufferers (UN/WHO, 1994, p.7). What is less than clear is the cultural differences of the region that have led to the condition being so prevalent. It is naïve to assume that the presence of HIV and AIDS in this region is simply a result of ignorance on the part of the people of sub-Saharan Africa, with regards to the specifics of the disease and sexual education. Issues such as gender relations and the attitudes of sub-Saharan African society towards sexual behavior are both important aspects which require attention before conclusions can be made. Through ethnographic studies and field work by anthropologists, it has been able to analyze and interpret cultural behavior in these societies, with the hope of isolating some of the causes of this epidemic. Therefore, anthropology, along with extensive scientific and medical research, can play an important role in the fight against HIV and AIDS.

Cultural differences with regards to the interpretation of scientific information and a misunderstanding between western scientists or researchers and their epidemiological

subjects have created many problems. Patton gives an example of such a misunderstanding by referring to studies on the Tuskegee people (p.80), and the confusion regarding the expression ‘bad blood’. The term ‘bad blood’ had been used by western researchers to explain the sexually transmitted condition of syphilis. ‘Bad blood’ was a vernacular term that was used by the local population, however its use by the western researchers to explain syphilis led to confusion, since they did not connect this term to the sexual transmission of syphilis, which they were aware of. The lack of understanding rendered a lot of the efforts to promote sexual health awareness and ‘anti-bacterial treatments’ as ‘both unethical and “unscientific”’ (Patton, 1990, p.80). Patton shows how such barriers of understanding can be compared to how AIDS is classified by the people of the regions where the epidemic is most prevalent. A lack of belief in medical and cultural conclusions, though counteractive in the fight against AIDS, is a result of how individuals perceive how diseases are caught and avoided. These cultural misinterpretations have a clear influence over how western epidemiologists portray AIDS in regions affected by the disease. By looking at the region anthropologically and ethnographically, it prevents such misconceptions from occurring, and gives us a better understanding as to the true causes why AIDS is prevalent in regions such as sub-Saharan Africa.

Witchcraft still plays an important role in Zambian society, despite the introduction of Christianity to the region by western missionaries. According to some local beliefs and traditions, all people have an element of witchcraft inside them, and that witchcraft can be used to explain incidents of tragedy and misfortune. For example, Yamba describes how a crash in the Zambian region of Chiawa resulting in the death of nine people was blamed on witchcraft, despite the driver being ‘found to be totally drunk’ (Yamba, 1997, p.204). It is not surprising then, that a tragic epidemic such as HIV and AIDS in this region is also similarly blamed on witchcraft, despite western scientific knowledge to the contrary. Interpretations of witchcraft on the other hand can be seen as a rational set of beliefs, which give some a logical explanation as to why certain people are unfortunate enough to contract HIV. As Yamba points out, ‘why else…would two men be exposed to the same woman and yet one would become infected while the other not?’ (Yamba, 1997, p.202). This raises the importance of gender when interpreting sub-Saharan African understanding of AIDS. Yamba’s theory is that witchcraft is a form of protest either against modern capitalist

society or post-colonial rule, and a way of interpreting existence following the emergence of the HIV and AIDS epidemic. He proposes that the outbreak fits logically into regional beliefs of witchcraft.

Caldwell argues in his article that contrary to some beliefs, ‘there is a distinct and internally coherent African system embracing sexuality, marriage and much else’ (Caldwell, 1989, p.187), which is as valid as other systems including those held in ‘Eurasian society’ (Caldwell, 1989, p.187). Caldwell explains how the African system has a greater emphasis on lineage and ancestral descent. Compared to western society, the bonds formed by marriage are significantly weaker, due to the economic autonomy of both parties as both maintain strong links with their lineage. This weakness is reinforced by the high prevalence of polygamy in sub-Saharan African society, which in itself is a contributing risk factor in the spread of the HIV virus due to an increased likelihood of contraction. Whilst western society is stratified by hierarchical divisions and dominated by religious influences, African women are free from the economic constraints which are present in such a system. Caldwell cites Schlegel and Barry who believe that the emphasis on training young women in sub-Saharan African to fulfil their future role as the providers of subsistence has come at the expense of not being ‘taught sexual restraint’ (Caldwell, 1989, p.191). The sexual freedom granted to women in this region presents a higher risk of HIV transmission, and increases the prevalence and acceptance of prostitution in sub-Saharan African society. This anthropological knowledge has helped explain how the differences between western and African systems of marriage and sexual behaviour have in some ways led to the emergence of the HIV and AIDS epidemic.

Yamba explains how the presence of commercial farms in Chiawa has led to the emergence of prostitution in the region, for a number of reasons. Since the men who work on these farms are based in camps where living with their spouse is impossible, there is an increased likelihood that the men will visit prostitutes when seeking sexual gratification. Commercial sex workers are also likely to be attracted to the area by the fact that the men working on the farms receive a regular wage, which would enable them to pay for their services. According to Yamba, the presence of commercial farming in Chiawa has made the study of HIV and AIDS in this area increasingly difficult, since the prostitution it has attracted has led to the region being ‘referred to

as a high risk environment' (Yamba, 1997, p.202). For a married or single man to visit a prostitute is commonly accepted in sub-Saharan Africa, which is in contrast to the western world where such practices are carried out with discretion due to the social connotations that it implies.

Anthropological studies such as those carried out by Yamba and Patton have helped to explain the presence of prostitution in areas where the incidence of HIV and AIDS is high, and such information can be used to help isolate areas that require urgent medical and educational attention.

Anthropology has significantly contributed in the fight against HIV and AIDS. By analyzing how western scientific research is conducted in sub-Saharan Africa, it has been able to isolate some of the racially prejudiced ideologies that influenced early ideas and solutions regarding the epidemic. It has also been able to assess the differences in understanding between western scientists or researchers and the people of the regions where AIDS is most prevalent. The study of traditional beliefs such as witchcraft have allowed us to understand regional ideas on the origins and causes of the epidemic, and allowed us to approach the subject ethically and without disregarding culture and tradition. By assessing the impact of religious ideas of abstinence, we are able to discover the importance of sex as an integral part of cultural practice. The studies on the sexual behavior of sub-Saharan African males and females by anthropologists have helped to explain gender roles in society and gives some indication as to how HIV and AIDS is spread between sexual partners. The differences between western and African marriage systems have contributed to explaining the sexual freedom of men and women regardless of marital status, and helps explain the high levels of promiscuity and prostitution seen in the sub-Saharan region.

Anthropology can today still hold a pivotal role in the ongoing fight against 'the greatest public health challenge of our time' (Caldwell, 1989, p.185).

Medical anthropology studies "human health and disease, health care systems, and biocultural adaptation". It views humans from multidimensional and ecological perspectives. It is one of the most highly developed areas of anthropology and applied anthropology, and is a subfield of social and cultural anthropology that examines the

ways in which culture and society are organized around or influenced by issues of health, health care and related issues.

The term "medical anthropology" has been used since 1963 as a label for empirical research and theoretical production by anthropologists into the social processes and cultural representations of health, illness and the nursing/care practices associated with these.

Furthermore, in Europe the terms "anthropology of medicine", "anthropology of health" and "anthropology of illness" have also been used, and "medical anthropology", was also a translation of the 19th century Dutch term "medische anthropologie". This term was chosen by some authors during the 1940s to refer to philosophical studies on health and illness.

2.3 Street Vending and HIV

Around 85 per cent of Mozambique's workforce make their living in the informal economy. It is a hard life with poor working conditions, low wages, little or inadequate social protection and usually no means of representation or public voice. They are particularly vulnerable to HIV because of lack of knowledge, choices and resources to fall back on. HIV is a major concern to informal sector traders, particularly the effects of stigma and discrimination In the markets it is common to see vendors just giving up their stalls because they can no longer face the exclusion and discrimination from their colleagues. With no job and no money, they and their families face so many problems. Often the children leave school to live on the streets because there is no food and they can't pay for transport. Many times abuse against them is heard. (ILO)

Women are physiologically more susceptible to HIV infection than men. Approximately 55% of adults living with HIV in Uganda and 57% in South Africa are women. While there is no research which links women's work in the informal economy with HIV infection, there are some studies which show that women street traders are a particularly vulnerable group. For example, studies in Uganda have found that young women, living and working in urban trading areas and making low incomes are at far higher than average risk of infection. Prevalence rates in these

trading centres are approximately 30% compared to a national average of 5%. (Lee, 2004)

However, risk is also governed by a range of social factors, which are influenced by women's insecure and marginalized economic positions. For instance, gender inequality and women's impoverishment may force women traders to remain dependent upon men for economic security which limits their control over protection measures and their ability to leave potentially high-risk relationships. Furthermore, women's financial dependency coupled with their precarious working locations such as at truck stops, in trading towns and working after dark, may influence their involvement in 'paid' relationships with transient men. (Lee, 2004)

HIV/AIDS also has a profound impact on women, their enterprises and households. The additional financial and physical burden of HIV/AIDS can cause the collapse of women's low-level enterprises and further undermine the economic and social stability of their households. AIDS has often resulted in the loss of the main income earner and an increase in dependents, and it has been this long-term burden which drives women traders into chronic poverty. (Lee, 2004)

Manderson traces anthropology's interest in disease to the discipline's professionalization as an applied science, the interest of other public health scholars in anthropological methods and theories, and the involvement of anthropologists in international health programs of multilateral organizations and bilateral aid programs. Building on anthropologists' earlier work with public health issues, the social science study of AIDS in Africa has required the efforts of both anthropologists sensitive to public health, biomedical and non-Western healing issues, and anthropologists who seek to analyze the AIDS epidemic as they would any other phenomenon in the field. Manderson evokes a common theme of both schools of anthropology by asserting that anthropological involvement has ensured that some account is taken of local knowledge, cultural influence on the patterns of disease, and structural barriers to good health. (Manderson, 1998)

The HIV/AIDS epidemic, Farmer argues, requires broad biosocial approaches emphasizing structural forces such as racism, sexism and inequality, of which structural violence is the pre-eminent model.

Castro and Farmer propose structural violence as a conceptual framework for understanding the HIV/AIDS epidemic. They argue that societies are shaped by large-scale social forces such as racism, sexism, political violence, poverty, and other social inequalities that are rooted in historical and economic processes. These forces, which together define structural violence, sculpt the distribution and outcome of HIV/AIDS. As an example, consider Schoepf's observation that one consequence of the economic crisis of the 1980s was a proliferation of multiple partner strategies, as poverty forced women to exchange sexual favors for financial support. (Schoepf, 1988). With the onset of AIDS, what once appeared to be a survival strategy has been transformed into a death strategy as macro level crisis generates conditions for micro level dislocation. We thus see the power of Farmer's observation that fundamentally social forces and processes come to be embodied as biological events (Farmer 1999).

Linking HIV/AIDS and structural forces, such as poverty, is critical to achieving effective prevention and treatment strategies. This is because the links between disease and poverty are profound though often ignored. In a major report on AIDS as a Development Issue, Collins and Rau argue that it is commonplace for HIV/AIDS program managers to acknowledge poverty as a causative factor, but to then say that poverty is beyond the scope of their programs (Collins 2000).

2.4 Nepalese context

The violence and conflict as well as hard working life in rural Nepal, working people have been displaced from rural areas. Peasant and conflict affected families seeking work as well as safe place to live, have moved to urban areas where employment opportunities in the formal sector are very limited. In addition to this, poverty and lack of gainful employment in the rural areas drive large numbers of people to the cities for livelihoods. These people generally possess low level of education and skills for the better paid jobs in the formal sector. Besides, permanent jobs in the organized sector are shrinking. In the absence of jobs in the public and private sectors, they have no option where to go but put up their own business to earn their livelihoods. This has led to a rapid growth of the informal sector in most of the cities of developing countries in general, and Kathmandu in particular (Timalsina, 2012).)

The regular data collection system of the Central Bureau of Statistics (CBS) of Nepal does not cover the informal sector which comprises of households with at least some market production. These households or units have low levels of organization and technology. Moreover, the numbers of employees of these production units are usually lower than the threshold number for inclusion in the list of establishments. It is quite likely that these units are not covered by the regular establishment or enterprise surveys. And while these units might be covered by household surveys, the standard schedules for these surveys do not usually include questions pertaining to production. Because of these issues, informal sector statistics are not collected through the regular survey system of the CBS. Since data on the informal sector and informal employment are not available regularly, if at all, the national accounts statistics of Nepal do not usually cover this sector, there by resulting in distorted estimates of the structure of the economy. Besides, this lack of information hinders the understanding of policy makers about social and economic issues related to informal sector activities, such as lack of social protection, limited access to credit, training, and markets, and differentials in wages and working conditions. It is thus important that the visibility of informal workers in labor force statistics and other data used in formulating policies needs to be enhanced (Suwal and Panta, 2009:9)

The industrial development in Nepal has not yet taken place in the real sense of the term. The less the industrial development implies that fewer are the jobs in the formal sector. In Nepal, there are limited employment opportunities in the formal sector that has limited the access to opportunities to all. However, the poor people are rather involved in informal businesses either in the form of self-employment or in the business of others.

The informal sector includes a significant number of street vendors, among others, that constitute a majority of the poor people. In cities, towns and even in villages throughout the country, thousands of people earn their living by selling a variety of goods in the streets. As jobs are limited in the rural areas, and agriculture sector is not able to consume all of the additional manpower, most of the poor people, with limited or no skills, have migrated to Kathmandu valley in search of better livelihood. These people are not competent for contesting jobs in the formal sector as they lack formal education. In such a backdrop, most of them get self-employed as street vendors.

It is hard to measure the economic impact that street vendors have on the economy. Their sales are almost informal with no record in the national Gross Domestic Product (GDP), while it is also difficult to estimate because of the lack of proper accounting in place. They pay taxes on neither the revenues nor personal income. Given this nature of the engagement, it is extremely difficult to make exact estimates of this underground economy as there is no record even of the number of street vendors that operate. Additionally, with no accounting system in place it is even more of an uphill task to reflect the volume of the business and analyze the impact they make on the economy or on the employment status in the country as well as on the other sectors (Dhungel, 2010).

Starting late February, the Kathmandu Metropolitan City (KMC) had launched a crackdown on street vendors on the instruction of Home Minister Bamdev Gautam. He had unsuccessfully tried to evict street vendors as Home Minister back in 2008 too. A committee to designate alternative areas for street trade had been formed but had failed to do its job. According to Constituent Assembly member and senior vice-chairman of the General Federation of Nepalese Trade Union (GEFONT) Binod Shrestha, around 50,000 to 60,000 people in the Valley conduct various businesses on the streets; of them 15,000 are street vendors. Instead of first coming up with an acceptable alternative for the vendors, the government has rushed to deprive them of their livelihood. No thought seems to have been spared for the tens of thousands of family members dependent on these breadwinners. The KMC has already cleared out Maharajgunj, Basundhara, Gongabu, Balaju, Banasthali, Sitapaila, Swayambhu, Kalanki, Balkhu, Kalimati, Ratnapark, Sundhara, New Baneshwor, Koteshwor, Gaushala and Chabahil (The Kathmandu Post, 2014).

HIV is characterized as a concentrated epidemic in Nepal with HIV prevalence of 0.30 per cent among adult aged 15–49 years in 2011. There are approximately 50,200 people estimated to be living with HIV, where four out of every five infections are transmitted through sexual transmission. People who inject drugs (PWIDs), men who have sex with men (MSM) and female sex workers (FSWs) are the key populations who are at a higher risk of acquiring HIV. Male labor migrants (who particularly migrate to high HIV prevalence areas in India, where they often visit FSWs) and clients of sex workers in Nepal are playing the role of bridging populations that are transmitting infections to low-risk general populations. The rate of occurring new

HIV infections throughout Nepal has reduced significantly during the last five years essentially owing to the targeted prevention interventions among key population groups. However, it is critical to improve the effective coverage of proven prevention interventions, especially among new entrants engaging in high-risk behaviours, and to sustain these interventions for achieving the national target of halving new HIV infections by 2015 (UNAIDS, 2012).

Conclusion

After the review of literatures, I have been able to point out some strengths and gaps of the existing theoretical reviews which are also based on empirical studies. This review has brought forth and enlightened various aspects of street vendors.

One of the major aspects is that the informal economy in any part of the globe and especially in developing countries is a permanent and growing feature of the economic landscape. It makes a crucial contribution to economic growth and employment and yet is neglected and overlooked. It has a huge contribution to every economy and nevertheless remains unrecognized.

People working in the informal economical sector are overlooked are deprived of different services and benefits like social protection, legal protection and even insurance and health facilities by the state. Unlike in the formal economical sector, the income and wage factor all depends upon the day you worked. For street vendors especially, sometimes they do not earn a single penny a day.

The increase of women indulging in the informal sector is growing day by day. Compared to men, women have higher risk factors and are more vulnerable to several street hazards like health problems, maternity issues, are susceptible to street based violence. Further, women being emotional and physiologically weak in terms of men are deprived of equal opportunities and remain behind in the informal work sector too.

There are several health issues that are of major concern for street vendors who have to bear changing weather conditions without a roof over their head. The most common health issues include cold, cough and chest pain, which they encounter on being exposed to dirt and pollution. Body pain is also a frequent complaint since vendors push their carts around the city or sit on concrete pavements and uneven surfaces for the entire day. Likewise, they work every day from dawn to dusk and even at night sometimes and are crushed between the fight for sustainability and

health related issues. Mothers with children on the streets, women breastfeeding their children and satisfying consumers at the same time are all common sights that are of serious concern.

The informal economy is also linked to poverty and social and economic inequality, which exacerbate the conditions for the transmission of HIV/AIDS. The current policy and legislative framework surrounding street trading perpetuates these conditions, having a particularly negative impact on women. These institutional frameworks need to change both to achieve greater efficiency and productivity, as well as equity within the informal economy in order to create an enabling environment to reduce poverty and prevent HIV transmission.

Looking in terms of the Nepalese context, no clear policies have been formulated to address street vendors. They are raising their voices to be recognized and also want to be included in the tax contribution system. The issues of childcare, healthcare, proper sanitation are the issues that need to be looked into for the street vendors.

Chapter III

RESEARCH METHODS

This chapter presents discussion on rationale for the selection of the study site, nature and sources of data sampling procedure, data collection techniques, method of data analysis and limitations of the study.

3.1 Rationale for Selection of the Study Site

One of the most important concerns of the research is the selection of the study site. For this purpose, I had selected Chabahil area for this research. Chabahil is located towards the north-eastern part of Kathmandu district in the Central Development Region of Nepal. Chabahil has a huge density of population residing in the area. It is a fully fledged commercial business area. According to the Kathmandu Metropolitan Ward Report of 2001 the population of Chabahil was 20,000 in 1991 which had almost doubled to 39,530 by 2001. There is no current specific data on the population size in Chabahil and there is an estimated population of more than 2,00,000 in Chabahil according to the ward office of Chabahil. The population in Chabahil comprise of the local original people of the area and people from all over Nepal. Even the street vendors come from different parts of Nepal to do the vending business. Chabahil has become a center point for business, transportation into and around the city, connects with the remote villages and is the first destination for villagers from Sindhupalchowk (Melamchi), Sunitakhan, Gokarna, Sundarijal, Mulkharka, Chisapani, Gagalphedi, Alapot, Bhadrabas, Sankhu etc. Therefore, the selected area has a high business turnover and estimated street vendors are around 450 t0 480.

3.2 Nature and Sources of Data

Both primary and secondary data were used in this research. Data were collected from the field by different kinds of research tools and techniques in order to fulfill the stated objectives and to answer the research questions. Primary data were gathered from the field through ethnographic method that includes case study, individual

survey, participant observation and Participatory Rural Appraisal (PRA) tool which includes Focus Group Discussion (FGD). Likewise, secondary data were gathered from various published and unpublished documents, records, journals, books, articles, dissertations etc.

3.3 Sampling Procedure

Street vending is a non recognized sector of economy in Nepal and therefore reliable data on the numbers of street vendors is rare to be found. Therefore, a field work observation for three weeks was done in December 2013 to get a picture of the estimated street vendors in Chabahil area. The researcher has made full day observation for continuously three weeks in different timings of the day and has estimated around 480 vendors to be found in Chabahil area.

Universe: There is an estimation of 480 street vendors in Chabahil.

Sample: Out of an estimated 480 street vendors in Chabahil 120 individual street vendors were selected using simple random sampling method of probability sampling. Similarly, from the 120 individuals; 6 individuals for case study and 6-8 informants/group for 4 FGD were selected using the purposive sample method.

Study unit: 120 individual vendors were selected for garnering quantitative and qualitative information. Among the 6 selected cluster areas, 20 respondents from each cluster were selected. Gender selection was based on their availability and willingness to participate in the interview schedule. However, their proportion in participation was tried to maintain as far as possible. The selection for FGD was done through purposive method. The name list was prepared according to their cluster and picked up randomly. For case study, 6 individuals were selected purposively to harvest pertinent qualitative information about the individual's socio-economic situation and understanding towards HIV and AIDS.

3.4 Data Collection Techniques

Different data collection techniques have been used to triangulate the information collected. The method of triangulation was used because it enhances the validity of the findings. For the collection of primary data, the following techniques were adopted:

3.4.1 Questionnaire

Individual survey among street vendors was conducted to collect personal information on their socio-economic demography, their knowledge, behavior and attitude towards HIV and AIDS and their knowledge in prevention. The individual survey was conducted among 120 street vendors to collect quantitative information focused on the socio-economic scenario and knowledge, behavior and attitude towards HIV and AIDS.

3.4.2 Case Study

The important data were collected using case study technique in anthropological research. P.V. Young (1988) asserts that a comprehensive study of a social unit, unit of a person, group, social institution district or community etc is called a case study. Therefore, the method of case study has been used to obtain the qualitative information of life experiences of the concerned street vendors. It helps us to understand the multiple aspects of the street vendors on the streets; their socio-economic demography, their daily challenges and difficulties on the streets and their knowledge and understanding towards HIV and AIDS. These case studies helped contextualize the collected information of street vendors and analyze the micro-situation of an individual street vendor.

3.4.3 Focus Group Discussion

Focus Group Discussion (FGD) is one of the traditional anthropological techniques of data collection. FGD has its own significant role to garner the qualitative data. In fact, FGD is a technique to Participatory Rural Appraisal (PRA). FGD technique was applied for both the men and women street vendors to discuss on their existing knowledge and behavior towards HIV and AIDS, on the modes of transmission, means of prevention, discussion on existing myths and perceptions towards HIV and AIDS and their vulnerability in transmitting HIV. A checklist was prepared and used for guiding and conducting the FGD.

3.4.4 Participant Observation

Participant observation was the foundation of anthropological research to involve establishing rapport building in a new community (Bernard, 1988:148) Participant observation in this research helped to collect significant qualitative and quantitative data on socio-demographic and economical situations of street vendors, their ways of dealing with customers, the challenges faced by them during their business hours and the physical status of the study site. The direct observation of the different activities of the street vendors were also useful to cross-check/triangulate the data gathered.

3.4.5 Emphasis on Triangulation

Survey questionnaire and qualitative findings and the above discussed tools/techniques under the ethnographic method helpd in triangulating the data/information needed for the qualitative study. “Triangulation” is the core aspect of the qualitative research (Uprety, 2008:79). In this study, the purpose of triangulation in qualitative and quantitative information was to get the validity, reliability and credibility of the findings of this research. Therefore, multiple techniques have been combined in this research to reduce the intrinsic biases and problems of collected information.

3.4.6 Method of Data Analysis

Analysis means categorizing, ordering, manipulating and summarizing the data to obtain answers to research questions. The purpose of analysis is to reduce data to intelligible and interpretable form so that the relations of research problems can be studied and tested (Derlinger, 1978 quoted in Uprety, 2008:88) The qualitative raw data were classified into three phases for analysis. Firstly, all qualitative data from the field, descriptive texts, notes and records were organized under different themes or sub-themes by reading them carefully for thematic classification.

Quantitative data regarding the socio-economic characteristics such as income, vending type, family profile, educational qualification etc. were first summarized manually in the tabular form in computer with the help of Ms. Excel and then some statistical tools like percentage, average and range were used for analysis. Some data were also presented diagrammatically.

3.5 Limitations of the Study

Despite the importance of the topic, the researcher underwent some limitations. They are as follows:

i. Street Vendors are seen all over Kathmandu. From the busy street lanes to crowded corners they are scattered not only in Kathmandu but in all the urban areas of Nepal. In Kathmandu the busy commercial areas like Asan, Ratnapark, Khulamanch, Hanumandhoka (Darbur Square), Naxal, Gangabu, Basundhara, Koteshwor, Baneshwor, Chabahil, Jorpati etc. are overcrowded with street vendors. However, this study was confined only to Chabahil area due to limited time and economic constraints.
ii. Due to the limited time and economical constraint, researcher could not make a large sample size that would otherwise ensure more reliable, valid and broadly applicable result.

iii. This study was mainly based on survey method due to the time constraint with the street vendors. It was quite difficult for the street vendors to allocate more time to draw qualitative information and data.

iv. The findings of this research might not be equally applicable in other sectors of informal economy workers.

3.6 Field Research as a Personal Experience

As a student of Anthropology, I always looked at the unlooked and unresolved social issues that existed in our societies. Moving around in terms of mobility from home to college and other places, I had always made an observation on the street vendors in different areas in Kathmandu and this observation had helped me prepare my research proposal for this study.

While beginning with the proposal development phase, I had made several observations very closely by spending several hours on the streets in order to observe the daily lifestyle and the ways in which they do their business. Having not done any kind of research earlier as a student I did not have the skills and experience and had hesitations to approach the street vendors. Therefore, in order to start getting the answers to the questions like HOW, WHY, WHEN, WHAT and many more I began with developing rapport with the street vendors from whom I purchase different goods like vegetables, fruits and sometimes clothes and even kitchen utilities. With all the fear, hesitation and at the same time excitement were all dominant in my mind. I was successful with rapport building and gradually got into their environment and psychological situation. Then continuously my notes and observation began expanding and I developed the necessary explanations as a descriptive narration.

Although street vendors lack sophisticated and materialized lifestyle and live in deprivation most of the time, indeed present themselves in a harmonious manner with good hospitality. They are very friendly to anyone who approach them and welcome the passerby in a friendly manner. The reasons for the street vendors to be friendly and welcoming were identified for tw reasons: firstly, they had to portray a welcoming nature despite their hardships so that they can attract the customers to buy

their goods, secondly they need to establish a further purchasing environment from the customer for future sustainability.

Street vending is a challenging job to perform. It is also a psychological turmoil of accidents, threats, unwanted quarrels and many more. On the other hand fear from local authority is always on the nerves. The street vendors are always on the watch for the raid from the local municipal authority. During my observation I had noticed the municipal authority destroying all the bangles the street vendor had that was put for sale. Unfortunately, she had no time to pack it and escape from there. Even during the questionnaire survey, I moved along with the fruit vendor from Chabahil Ganeshthan to Chabahil Stupa as he was avoiding and escaping the raid from the authorities. However, despite the tension situation the vendor was more than happy to support me with my questions put forward to him.

Women and children always come together and cannot be looked in isolation was also one observation that I made. Around 4:00 and after in the late afternoon children in their school uniform can be seen with the mother vendors. They come to where their mother is straight from school, eat some snacks provided to them there and then on the road side and either are seen playing in groups on the streets itself of helping the mother to weigh the goods, in packing them in a plastic bag, running around to change the money given by customers etc. Likewise, small children are also with their mothers besides their pile of goods for sale. The small children are either sleeping in a small corner, or in a small pouch like thing beside their mother, they are found being breast fed and the worst part is that they crawl on the streets as the street is their playing station.

One interesting observation was the bargaining that takes place between the vendor and the customer. The bargaining is very heavy and sometimes even takes place for 3-5 minutes. No side wants to compromise. Sometimes it is the street vendors win - win situation and sometimes vice versa.

However, there are numerous facts to mention here about the field experiences. I have tried to capture as much as possible and it is quite impossible to include even the

smallest of the fact. No work is easy and I would like to quote a proverb here "LIFE IS NOT A BED OF ROSES". Even though with all the inexperience's I have completed my field work successfully with my single effort gaining the experiences in field work.

CHAPTER IV
SOCIO - DEMOGRAPHIC AND ECONOMIC SITUATION OF STREET VENDORS

This chapter deals with the socio-demographic and economic situation of Street Vendors in Chabahil area. The socio-demographic and economic situation have been dealt with the indicators like district, age, sex, education status, marital status, ethnicity, estimated income, vending specification, family relations etc.

4.1 Street Vendors Distribution by District and Sex

Table 4.1: Street Vendors Distribution by District and Sex.

District	Male	Female	Total	%
Bara	1		1	1%
Bhojpur		3	3	3%
Chitwan	2		2	2%
Dolakha	-	3	3	3%
Gorkha	-	2	2	2%
Jhapa		10	10	8%
Kanchanpur	2	2	4	3%
Kathmandu	7	10	17	14%
Kavrepanchowk	15	14	29	24%
Makwanpur	1		1	1%
Morang	-	4	4	3%
Okhaldhunga	-	2	2	2%
Parsa	2	-	2	2%
Sarlahi	2	-	2	2%
Shankhusabha	2	2	4	3%
Sindhuli	8	2	10	8%
Sindhupalchowk	1	2	3	3%
Taplejung	-	2	2	2%

District	Male	Female	Total	%
Teherathum	2	-	2	2%
Udayapur	3	3	6	5%
India	11	-	11	9%
Total	59, (49%)	61, (51%)	120, (100%)	100%

The above table shows the district from where the street vendors have come from and their sex wise distribution in the districts. Among the 120 respondents there were 61 female and 59 male street vendors. The majority of the street vendors were from Kavrepalanchowk and they were 15 male and 14 female. Even the residents of Kathmandu made a substantial number as there were 10 female and 7 male street vendors making a total of 17 vendors among the 120. Street Vendors from India are also alarming as there were 11 street vendors from India. However, the street vendors from India were all male only.

4.2 Age and Sex Distribution of Respondents

The table below shows the age and sex distribution of respondents.

Table 4.2: Age and Sex Distribution of Respondents

Age range	Mid Value (x)	Male			Female			Total		
		f1	c.f.2	fx3	f.	c. f.	fx	f.	c.f.	fx
0-20	10	4	4	40	2	2	20	6	6	60
20-25	22.5	6	10	135	4	6	90	10	16	225
26-30	27.5	9	19	247.5	18	24	495	27	43	742.5
30-35	32.5	20	39	650	18	42	585	38	81	1235
35-40	37.5	10	49	375	2	44	75	12	93	450
40-60	50	10	59	500	17	61	850	27	120	1350
Total		59		1947.5	61		2115	120		4062.5

% of Male Vendor = 49%

Mean/Average age of Male = 33 Year

1 Frequency
2 Cumulative Frequency
3 The product of Mid Value (x) and the frequency

% of Female Vendor = 51%

Mean/Average age of Female = 35 Year

Mean/Average age of Male and Female = 34 Years

It can be seen in the table that among the 120 respondents the majority of the respondents were in the age group of 31 - 35 years having an average age of 34 years. The female venders represented 51% with an average age of 35 years. Similarly the male vendor represented the remaining 49% with an average age of 33 years.

4.3 Street Vendors Distribution by Caste

Table 4.3: Street vendors distribution by caste.

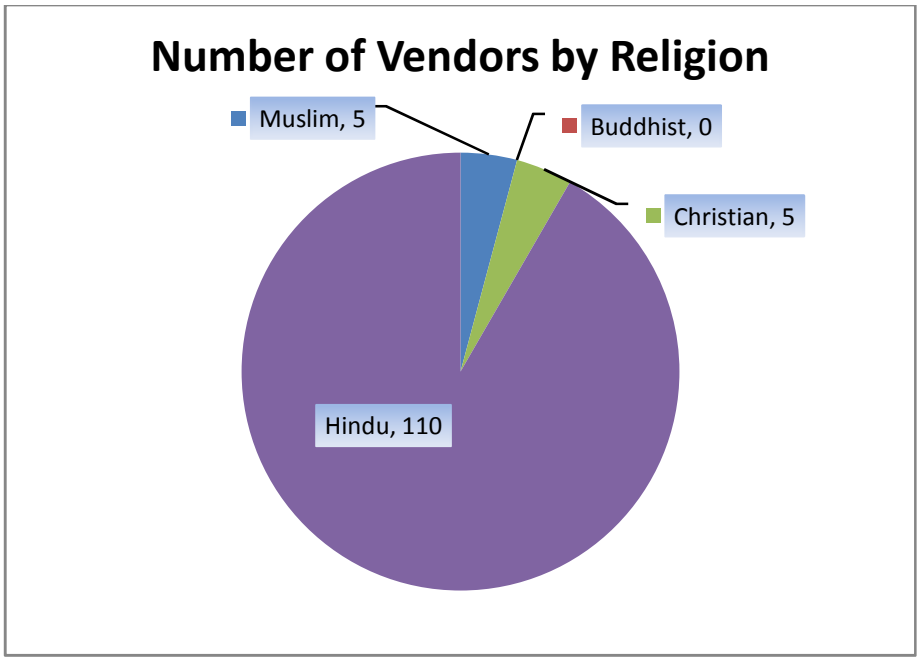
Caste	Male	Female	Total	%
Brahmin	23	22	45	38%
Chettri	9	20	29	24%
Limbu	0	2	2	2%
Madeshi	5	3	8	7%
Newar	4	5	9	8%
Rai	3	4	7	6%
Tamang	4	1	5	4%
Magar		2	2	2%
Others	11	2	13	11%
Total	59	61	120	100%

The above table shows that 38% of the street vendors were Brahmin, followed by 24% of Chhetri. There were other ethnic groups like Madhesi, Rai, Tamang, Newar and others.

4.4 Distribution of street vendors by religion:

The figure below shows the distribution of street vendors by the religion they practice. It can be seen that among the 120 respondents majority of them i.e. 110 were Hindus. Among the remaining 10 street vendors 5 of them were Muslims and 5 were Christians. It was quite alarming that there were not a single Buddhist representation among the street vendors.

Figure 4.4 Distribution of street vendors by religion:



4.5 Educational Level of Respondents

Looking at the table from the educational point of view, there is a proportionate distribution of the respondents educational level. 25% of the respondents have been to school and received basic level education i.e. up to the primary level. The respondents to reach up to secondary level is also quite high as they make up 23% of the total respondents. There were 12% of respondents in the Bachelors' level and among the total 120 respondents there was only 1% representing the Masters' level education. However, the respondents who have never gone to school make up 18% of the total respondents which is a significant number indeed.

Table 4.5: Educational Level of Respondents

Education	Male	Female	Total	%
Illiterate	8	14	22	18%
Primary	13	17	30	25%
Lower Secondary	14	8	22	18%
Secondary	15	12	27	23%
Intermediate/+2	2	2	4	3%
Bachelors'	6	8	14	12%
Masters'	1		1	1%
Total	59	61	120	100%

As found in the table above respondents have a varied educational background and a substantial number of them are illiterate too. On the other hand, it can also be seen that people with a Master's degree in hand are into the street vending occupation. Thus, a case is presented here to hear the respondent’s story from his side.

Case: 1 Bitter Reality

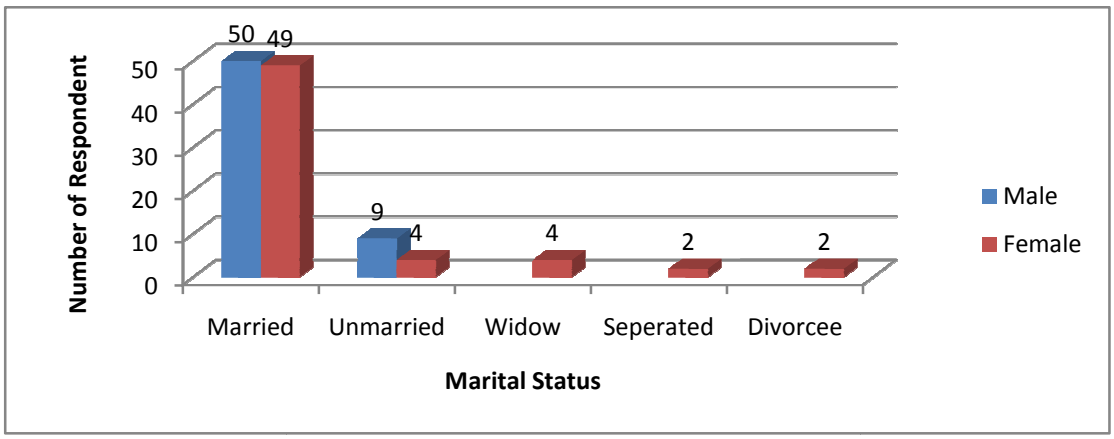
A 31 year old Mahesh Neupane has completed his Master's degree in Business Administration and is into street vending from the last 6 years. Mahesh is from Bara and comes from a middle class family. Their earnings from agriculture were just sufficient fro them with less chances for saving. His father is a retired Nepal Government Official and his mother is a housewife. He has two younger brothers who are at present studying in the United States of America. His history to Kathmandu was a few years back after he completed his 10+2 from Bara. Since then, his entire studies was supported by his father.

After completing his Masters' in Business Administration he searched for a job for around a year or so. Disheartened, everywhere he applied he began with street vending. He sells Electrical Accessories like mobile chargers, mobile parts, emergency lights, etc on the footpaths of Chabahil to Chuchepati. Here he lives alone in a rented room in Mitrapark, He does street vending from early morning around 8:00 am to around 7:00 pm in the evening. He does not want to return to Bara because he does not see any scope there and intends to carry on this self-employed job until he gets a job in the formal work sector. He earns around Rs. 18,000/month and expresses that he is not satisfied with it. He considers it a bitter reality that education, qualification and employment opportunities in our country do not go in par with each other and people like him need to bear the consequences of this reality.

He sees positive and negative impact of street vendors as there are several hazardous situations associated with it. The good thing about this job he expresses is the earning as they do not pay tax. But rather than that health hazards, fear and threat from local authorities always keeps them running.

4.6 Marital status of respondents:

Figure 4.6: Marital status of respondents.



The above figure shows us the picture of the marital status of street vendors. It can be seen that among the 120 respondents 50 male and 49 female street vendors were married, there were 9 male and 4 female who were unmarried, there were 4 widows, 2 women who were separated and 2 women who were divorced.

4.7 Family Relation of Respondents

Out of 120 respondents, 90 of them live with their families in Chabahil and surrounding area and this represents 75% of the total respondents.

Table 4.7: Family relation of respondents

Education	Male	Female	Total	%
Alone	7	2	9	8%
With Relatives	6	6	12	10%
With Family	37	53	90	75%
With Peers/friends			0	0%
With co-workers	9		9	8%
Others			0	0%
Total	59	61	120	100%

It can be seen that respondents living alone, with relatives and with co-workers are very few.

4.8 Respondents Vending Specification and Income Range

This table has tried to analyze the income range of street vendors according to their vending specification.

Table 4.8: Respondents Vending Specification and Income Range

Income Range	0-10000	10000-15000	15000-20000	20000-25000	25000-30000	30000-35000	Total
Fruits	4	6	1	-	-	2	13
Clothes	6	8	7	-	-	3	24
Game/Toys	2	2	2	-	-	-	6
Vegatables	-	17	4	-	4	3	28
Electricity Accessories	-	4	1	-	-	-	5
Stationery	-	-	-	-	-	-	-
Food & Snacks	4	6	7	8	-	-	25
Kitchen/Toilet Utilitie	-	1	-	3	-	-	4
Cosmeties/ Women's Utilities	3	-	-	-	-	-	3
Souvenirs	-	-	-	-	-	-	-
Shoes/Bags	-	-	2	2	-	4	8
Others	2	2	-	-	-	-	4
Frequency (f)	21	46	24	13		12	120
Mid Value (x)	7,500	12,500	17,500	22,500	27,500	32,500	120,000
Fx	157,500	575,000	420,000	292,500	-	390,000	1,835,000
Average Income of vendors NPR 15,292							

The table shows that among the 28 respondents in the vegetable vending sector majority of them i.e. 17 of them have an income ranging from Rs. 11,000 to 15,000. The 24 vendors in the clothes sector have a vast difference in the income range as 6 of them have an income range below Rs. 10,000, 8 of them have a range of Rs. 11,000 -

Rs. 15,000, and again 7 of them have the range of Rs. 15,000 - Rs. 20,000. There are 3 vendors who earn more than Rs. 31,000/month. Likewise the vendors in the food and snacks category have a varied income range as they earn from Rs. 10,000 and below to Rs. 25,000/month. The other categories also have different income ranges as per the specification of the vendors as can be seen. I have presented a case here that reflects street vending to be a means of livelihood.

Case 2: Street Vending an option for livelihood

Santosh Prasad Baral, 35 a permanent resident of Kavrepalanchowk is a father of 2 children and is currently living in a rented flat in Chabahil behind the Ganesh temple. He belonged o a very poor family who did not have sufficient land for cultivation and relied on the wages of working in others land. He lost his father at an early age and recalls that he could have studied more if he was alive. His struggling mother could not afford to continue his studies after his SLC as there were his younger brother and sister. In Kavrepalanchowk, he began his work by teaching in a school at the Primary Level. His salary was hardly enough to sustain and support his mother. During this time he got married and responsibilities got over burdened. He decided that he will not keep his family in the same economical situation forever and therefore decided to come to Kathmandu to test his fortune.

He felt he was lucky enough to have a close friend in Kathmandu with whom he stayed. His friend was already doing street vending in Asan area and suggested the same for him. He immediately with the help of his friend started the same work in Asan area. After 6 months he brought his wife too and since then they are doing the vending work together but in two different spots. Both sell clothes in different locations in Chabahil. Asan being over crowded they changed their venue with the scope of better opportunity in Chabahil.

Santosh alone has an income of more than Rs. 35,000/month and his wife makes an income of around Rs. 15,000/month. They live in a rented flat in Bulbule, Chabahil and are satisfied with their livelihood. The children go to a boarding school in Boudha and they perform well in school. According to Santosh, there are various risks and challenges, threats in the vending work, income is also good when you can dedicate yourself. Now he is thinking of purchasing a small piece of land and is intending to build a house and bring his mother from the village too.

4.9 Previous Occupation of Respondents

Among the total 120 respondents 58 respondents i.e 48 % of them were engaged in farming in their own lands prior to taking street vending as their occupation. Among them it can be seen that there were 17 male and 41 female who were involved in farming. Respondents not working at all before doing street vending is also highlighted here as it can be seen that 31 of the respondents (20 male and 11 female) were not working at all. This indicator supports the above indicator of men and women involved in farming in own land as there were fewer men seen to be working in the farms and the numbers of men not working at all is greater compared to women not working at all. 13% of the respondents have also quitted from a formal salaried work for reasons of their own and entered street vending. However, the respondents have also been engaged in different sector of work like Shar-cropping, trade and other kinds of informal work.

Table 4.9: Previous Occupation of Respondents

Income Range	Male	Female	Total	%
Farming in own land	17	41	58	48%
Salaried work	14	2	16	13%
Livestock raising			0	0%
Shar – cropping	4		4	3%
Trade	3	2	5	4%
Not working	20	11	31	26%
Others	1	5	6	5%
Total	59	61	120	100%

4.10 Respondents Reason for Choosing Street Vending

The given table shows the different reasons or situations for the street vendors to adapt street vending as their occupation for livelihood. 53 male and 40 female have chosen street vending as their occupation as a means of income for their living. This makes up 78% of the total 120 respondents. So here, it is the majority of the venders that chose street vending for livelihood as they are the bread winners of the family. 11% of the street vendors however, have chosen street vending to support the family due to their low economic conditions. Other street vendors chose street vending because of the lack of skill and education to be engaged in other work sectors and for their own reasons.

Table 4.10: Respondents Reasons for Choosing Street Vending

Reasons for Street Vending	Male	Female	Total	%
For Income	53	40	93	78%
Low economic condition (specify)	2	11	13	11%
After retirement from previous work			0	0%
Absence of skill/education for formal work	2	4	6	5%
Others	2	6	8	7%
Total	**59**	**61**	**120**	**100%**

Here, I have presented a case where a college boy is supporting his studies in Kathmandu through street vending.

4.11 Respondents Age Distribution and Vending Experience in years

The table gives a picture about the respondent's age and the number of years in vending occupation. 52% of the respondents who belong to different age groups have been doing street vending for up to 5 years or less. The highest number of street vendors to be in street vending for less than 5 years is 22 who are in the age group o f

26 - 30. Similarly, 13 respondents within 31 - 35 years of age are also into street vending for less than 5 years. It shows that street vendors from the age of 26 to 35 make the highest population and are doing street vending for less than 5 years. Simarly 26 respondents who are above 25 years of age have been doing street vending above 5 years and nearly 10 years also. Among the 12 0 respondents there are 32 respondents above the age of 31 and are doing vending work 10 years and above.

Table 4.11: Respondents Age Distribution and Vending Experience in Years

No. of yeas in street vending	**0- 20 Yrs**	**20 - 25 Yr**	**25 - 30 Yrs**	**01 - 35 Yrs**	**35 - 40 Yrs**	**40 Yrs Above**	**Total**	**%**
up to 5 yrs	6	10	22	13	4	7	62	52%
6 – 10 yrs	-	-	5	13	6	2	26	22%
10 – 15 yrs	-	-	-	5	-	6	11	9%
15 – 20 yrs	-	-	-	3	2	6	11	9%
20 - 25	-	-	-	4		6	10	8%
Total	6 (5%)	10 (8%)	27 23%	38 32%	12 10%	27 23%	120 100%	100%

CHAPTER V

KNOWLEDGE, BEHAVIOR AND ATTITUDE

This chapter deals with the knowledge, behavior and attitude of Street Vendors towards HIV and AIDS. It further reflects the understanding they have towards it, what they know and how they reflect it in their behavior can also be seen in this chapter. Further, attitude towards HIV and AIDS is also portrayed.

5.1 Respondent Informed About HIV and AIDS

The table given below shows that 97% of the respondent's i.e. among the 120 respondents 59 male and 57 female are informed about HIV and AIDS and that gives a total of 116 respondents who are informed about HIV and AIDS at least by some means. The 3% of respondents do not know anything about it and have never heard about HIV and AIDS so far.

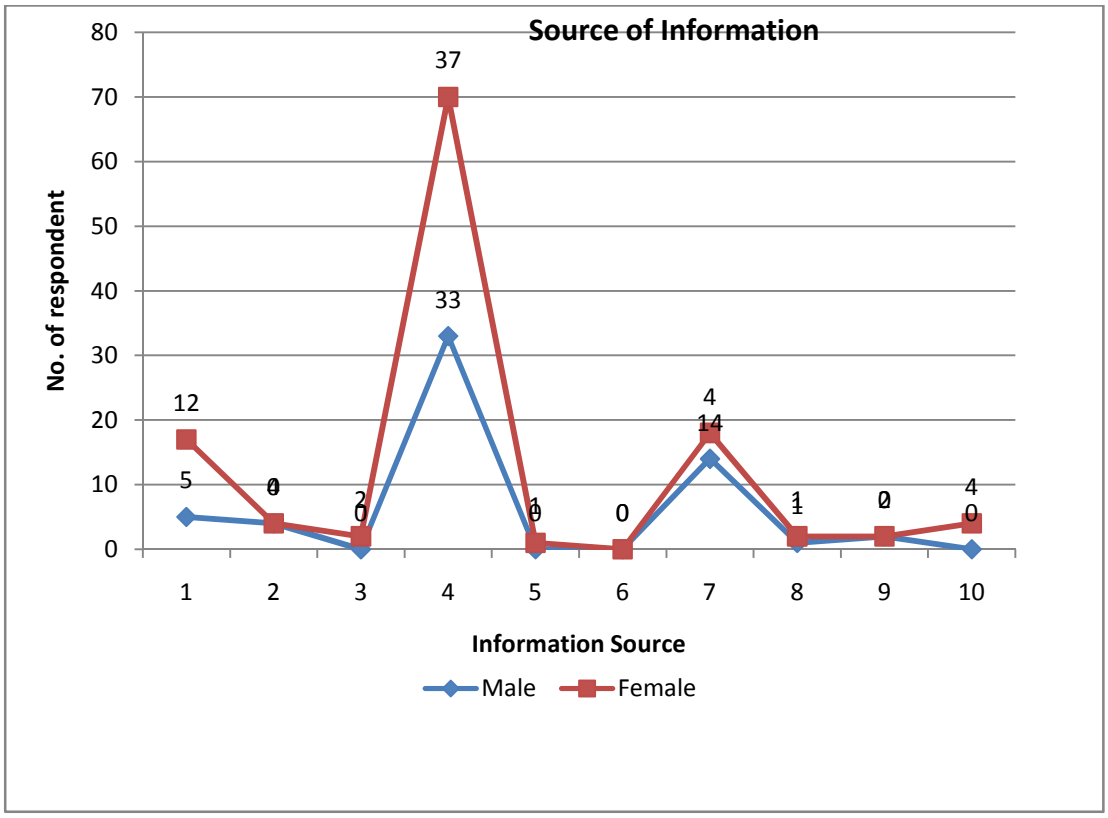
Table 5.1: Respondents Informed About HIV and AIDS

Response	Male	Female	Total	
Yes	59	57	116	97%
No			0	0%
Don't know		4	4	3%
Total	**59**	**61**	**120**	**100%**

5.2 Respondents source of information on HIV and AIDS

There are various means of getting information and the figure below shows the different sources from where the respondents were informed about HIV and AIDS. Radio is the leading source of information as can be seen that 58% of the respondents have heard about HIV and AIDS through radio programs. Television and school follow as the source of information by having 15% and 14% respectively. The figure also reflects that hospitals, health posts and clinic have 0% contribution in being a source of information on HIV and AIDS.

Figure 5.2: Respondents Source of Information on HIV and AIDS



5.3 Respondent's understanding towards HIV and AIDS

The respondents have a varied understanding towards HIV and AIDS.

Table 5.3: Respondent understands towards HIV and AIDS

S. No	Options	Responses
1.	HIV is a virus	34
2.	HIV is a disease	70
3.	HIV is the result of sin from previous life	4
4.	Disease that comes from having unprotected sex with many people	34
5.	Disease that has no treatment	36
6.	Others	2

As can be seen in the table here there were 70 responses that consider HIV to be a disease. Likewise, there are 36 responses that consider HIV to be a disease that has no

treatment. Again, 34 responses that consider HIV to be a virus and also a disease that comes from having unprotected sex with many people. It cannot be ignored that respondents hold the belief that HIV is still the result of sin from previous life. There is a case presented here that tries to show how a persons' knowledge and doubt is controlled by the fear associated to be HIV infected.

Case 4: Doubt and Fear Over Rule Knowledge

Bimala Tamang, a 35 year old woman is originally from Udaypur and is currently residing in Chuchepati, Kathmandu with her husband and one daughter. She was married at the age of 17 and prior to that she never got the opportunity to go to school. Helping her parents in farming, raising cattle and helping with the household chores were her key responsibilities. Marriage had no other options as she continued with the same kind of work. She was married to a brother of three and their's was a joint family. The limited land for cropping, lack of education and skills for other paid jobs and the large family had put them to extreme poverty. Her husband too was not educated enough for other skilled employment. Living a poverty stricken life they decided to come to Kathmandu in search of any kind og work available for them. They were attracted by others too who had started moving to Kathmandu for the same. Therefore, it was 16 years back that they came to Kathmandu. With the limited skills in farming and cattle raising they were moving all over in search of work. They had a neighbor already staying in Kathmandu in a rented room, so they were the guests there for a couple of days and even months.

It was after five months that her husband got work. His work was to help in the construction of houses. Similarly Bimala also began work with a small shop on a "nanglo" called "nanglo pasal" with accessories like cigarette, biscuits, chocolates and etc. Their situation slowly began to change as they started earning from their livelihood. At present she sells clothes on the footpath of Chabhil and her husband works in a wool factory in Jorpati. They live in a rented room in Chuchepati with their daughter. The daughter goes to a boarding school and they too are satisfied with the current economic condition.

However, with regard to her understanding on HIV and AIDS she has heard about it from radio and people must keep distance from those infected with it in order to protect one self. She feels that she may also get HIV infected in future through her husband. as he works in the factory . She is concerned about her health situation because she is suffering from abdominal pain and has white discharges regularly. She has the doubt that her husband is betraying her and visiting others for sexual pleasure. S is worried and nervous to go for any kind of medical checkup as she is afraid to hear the result.

5.4 Respondent's assumptions about HIV and AIDS

The table below clarifies the respondent’s assumptions towards HIV and AIDS. Majority of the respondents have clear understanding regarding myths and assumptions. As can be seen, 68% do not consider it a sin to be infected by HIV where as 15% still regard it as a sin and the remaining 17% do not know. Similarly,

majority of the respondents hold the opinion that HIV is not transmitted by sharing a meal, HIV can be prevented by abstaining from sexual intercourse, HIV is not transmitted by holding hands. However, respondents do not know about the confidential testing of HIV within their communities as shown in the table 40% of the respondents fall in the group.

Table 5.4: Respondent's assumptions about HIV and AIDS

Assumptions	Yes	No	Don't Know	Total
It a sin to be infected with HIV	18	82	20	120
	15%	68%	17%	
HIV can be transmitted by sharing a meal with someone who is HIV infected	22	81	17	120
	18%	68%	14%	
People can protect themselves from HIV transmission by abstaining from sexual intercourse	90	19	11	120
	75%	16%	9%	
A person can get HIV by holding his /her hand with a person who Is infected by HIV	12	90	18	120
	10%	75%	15%	
It is possible in your community for someone to get a confidential test to find out if they are infected with HIV	57	23	40	120
	48%	19%	33%	

This information is further supported by the respondent's group response in Focus Group Discussion (FGD).

Groups' understanding of HIV and AIDS in FGD

Among the participants taken for FGDs, half of the participants shared that HIV is a disease and is transmitted through unprotected sex. The other half also expressed that it is a disease that has no treatment and people die quickly once they are infected with it. They have heard that HIV is not transmitted by shaking hands or sharing a meal but still have doubts to trust the information and are bias towards it. So they believe that staying away from HIV infected people is the best possibility because it is a disease and anything can happen.

5.5 Respondent's understanding on HIV transmission

Respondents have a varied understanding about the transmission of HIV from one individual to the other. The table below shows that in most of the cases HIV is transmitted through unprotected sexual intercourse as there are 47 responses that support it. 38 responses support the transmission through sharing of unsterilized needle and syringe. HIV transmission through blood transfusion, from pregnant mother to child, through breast feeding and by transplanting of body parts have all been quoted by the respondents. However, the base being 120 for all the responses, it can be seen that the understanding level is yet poor among the respondents.

Table 5.5 : Respondent's understanding on HIV transmission

S. No	Options	No of Answer
1.	Through unprotected sexual intercourse	47
2.	Sharing unsterilized needle and syringe	38
3.	Blood transfusion	39
4.	Sharing unsterilized blades/razors	36
5.	From pregnant mother to child	23
6.	through breast feeding by infected mother	18
7.	Transplantation of body parts	14
8.	Others	1

There is a case presented here that reflects the differences in the knowledge people have and the behavior they practice.

Case 5: Behavior A dominant Factor For Knowledge

Priya Rai a 28 year old, married woman living alone in a rented room in Chabhil. She is originally from Sindhupalchowk and has studied only upto the primary level. She was married at the age of 26 and was living in Sindhupalchowk with her inlaws. They were from a poor family and had some cultivating land where she worked. After her husband went for foreign employment to Qatar, she also left her hometown and shifted to Kathmandu to be independent. It has been around 1 year that her husband has gone to Qatar and the only means of communication among them is the mobile phone.

With the help of her friends in Chabhil, she began street vending and started selling kitchen and toilet utilities in Chabhil itself. It has just been a year that she started with this and earns around Rs. 22, 000/month. She is not satisfied with her income as it is not sufficient for her and is also dependent upon the income of her husband. Her husband sends her money in every three months of which she spends and as well puts the rest in bank.

Priya further shares that, despite her work and freedom living alone, she feels very lonely and for which she sometimes spends her time with friends. She has a special friend with whom she shares her feeling and has sexual intercourse too. She knows that HIV is transmitted through unsafe sex but does not find it necessary to protect herself from transmitting HIV because she trusts the friend.

5.6 Respondent's attitude towards Condom Use

Condom use is considered to be the most popular means of prevention method for HIV transmission. The table gives a clear picture on the behavioral aspect of the street vendors towards condom use. As can be seen 98 respondents i.e. 82% do not use condom every time they have sexual intercourse. It is only the remaining 17% who use condoms every time they have sexual intercourse. However, There is a small percentage i.e. 2 % of the total 120 respondents who do not know about condom use at all.

Table 5.6: Respondent's Attitude Towards Condom Use

Condom use	Male	Female	Total	%
Yes	12	8	20	17%
No	47	51	98	82%
Don't know		2	2	2%
Total	59	61	120	100%
	49%	51%	100%	

The table above on attitude towards condom use and the above shared case is further supported by the Focus Group Discussion on Street Vendors Vulnerability to HIV transmission which is presented below.

The respondent's attitude towards condom use is further elaborated in the case presented below.

Case 6: Knowledge vs Prejudice

A 28 year old Akram Majir from Bihar, India is a married man with four children. Theirs is a joint family and he along with his two brothers live together in their hometown. He came to Nepal, Kathmandu around 8 years back with the objective of doing business on this land. In Bihar they do not have sufficient land of their own so they go to work on wages on others land. However the income derived is not sufficient for their living. He did not feel comfortable working as a street vendor in his hometown and therefore, came here for it.

Akram, moved to Kathmandu around 8 years back and since them is working as a street vendor and sells snacks (pani puri) on the streets, road corners and junctions of Chabahil. He moves on the streets of Chabahil from one end to the other to sell his pani puri to the passerby's. He lives in a small rented room in Chabahil with his friends and visits his family in every 4 to 6 months. He earns around Rs. 20,000/month and sends home almost all the money. He begins to sell his stuff from the afternoon to late evening.

He has a quite fair understanding about HIV and AIDS but still has doubts on the transmission and prevention methods. He understands that correct use of condom prevents HIV transmission but does not use a condom every time he has sex and also visits sex workers sometimes and has unprotected sex. He further expresses that he visits the same sex worker and does not find it necessary to use a condom because she is clean enough, looks healthy and does not go with rough and weird looking people.

Focus Group Discussion on Street vendors' vulnerability to HIV transmission:

Among the participants taken for FGD, all female participants do not consider themselves to be direct vulnerable to being HIV infected but have the feeling that they may get infected through their husbands if they go out to others. They have the opinion that men cannot be trusted and anything can happen. However, majority of the men do not find themselves vulnerable to HIV transmission because they shared that they are not in contact with sex workers. However, some men shared that even though they have unprotected sex with their friend of partner they trust them and therefore there is no chance for HIV transmission.

5.7: Respondents' Knowledge on Confidential HIV Testing

Among the total 120 respondents 77 of them I.e. 79% of them have never had a HIV test in any time of their lives. The 14% i.e. 14 respondents have had a HIV test for several reasons of their own. A 7% of the respondents do not know anything about HIV testing.

Table 5.7: Respondents' Knowledge on Confidential HIV Testing

HIV testing	Male	Female	Total	%
Yes	3	11	14	14%
No	44	33	77	79%
Don't Know	-	7	7	7%
Total	**47, (39%)**	**51, (43%)**	**98 (82%)**	**100%**

CHAPTER VI

KNOWLEDGE ON HIV PREVENTION

This chapter deals with the knowledge on prevention of HIV transmission among the street vendors. It further deals with individual preventive measures to find out the knowledge respondents have towards the prevention of HIV transmission.

6.1 Respondents' Knowledge on HIV Prevention By Having One Uninfected Faithful Sex Partner

It can be seen from the table that 83% of the respondents have the view that HIV can be prevented by having one uninfected faithful sex partner and whereas 8%of the total respondents do not hold the similar view. There is a 12% of respondents who have no idea about the matter.

Table 6.1: Respondents' Knowledge on HIV Prevention By Having One Uninfected Faithful Sex Partner

Options	Male	Female	Total	%
Yes	53	46	99	83%
No		9	9	8%
Don't Know	6	6	12	10%
Total	**59**	**61**	**120**	**100%**

6.2 Respondents' Knowledge on Correct Use of Condom for HIV Prevention

It is seen from the table that majority i.e. 82% of the population have a clear understanding that correct use of condoms can prevent HIV transmission. On the other hand there is still 17% of the population that do not know or are not clear about the prevention of HIV transmission through the correct use of condoms.

Table 6.2: Respondents' Knowledge on Correct Use of Condom for HIV Prevention

Options	Male	Female	Total	%
Yes	48	50	98	82%
No	-	2	2	2%
Don't Know	11	9	20	17%

A Focus Group Discussion done with the respondents on the means of HIV prevention also supports the above findings for HIV prevention and is presented below.

Focus Group Discussion on the Prevention from getting infected with HIV

Among the participants taken for FGD, all the participants held the opinion that being honest with husband/wife in the married case and friend in the unmarried case is the best possible way to prevent oneself from HIV infection. However, half of the participants also suggested that in case of having multiple partners for sexual intercourse then the correct use of condom for protected sex is the best possible means to prevent oneself from being infected from HIV.

6.3 Respondents' Knowledge on HIV Prevention Through Mosquito Bites

The table has tried to view the myth of HIV transmission on the basis of the respondents' educational level. It shows that there is a minimal percentage of respondents who assume that HIV is transmitted through mosquito bite and majority of them i.e. 61 % have the knowledge that HIV is not transmitted through mosquito bite. However, it cannot be ignored that there is still 30% of the total 120 respondents who are still confused and do not know about it.

Table 6 3: Respondents' Knowledge on HIV Prevention Through Mosquito Bites

Education	Yes	No	Don't Know	Total	%
Illiterate	3	5	14	22	18%
Primary	2	20	8	30	25%
Lower Secondary	-	18	4	22	18%
Secondary	2	19	6	27	23%
Intermediate/+2	2	2	-	4	3%
Bachelors'	2	8	4	14	12%
Masters'	-	1	-	1	1%
Others	-	-	-	0	0%
Total	11 (9%)	73 (61%)	36 (30%)	120 (100%)	

6.4 Respondents Knowledge on HIV Prevention by Abstaining/Avoiding Sexual Intercourse

Majority of the respondents have the understanding that HIV can be prevented by abstaining/avoiding sexual intercourse. It can be seen that 62% of the respondents have this understanding. However, it cannot be neglected that 17% of the respondents that is 20 respondents out of 120 are still unaware or do not know the proper means of prevention from HIV.

Table 6.4: Respondents Knowledge on HIV Prevention by Abstaining/Avoiding Sexual Intercourse

Response	Male	Female	Total	%
Yes	37	37	74	62%
No	15	11	26	22%
Don't Know	7	13	20	17%
	59	61	120	100%

6.5 Respondents' Knowledge on Mother to Child Transmission

It is reflected in the table that 55% of the respondents hold the view that HIV is transmitted from a pregnant mother to the child. A minimal percentage i.e 2% do not think that HIV is transmitted through mother to child. Here again, a huge percentage i.e 43 % of the respondents do not know whether HIV is transmitted from a pregnant mother to a child.

Table 6.5: **Respondents' Knowledge on Mother to Child Transmission**

Response	Male	Female	Total	%
Yes	36	30	66	55%
No		2	2	2%
Don't Know	23	29	52	43%
Total	59	61	120	100%

6.6 Respondents Knowledge on HIV Prevention by Taking HIV Tested Blood

82% of the respondents have the understanding that HIV can be prevented by taking HIV tested blood where as 3% of the respondents still doubt and do not hold the view that HIV can be prevented by taking HIV tested blood. Again here too, a huge percentage i.e. 15% of the respondents still do not know that HIV can be prevented by taking HIV tested Blood.

Table 6.6: Respondents Knowledge on HIV Prevention by Taking HIV Tested Blood

Response	Male	Female	Total	%
Yes	50	48	98	82%
No	-	4	4	3%
Don't Know	9	9	18	15%
Total	59	61	120	100%

6.7 Respondents' Knowledge on HIV Transmission by Not Sharing Razors/Blades

The table below clearly shows that 78% of the respondents have the understanding that HIV can be prevented by not sharing razors and blades. There still exists a substantial percentage of respondents who are still unaware or do not know about it.

Table 6 7: Respondents' Knowledge on HIV Transmission by Not Sharing Razors/Blades

Response	Male	Female	Total	%
Yes	49	44	93	78%
No	2	2	4	3%
Don't Know	8	15	23	19%
Total	**59**	**61**	**120**	**100%**

6.8 Respondents' multiple responses on the means of HIV prevention

The table below shows respondents varied views and opinions regarding the means of HIV prevention. It can be seen from the table that the highest response is for using condoms where 94 respondents have expressed their views. It is followed by avoiding sex with sex workers where 72 responses has supported it. Again there are 64 responses that hold the view that HIV can be prevented by avoiding sex with injecting drug users. The next high response supports the view to limit sex to one partner/stay faithful and is supported by 60 responses. However, there are other mixed views as well which are demonstrated in the table below.

Table 6.8: Respondents' multiple responses on the means of HIV prevention

S. No	Perceptions towards HIV transmission	No of Answer
1.	Abstain sex	46
2.	Use condoms	94
3.	Limit sex to one partner/stay faithful	60
4.	Limit no. of sex partners	36
5.	Avoid sex with sex workers	72

S. No	Perceptions towards HIV transmission	No of Answer
6.	Avoid injections	56
7.	Avoid sex with persons who have many partners	52
8.	Avoid sex with homosexuals	38
9.	Avoid sex with Injecting Drug Users	64
10.	Avoid blood transfusions	50
11.	Seek protection from the traditional healers	30
12.	Avoid sharing razors/blades	50
13.	Avoid kissing	18
14.	Avoid sex with someone who has AIDS	56
15.	Avoid mosquito bites	12
16.	Don't know	2

CHAPTER VII

SUMMARY AND CONCLUSIONS

This chapter presents the summary of the thesis and the major conclusions developed based on the empirical findings.

7.1 Summary

The focus of this study was on identifying and understanding the existing knowledge, behavior and attitude towards HIV and AIDS among the street vendors in Chabahil are of Kathmandu district. It aimed to study the perceptions, information and knowledge of street vendors and also aimed to looking at their behavior patterns and the prevention aspect among them. In brief, this thesis had a set of the following specific objectives: (i) to study the socio-economic situation of street vendors in Chabahil area; (ii) to study the existing knowledge, behavior and attitude of street vendors towards HIV and AIDS, and (iii) to examine the knowledge on HIV prevention among street vendors.

The reviews made have been used for organizing the study. It was reflected in the review that street vendors are in poverty and poverty is a leading factor for the transmission of HIV. Among the estimated 480 street vendors in Chabahil are a total of 120 were drawn for the survey through questionnaire. The Chabahil area was divided into 6 clusters and 20 respondents were drawn through random sampling from each cluster that accounted for the total of 120 respondents. Likewise, for qualitative data, Focus Group Discussion and Case Studies were also done and the samples were drawn using the purposive sampling method. Hence, both quantitative and qualitative data have been collected to obtain data of respective nature.

The socio-demographic and environmental situations of street vendors of Chabahil area are presented in tabular form. The key findings derived from the socio-demographic and economical situation of street vendors in Chabahil area can be summarized as follows:

a. Majority of the street vendors i.e 24% are from Kavrepalanchowk, which is followed by Kathmandu to be 14%. Street Vendors from India make the third highest ranking as there are 9% of street vendors coming from India and doing the vending business in Chabahil area,
b. The age distribution of majority of street vendors in Chabahil area ranges from 26 years and the average age of street vendors is 34 years
c. The education level of 23% of the street vendors is Secondary and 43% of the street vendors is Primary and Secondary.
d. Majority i.e. 75% of the street vendors live with their families in Chabahil and surrounding areas
e. The average income of the street vendors is NPR 15, 252.00.

The study has further made an attempt to examine the knowledge, behavior and attitude of street vendors towards HIV and AIDS. Majority of the street vendors i.e. 97% of them have heard about or are informed about HIV and AIDS and among them are 59 male and 57 female. 58% of them have heard about HIV and AIDS in the radio through several programs. It was interesting to find out that there were no respondents to have heard about HIV and AIDS from hospital, health post or a clinic.

Likewise, 70% of the respondents understand HIV as a disease, 34% understand it as a virus, again 34% understand it to be a disease that is transmitted through unprotected sexual intercourse and 36 % understand it as a disease without treatment.

With regard to the assumptions on HIV 75% believe that HIV can be prevented by abstaining from sexual intercourse. The respondents were not much aware about the confidential testing of HIV as only 48% of them had the opinion that it was possible whereas 19% responded as not possible and the remaining 33% did not know anything like that.

83% of the street vendors believe that HIV can be prevented by having one uninfected faithful sex partner, 30% do not know whether HIV is transmitted through mosquito bite. 82% of the street vendors never use condoms while they have sexual intercourse and on the other hand 82% of them know that HIV is prevented by the correct use of condoms.

7.2 Conclusions

The objective of this study was to gain an understanding about the socio-demographic and economical situation, to know the knowledge, behavior and attitude towards HIV and AIDS and to know the knowledge on prevention towards HIV and AIDS among street vendors. Based on these objectives and research data, the following conclusions have been deduced:

(i) Women's involvement in the informal sector economy is high in comparison to the male counterpart. Lack of education, inadequate skills, speedy modernization and their poverty stricken present has compelled them to occupy the unrecognized sector further depriving them to their rights for social protection. Women with low levels of education and skills find it easier to enter street vending as the means of income.

(ii) Street vending has resulted as the ultimate solution for livelihood strategy among the rural and urban poor. Majority of the street vendors are engaging in street vending for the generation of income to carry on with their livelihoods.

(iii) Prejudice perceptions towards HIV and AIDS are still rampant among the street vendors. Though informed about HIV and AIDS through any kind of media, they still hold their biasness towards HIV and AIDS.

(iv) Condom use among the street vendors is apparently low that increases their vulnerability to HIV transmission. As internal migration is co-related to street vending activities

(v) Hesitation, shyness, lack of openness still exists among street vendors while talking about HIV and AIDS.

(vi) Transferring knowledge into behavioral practice is the key challenge among street vendors in the prevention of HIV. They are well informed and have the understanding about the transmission and prevention mechanisms but yet fail to adapt it in their personal behaviors.

(vii) Street vending in the urban setting is highly vulnerable to various contexts like social security, health and sanitation and financial security. The street vendors live in rented rooms with low facility, their business being directly

on the street are always on the verge to road related accidents, the pollution and their working nature has even put them to high health hazards. Finally, their sector of work which is unrecognized has deprived them of all the rights and securities associated to them.

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ANNEX – I:

Individual Survey Questionnaire

A. General Information: **Date of interview:** _____

1. **Respondent's name:** _____
2. **Sex:** Male ( ) Female ( ) Third Gender ( )
3. **Age:** _____
4. **Marital status:** M ( ) UM ( ) S ( ) D ( ) Wd/Wdr ( )
5. **Caste / Ethnic group:**

Brahmin	( )	Gurung	( )	Rajbanshi	( )
Newar	( )	Chetri	( )	Magar	( )
Tharu	( )	Rai	( )	Tamang	( )
Dalit	( )	Limbu	( )	Satar	( )
Other	( )				

6. **Religion:** Hindu ( ) Muslim ( ) Buddhist ( ) Christian ( ) Other (specify) _____
7. **Educational Qualification:**

Illiterate	( )	Secondary	( )	Masters'	( )
Primary	( )	Intermediate / + 2	( )	Others	( )
Lower Secondary	( )	Bachelors'	( )		

8. **Permanent address**:_____
9. **Current address**:_____
10. **Street vending specification**:

Fruits	( )	Clothes	( )	Games / Toys	( )
Vegetables	( )	Electrical accessories	( )	Stationary	( )
Food & snacks	( )	Kitchen / Toilet utilities	( )	Cosmetics / Women's utilities	( )
Souvenirs / Gift items	( )	Shoes / Bags	( )	Others	( )

11. **No. of years in street vending**:
    up to 5 yrs ( ) 5 – 10 yrs ( ) 10 – 15 yrs ( ) 15 – 20 yrs ( ) 20-25 yrs ( )
12. **With whom do you live with?**

Alone	( )	With relatives	( )	With coworkers	( )
With Family	( )	With peers / friends	( )	Others	( )

13. **If you do not live with family how often do you visit them?**

1 – 3 months	( )	4 -6 months	( )	7 – 9 months	( )
once a year	( )	Do not visit	( )	others	( )

14. Why did you choose street vending as your work?

For Income ( ) Low economic condition ( )

After retirement from previous work ( ) Absence of skill/education for formal work ( )

Others ( )

15. Average monthly income:

Below 10,000 ( ) 15,000 – 20,000 ( ) 25,000 – 30,000 ( )

10,000 – 15,000 ( ) 20, 000 - 25,000 ( ) 30,000 – 35000 ( )

16. **Is the income sufficient for your living?**

Yes ( ) no ( ) don't know ( )

17. If not sufficient, how do you meet your needs?

Borrow from friends / relatives ( ) Take loan from women's group ( )

Take personal loan ( ) Take loan from cooperatives ( )

other work ( )

18. What was your previous occupation?

Farming in own land ( ) Salaried work ( ) Livestock raising ( )

Shar – cropping ( ) Trade ( ) Not working ( )

Others ( )

19. How many members in your family work?

Only 1 ( ) 2 ( ) 3 ( ) 4 and above ( )

20. Family profile:

S. No.	Relationship	L/D	Age	Education	Occupation	Address	Remarks

B. <u>Specific Information on Knowledge, Behavior and Attitude towards HIV and AIDS:</u>

1. Have you ever heard about HIV and AIDS?

Yes ( ) No ( ) don't know ( )

2. From which source have you heard about HIV and AIDS?

School ( ) Newspaper ( ) Health workers / Social Workers ( )

Radio ( ) Family / relatives ( ) Hospitals / Health post / clinic ( )

TV ( ) Friends ( ) Organizations ( )

Others ( )

3. What do you understand by HIV and AIDS?

HIV is a virus ( )

HIV is a disease ( )

HIV is the result of sin from previous life ( )

Disease that comes from having unprotected sex with many people ( )

Disease that has no treatment ( )

Others ( )

4. **Is it a sin to be infected with HIV?**
   Yes ( ) No ( ) Don't know ( )

5. **In your opinion how is HIV transmitted from one person to another?**
   Through unprotected sexual intercourse ( )
   sharing unsterilized needle and syringe ( )
   Blood transfusion ( )
   sharing unsterilized blades/razors ( )
   From pregnant mother to child ( )
   through breast feeding by infected mother ( )
   Transplantation of body parts ( )
   Others ( )

6. **Do you think you may get infected with HIV in future?**
   Yes ( ) No ( ) Don't know ( )

7. **Do you know anyone who is infected with HIV or has died of AIDS?**
   Yes ( ) No ( ) Don't know ( )

8. **Can a person get HIV by sharing a meal with someone who is HIV infected?**
   Yes ( ) No ( ) Don't know ( )

9. **Can a pregnant woman infected with HIV transmit the virus to her unborn child?**
   Yes ( ) No ( ) Don't know ( )

10. **What can a pregnant woman do to reduce the risk of transmission of HIV to her unborn child?**
    Take medication ( ) Don't know ( ) Others (specify) _____

11. **Can a woman with HIV transmit the virus to her new born child through breast feeding?**
    Yes ( ) No ( ) Don't know ( )

12. **Can people protect themselves from abstaining from sexual intercourse?**
    Yes ( ) No ( ) Don't know ( )

13. **Can a person get HIV by holding his /her hand with a person who Is infected by HIV:**
    Yes ( ) No ( ) Don't know ( )

14. **Is it possible in your community for someone to get a confidential test to find out if they are infected with HIV?**
    Yes ( ) No ( ) Don't know ( )

15. **Do you use a condom every time you have sex?** Yes ( ) No ( )

16. **Have you had unprotected sex in the last 6 months?**

    Yes ( ) No ( ) Cannot remember ( )

17. **If yes, with whom did you have unprotected sex in the last six months?**
    Husband/wife ( ) friend/partner ( ) sex worker ( ) other (specify) _____

18. **Have you had a HIV test?** Yes ( ) no ( )

19. **If yes, can you share your result?** _____

20. **When did you go for this test?** _____

21. **Did you have the second test?** Yes ( ) no ( )

22. **If yes, can you share your result? _____**

23. **Are there any HIV and AIDS related programs for you?** Yes ( ) no ( )

24. In your opinion are HIV and AIDS related information and programs necessary for you?

Yes ( ) no ( ) don't know ( )

C. <u>Specific information on HIV prevention:</u>

1. What can a person do to avoid getting HIV infected?

Abstain sex	( )
Use condoms	( )
Limit sex to one partner/stay faithful	( )
Limit no. of sex partners	( )
Avoid sex with sex workers	( )
Avoid injections	( )
Avoid sex with persons who have many partners	( )
Avoid sex with homosexuals	( )
Avoid sex with Injecting Drug Users	( )
Avoid blood transfusions	( )
Seek protection from the traditional healers	( )
Avoid sharing razors/blades	( )
Avoid kissing	( )
Avoid sex with someone who has AIDS	( )
Avoid mosquito bites	( )
Don't know	( )
Others	( )

2. Can HIV be prevented by having one uninfected faithful sex partner?

Yes ( ) No ( ) Don't know ( )

3. Can HIV be prevented by using a condom correctly every time a person has sex?

Yes ( ) No ( ) Don't know ( )

4. Can a person get HIV from mosquito bites?

Yes ( ) No ( ) Don't know ( )

5. Can HIV be transmitted from a pregnant women to her child?

Yes ( ) No ( ) Don't know ( )

6. Can people protect themselves from HIV by abstaining / avoiding sexual intercourse?

Yes ( ) NO ( ) Don't know ( )

7. Can people protect themselves from transmitting HIV by not holding hands with HIV infected people?

Yes ( ) No ( ) Don't know ( )

8. Can people protect themselves from HIV by not sharing razors/blades?

Yes ( ) No ( ) Don't know ( )

9. Can HIV be prevented by taking HIV tested blood?

Yes ( ) No ( ) Don't know ( )

10. Should a HIV infected woman give birth to a child?

Yes ( ) No ( ) Don't know ( )

Thank you for your valuable time and contribution!

ANNEX – II:

Checklist for Case Study

1. **Name**
2. **Age**
3. **Caste / Ethnicity**
4. **Education**
5. **Marital status**
6. **Address:**

   Permanent

   Present

7. Migration history:

   When did you come to Kathmandu?

   The driving factor for migrating to Kathmandu?

   Did you come alone or with your family?

   Were you married or single when you migrated to Kathmandu?

   If you came alone, how often do you visit you family back home?

   Where was your first destination in Kathmandu?

   Whom did you stay with for the first time after arriving Kathmandu?

8. Work history:

   What was your first job/work in Kathmandu?

   Had you any working experience when you came to Kathmandu?

   Why did you choose the above work?

   How and why did you choose this specific street vending?

   Are you satisfied with you work?

9. Knowledge, Behavior and Attitude with regard to HIV and AIDS

   What knowledge do you have on HIV and AIDS? Probe!

   What do you know about the transmission of HIV

   What do you know about how a person can avoid getting HIV transmitted?

   How do you think you can protect yourself from HIV infection?

Annex – III:

Checklist and description of participants for Focus Group Discussion (FGD):

Discussion Topic: Vulnerability and Prevention.

Socio-demographic description of the FGD Participant's

S. No.	Name	Sex	Age	Caste/Ethnicity	Education	Type of vending	Remarks

Specific Questions:

i. What do you understand by HIV and AIDS?
ii. How are street vendors vulnerable to HIV transmission?
iii. In what ways can you prevent yourself from getting HIV infected?