CHAPTER ONE

Introduction

1.1 General Background

Nepal is a landlocked country with a population of 27.7 million. It is a country of contrasts with the Himalayan Mountains, middle hills, and open plains bordering India. More than 42 percent of the populations live in rural areas.

AIDS, or acquired immunodeficiency syndrome, is caused by the human immunodeficiency virus (HIV), which is spread through blood, semen, vaginal secretions, and breast milk. The most common method of transmission is unprotected sexual intercourse with an HIV-positive partner. Other routes include transfusions of HIV-infected blood or blood products; tissue or organ transplants; used of contaminated needles, syringes, or other skin-piercing equipment; and mother- to- child transmission during pregnancy birth, or breast-feeding. HIV is extremely fragile. It cannot survive long outside the body's fluids or tissue and it cannot penetrate unbroken skin.

HIV kills by weakening the body's immune system until it can no longer fight infection. Opportunistic infections are illness such as pneumonia, meningitis, some cancer, tuberculosis (TB), or other parasitic, viral, and fungal infections that occur when the immune system is weakened.

HIV generally progresses over a decade before developing into AIDS, but there is a long delay after infection before symptoms become evident. Early HIV- related symptoms include chronic fatigue, diarrhoea, fever, Wight loss, persistent cough, skin rashes, herpes and other oral infections, swelling of the lymph nodes, and memory loss or other mental changes.

AIDS is almost always fatal without treatment, although a few individuals have survived with AIDS untreated for up to 20years. Current drug regimens, such as highly

active antiretroviral therapy (HAART), slow the virus' replication in the body. Slower replication rates lessen the burden on the immune system, thereby reducing HIV-rated illnesses and allowing patients to live longer, higher-quality lives. There is no cure for AIDS: The disease resurges if HAART is halted. (Population Bulletin, vol. 61, No. 1 March 2006, pg.-3/4)

Acquired Immune Deficiency Syndrome (AIDS) was first recognized internationally in 1981. As of 2006, an estimated 40 million adults and children around the world were living with human immunodeficiency virus (HIV) and AIDS (Lamptey et al., 2006). AIDS is caused by HIV and once infected with the virus, a large proportion of those infected die within 5-10 years (WHO, 1992). The HIV/AIDS pandemic is one of the most serious health concerns in the world today because of its high case fatality rate and the lack of a curative treatment or vaccines. Epidemiological studies have identified sexual intercourse, intravenous injections, blood transfusions, and fetal transmission from infected mothers as the main routes of transmission of HIV. HIV cannot be transmitted through food, water, insect vectors or casual contact.

The first case of AIDS in Nepal was reported in 1988. The National Centre for AIDS and STD Control (NCASC) of the Ministry of Health and Population has estimated an average of 70,000 adult HIV-positive people in Nepal (NCASC, 2006a). As of September 2006, a total of 1,171 AIDS cases among the 7,894 cases of HIV infection were reported to NCASC (NCASC, 2006b). However, these figures are probably grossly underestimated given the existing medical and public health infrastructure and limited HIV/AIDS surveillance system in Nepal. (Nepal Demographic and Health Survey, 2006 pg: 199)

The first case of HIV/AIDS was reported in Los Angeles in June 5, 1981 and the first case of HIV/AIDS in Nepal was identified in 1988. In the developing world unsafe commercial sex is the major transmission route for Sexually Transmitted Diseases (STDs) and HIV infections, thus, making female sex workers (FSWs) one of the groups at highest risks. Even though FSWs might be aware of these diseases, they will lack the means and/or knowledge and skills of preventing them. Furthermore, the treatment of

STD is often delayed or not sought at all because of the stigmatization associated with both the diseases and the group. Still rapidly growing, the epidemic is reversing development trends, taking away millions of lives, widening the gap between the rich and poor, and leaving thousands of young children orphaned.

Nepal has crossed the "low risk" stage of HIV epidemic and entered the "concentrated epidemic" stage. This means that the prevalence of HIV among the general population is still very low, with cases of antenatal HIV infection numbering less than one percent. But HIV prevalence among defined sub-population groups is more than five percent. Those defined sub-populations, which represent the core "high-risk" groups, are FSWs, injecting drug users (IDUs) and returning migrant lobour population (such as in far-western Nepal) from India (BSS of FSWs and Clients in Ktm. Valley: Round I (New ERA/SACTS, 2003 pg:1).

1.1.1 Global Overview of HIV/AIDS

Promising developments have been seen in recent years in global efforts to address the AIDS epidemic, including increased access to effective treatment and prevention programmes. However, the number of people living with HIV continues to grow, as does the number of deaths due to AIDS. A total of 39.5 million people were living with HIV in 2006—2.6 million more than in 2004.This figure includes the estimated 4.3 million adults and children who were newly infected with HIV in 2006, which is about 400 000 more than in 2004.In many regions of the world, new HIV infections are heavily concentrated among young people (15–24 years of age). Among adults 15years and older, young people accounted for 40%of new HIV infections in 2006.

Almost three quarters (72%) of all adult and child deaths due to AIDS in 2006 occurred in sub-Saharan Africa: 2.1 million of the global total of 2.9 million. Overall sub-Saharan Africa is home to an estimated 24.7 million adults and children infected with HIV—1.1 million more than in 2004. In the past two years, the number of people living with HIV increased in every region in the world. The most striking increases have

occurred in East Asia and in Eastern Europe and Central Asia, where the number of people living with HIV in 2006 was over one fifth (21%)higher than in 2004. The 270 000 adults and children newly infected with HIV in Eastern Europe and Central Asia in 2006 showed an increase of almost 70% over the 160 000 people who acquired HIV in 2004. In South and South-East Asia, the number of new HIV infections rose by 15%in 2004–2006, while in the Middle East and North Africa it grew by 12%. (2006 AIDS epidemic update pg: 3)

An estimated 2 million people are living with HIV in Latin America and the Caribbean, including the estimated 170,000 who became infected during 2006. Around 84,000 people died of AIDS in the same year. All the main modes of transmission exist in most countries, along with significant levels of risky behaviour - such as early sexual debut, unprotected sex with multiple partners and the use of unclean drug-injecting equipment. The largest HIV epidemic is in Brazil, where around 620,000 people are living with the virus, though the death rate has fallen due to widespread access to treatment. Adult HIV prevalence in Haiti and the Bahamas is more than 3% - higher than anywhere else outside sub-Saharan Africa. (www.avert.org/aidslatinamerica.htm)

An estimated 8.6 million people were living with HIV in Asia in 2006, including the 960 000 people who became newly infected in the past year. Approximately 630 000 died from AIDS-related illnesses in 2006. The number of people receiving antiretroviral therapy has increased more than threefold since 2003, and reached an estimated 235 000 by June 2006. This represents about 16% of the total number of people in need of antiretroviral treatment in Asia. Only **Thailand** has succeeded in providing treatment to at least 50% of people needing it (2006 AIDS epidemic update pg: 24).

According to estimates from the UNAIDS/WHO AIDS Epidemic Update (November 2006), around 37.2 million adults and 2.3 million children were living with HIV at the end of 2006. During 2006, some 4.3 million people became infected with the human immunodeficiency virus (HIV), which causes AIDS. The year also saw 2.9 million deaths from AIDS - a high global total, despite antiretroviral (ARV) therapy,

which reduced AIDS-related deaths among those who received it. Deaths among those already infected will continue to increase for some years even if prevention programmes manage to cut the number of new infections to zero. However, with the HIV-positive population still expanding the annual number of AIDS deaths can be expected to increase for many years, unless access to ARV medication is greatly improved.

1.1.2 STI/HIV/AIDS Epidemiological Situation in Nepal

The first case of AIDS in Nepal was reported in 1988. Since then, the numbers have risen among the country's 27 million people. By the end of 2005, more than 950 cases of AIDS and over 5,800 cases of HIV infection were officially reported, with three times as many men reported to be infected as women. However, given the limitations of Nepal's public health surveillance system, the actual number of infections is expected to be much higher. UNAIDS estimates that75,000 people were living with HIV at the end of 2005.Nepal's HIV epidemic is largely concentrated in high-risk groups, especially female sex workers (FSW), IDUs, MSMs and migrants. Injection drug use appears to be extensive in Nepal and to significantly overlap with commercial sex. Another important factor is the high number of sex workers who migrate or are trafficked to Mumbai, India to work, thereby increasing HIV prevalence in the sex workers' network in Nepal more rapidly. (The World Bank, Nov. 2006)

Since sexually transmitted infections are proven co-factors increasing the risk of HIV transmission, their appropriate diagnosis and treatment are critical. It is estimated that there come about 200,000 new STI episodes in Nepal in every year (MoH, 2002). Therefore, this component cannot be left out while addressing HIV/AIDS. Seroprevelance and behavioural data indicate a high potential for HIV/AIDS epidemic in Nepal. It is estimated that about 100,000-200,000 young adults will become infected and 10,000-15,000 AIDS related deaths might occur annually if the present situation of intervention is not improved progressively (MoH, 2002). The following Table summarizes the global epidemiological situation of HIV/AIDS.

Table 1: Global Figures of HIV/AIDS – UNAIDS 2006

Indicators	Year	Nepal	South and East- Asia	World
Adults and children living with HIV/AIDS	2005	75,000	7600000	38.6
Adults living with HIV/AIDS	2005	74,000	7400000	36300000
Women (ages 15+) living with HIV/AIDS	2005	16,000	2200000	17300000
Children (ages 0-15) living with HIV/AIDS	2005	nd	170000	2300000
AIDS orphans currently living (ages 0-17)	2005	nd	nd	15200000
Adults and child AIDS deaths (ages 0-49)	2005	5100	560000	2800000
Adults and children newly infected with HIV	2006	nd	860000	4.3

Source: 2006 Report on the Global AIDS Epidemic (UNAIDS 2006)

1.1.3 HIV/AIDS Vulnerable and High Risk Groups in Nepal

Nepal is facing increases in HIV prevalence among high risk groups such as sex workers, injecting drug users (IDUs), men who have sex with men (MSM), and migrants. There is an urgent need to scale up effective interventions, especially among IDUs. Nepal's poverty, political instability and gender inequality, combined with low levels of education and literacy make the task all the more challenging, as do the denial, stigma, and discrimination that surround HIV/AIDS.

Nepal's epidemic will continue to grow if immediate and vigorous action is not taken and will be largely driven by injection drug use and sex work. Major risk factors are as follows:

Continued Spread among Injecting Drug Users (IDUs): In most Asian countries, IDUs are the first community to be affected by HIV. Nepal was the first developing country to establish a harm reduction program with needle exchange for IDUs. However, due to the program's limited coverage, the impact on HIV transmission has been limited. HIV prevalence among Nepal's estimated 19,850 IDU svaries by location. 22% of IDUs are HIV positive in Pokhara, whereas52%, 33% and 8% are HIV positive in Morang, Sunsari, and Jhapa districts respectively (FHI 2005). HIV prevalence among Kathmandu's5-6,500 IDUs has decreased from 68% to 52%.

Trafficking of Female Sex Workers: Due to their highly marginalized status in society, female sex workers in Nepal have limited access to information about reproductive health

and safe sex practices. Cultural, social, and economic constraints bar them from negotiating condom use with their clients or obtaining legal protection and medical services. Almost 60% of their clients, who are mainly transport workers, members of the police or military, wage earners, and migrant workers, do not use condoms. While nationally, HIV prevalence among FSWs is 4%, infection rates among street-based sex workers in the Kathmandu valley are between 15-17%. Nationally, clients of FSWs have an estimated HIV prevalence rate of 2%. A major challenge to HIV control in the country is the trafficking of Nepalese girls and women into commercial sex work in India, and their return to Nepal. About 50% of Nepal's

FSWs previously worked in Mumbai, India, and some 100,000 Nepalese women continue to engage in the practice there. It is estimated that 50% of Nepalese sex workers in Mumbai brothels are HIV positive (FHI 2004).

Changing Values among Young People: Young people are increasingly vulnerable to HIV due to changing values, group norms, and independence. Girls, even if they have knowledge about HIV/AIDS and other sexually transmitted infections (STIs), do not have the means of protecting themselves due to their traditionally lower social status. Teenagers, although apparently highly aware of the HIV risk (based on behavioural surveys), do not necessarily

translate this awareness into safe sex practices. A high prevalence of premarital sex exists, with 20% of teenagers considering it acceptable among young people.

High Rates of Migration and Mobility: 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, such as family, has been shown to promote unsafe sexual practices, such as having multiple sexual partners and engaging in commercial sex. A 2002 study suggests that HIV prevalence is nearly 8% in migrants returning from Mumbai.

Low Awareness among Men Who Have Sex with Men (MSM): Although accurate data on sex between men are not available, a recent report suggests that MSM activity in Nepal is not different from the MSM activities of the rest of the South Asia region. Current HIV prevalence among urban-based MSM is 4%. The knowledge of safe sex and

condom use is low in this community. Furthermore, many men who have sex with men are also married, which puts their spouses at risk of becoming infected with HIV. The Blue Diamond Society is a Non-governmental Organization (NGO) founded in 2001 to address the needs of Nepal's sexual minorities. It provides community based sexual health, HIV/AIDS, and advocacy services for local networks of sexual minorities. (The World Bank, Nov. 2006)

1.2 Statement of Problems

The problem of HIV/AIDS is affecting the entire world and Nepal is no exception. Nepal, one of the poorest countries in the world, with her poor health services, low level of literacy, high prevalence of socio-economic disparities along with gender, caste/ethnicity, and heavily donor dependent nature, now must prepare to fight the HIV/AIDS epidemic that is growing in the country. As in all national capitals, the cityscape of Kathmandu valley and the social structure of its urban population includes female sex workers whose numbers increase with the increases in-migration, unemployment, and poverty in the city. Due to the hidden nature of the sex profession, the actual number of female sex workers in Kathmandu valley is not known. CREHPA and New ERA have given estimates that range from 4000 to 5,000 in 2001. Young girls and married women sell sex in the valley in various guises. The professions most commonly recognized for selling sex in the valley include: waitresses in cabin and dance restaurants, dancers in dance restaurants and discos, and masseuses in massage parlours. These women who engage in the provision of sexual services for commercial consideration put themselves at special risk of health problems for a variety of reasons. Frequent sexual contact with a variety of partners makes these women especially vulnerable to Sexually Transmitted Infections (STI), and HIV/AIDS. It has been reported that HIV/AIDS has reached almost all districts of Nepal although surveillance study of all districts is yet to be carried out. Due to political instability, conflicts, socio-economic problems thousands of people have migrated to the capital city as a result there has been rapid increases of sex workers and their working places in Kathmandu. There has

been much attention focused on female sex workers with rates of HIV among them greatly increasing from one percent in 1992 to 17 percent in Kathmandu in 2000, with FSWs showing rates of 73 percent if they had worked in Mumbai or 75 percent if they were injecting drug users (FHI/Nepal).

Many FSWs are being vulnerable to HIV/AIDS due to their unfavourable socio-economic status, risky sexual behaviours, lack of education, and lack of proper awareness of causes and consequences of HIV/AIDS. In this regard, this study aims to explore the following research questions:

- What is their level of knowledge, awareness and attitude towards HIV/AIDS?
- What is the extent of awareness and sexual practices among FSWs?
- What might be the pattern of sexual behaviour, practice and contextual factors leading them to enter the sex trade?

1.3 Objectives

The general objective of the present study is to generate an overall understanding of FSWs of Kathmandu. The specific objectives of the study are:

a. To identify the socio-demographic characteristics of FSWs,
b. To find out the knowledge and attitude of FSWs regarding STDs and HIV/AIDS
c. To explore the sexual behaviour and sexual practice of FSWs, and to investigate the factors leading them to enter the sex trade.

1.4 Rationale of the Study

In much of the world, HIV/AIDS has for a long time been seen as a problem that affects men, specifically gay men, and as a result of this preconception, the harm that it does to women around the world has been largely overlooked. Yet today nearly half of all adults living with HIV around the world are women.

Globally, women make up 60% of the 15-24 year olds who are HIV+. Around 76% of women living with HIV are in sub-Saharan Africa. Among young people living with HIV in this region, three in every four are female.

Most HIV+ women have been infected with HIV through heterosexual sex. Physically, women are more susceptible than men to HIV infection through heterosexual sex, and this fact alone means that special attention must be paid to protecting them if they are not to be disproportionately affected by the epidemic.

Information drawn from different studies shows that during heterosexual sex, women are about twice as likely to become infected with HIV from men as men are from women.

Women's lack of economic power enables their sexual exploitation is via prostitution. Poverty is the most common cause of prostitution, but whatever its cause, female sex workers are in a very high-risk group. Women who desperately need money to care for their children, many of them widowed by AIDS, are not in a position to insist that their customers wear condoms. This means that they are not only at risk of becoming infected with HIV, but that if they are already HIV+, they can pass the virus on to their customers. Often, these customers take AIDS home to their families.

Female sex workers are, in many countries, both frowned on socially and criminalized. It is very difficult for these women to access the healthcare services they need in order to stay healthy if they risk arrest or punishment when their profession is known. This stigmatization increases the vulnerability of a group that is already at considerable risk.

Sex workers in Nepal can be categorized in many types according to the varieties of settings they operate such as cabin restaurants, massage parlours, etc. where FSWs work as employees. Since women are not employed as sex a worker, which is illegal in Nepal, they are employed as dancers and waitresses in dance restaurants, disco and cabin restaurants. Other groups work in massage parlours, hotel, local wine shop (bhatti pasal), garment/carpet factory, squatter areas, and residential settlement and so on. Mainly,

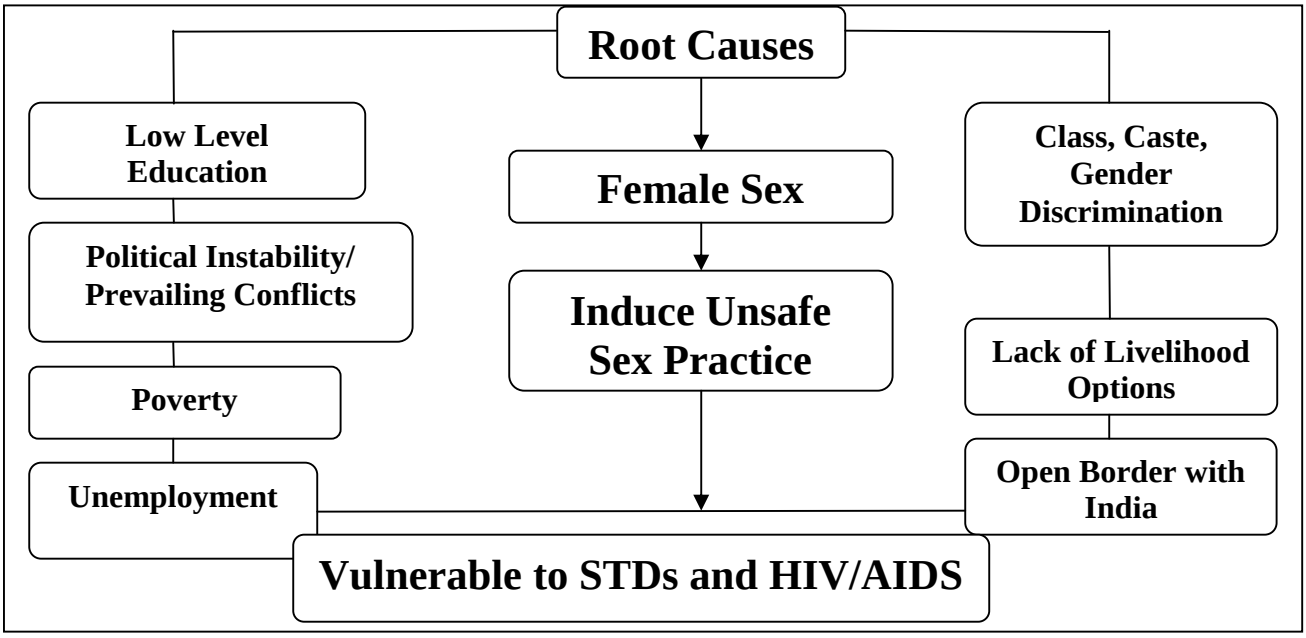
Cabin restaurants, massage parlours are growing day by day. Cabin restaurants spread all over the valley and massage parlours are mainly in Thamel. So, it shows the number of FSWs is growing in Cabins and Massage. The growing problem of HIV/AIDS epidemic worldwide has led to increased attention to the need for understanding behaviour, knowledge of, and attitude of these female sex works towards HIV/AIDS. Therefore, this study tries to throw lights on the socio-cultural and socio-economic condition of FSWs of Kathmandu, and their knowledge and awareness towards HIV/AIDS. Furthermore, this study also explores the sexual behaviour, practices and contextual factors that motivated to enter the sex trade.

Academically, the study will be helpful for further researcher, students and other general public interested in the topic in question. Practically it could be helpful to policy makers-HMG, health workers, social workers and NGOs working in this field. Hopefully, this research will have global significance.

1.5 Conceptual Framework

HIV/AIDS, STI and STD virus is not a crisis of merely those who are living with it, rather it has posed a developmental challenge to all. The consequences are farfetched and of strong magnitude leaving no sector untouched. Although causal relationship of these fatal viruses are behaviour driven and virus specific, a number of other important factors play a vital role in leading to such behaviour. Lack of education, misconception on the mode of transmission, poverty, conflict, discrimination, lack of control over one's body, social structure, unemployment, open border with India, lack of sustainable livelihood options are only to name few. These aforementioned factors may lead to migration, trafficking, commercial sex works and drugs use habits that put them at vulnerable to HIV/AIDS, STI and STDs. Taking all these factors into account, the researcher has drawn the following conceptual framework associated with the HIV/AIDS, STIs and STDs.

Conceptual Framework



1.6 Organization of the Study

This study is divided into five chapters. The first deals with background of the study, statement of problems, objectives of the study, rationale of the study, and organization of the study. The second chapter deals with the review of related literature.

The third chapter is concerned with methodology of the study, which includes site selection, research design, nature, and sources of data, sampling procedure and sample size, data collection techniques, and data processing and analysis.

Similarly, chapter four provides information about the socio- demographic characteristics, the knowledge and attitude of FSWs regarding STD&HIV/AIDS, the sexual behaviour and sexual practice of FSWs, the factors leading them to enter the sex trade.

At last, chapter five presents the summary of major findings, conclusion and recommendation.

CHAPTER TWO

2.1 Review of Literature

In this chapter the researcher will review books, journals, research works, articles and other related literature will be reviewed to obtain in-depth knowledge and information about FSWs. All the d assessments and studies conducted on sex workers of Kathmandu and other parts of the country were also consulted and reviewed.

2.1.2 Commercial Sex Work, Sexual Behaviour and HIV/AIDS/STDs

Throughout the civilization, commercial sex works have been universal and have almost remained so. It is only that the patterns and connotations of commercial sex work, and the life style of CSWs have differed considerably in different periods and in diverse cultures because of the role of women and the institution of controlled sex.

Commercial sex work is not a new phenomenon. It is as old as the institution of marriage or say as old as human civilization since society attempted to regulate controlled sex relationships through the institution of marriage and family. When sex behaviour was institutionalized through marriage, in certain sanction of the society usually in the middle and upper classes, women chastity before marriage and complete marital fidelity and strict confinement to the role of housekeeper and mother after marriage were over emphasized and valued. Also the non-adherence to these social norms and conduct by woman brought her not to serve disapproval but dire penalties and social ostracism. On the other hand, considerable latitude in sex was granted to men because of the prevalent double standard of sexual morality (Patai, 1967:5 and Ranganayaki, 1958:22).

An ancient historical record about the history of CSW is believed to be the Books of Moses. According to them, CSWs were common among the Jews in the 18th century BC (Sanger et al, 1986:13).Commercial sex work was adopted all over the world. The significant charter is that most of the virgins were seized and assaulted their chasteness in the names of Church. This type of exploitation was found in all religion even in the

Hindu. Some religious epics illustrate the CSW and commercial sex work in India and Nepal.

Religious, socio-cultural practices and other traditional rigidities especially with respect to sex and reproductive health have made task more difficult in the context of Nepalese society. It is paradox that sex is one of the most common things we have in our life, still we talk least about it in our society. It is a subject that is considered being a very personal secret and confidential. Whenever children ask their parents about sex and sexual organs, they either ignore them or scold them or even tell them utter lies (Gurubacharya, 1994:2). People feel uneasy and embarrassed when asked about their sexual activities and then they provide deliberately inaccurate information.

The risk of acquiring STDS and HIV/AIDS infection is especially high among sexual partners, if the age difference among them is significantly large and if the individual have /multiple sex partners of unprotected sex (George et al, 1998). Also the risk of contacting with sexually transmitted diseases is higher especially for young people who become sexually active early and are therefore more likely to change partners (UNFPA, 1998:1). Furthermore, various studies in developing countries have shown that young people have very poor knowledge about sex and sexuality, contraception and STDs and their prevention.

In Nepal, AIDS was first recorded in 1998 and it was only in 1991 that a national reporting system was initiated (Subedi and et al, 1994) . Since then there has been a growing number of studies on HIV/AIDS, STDS and related issues like CSWs(Bhatta at el, 1993, NEW ERA 1995); injecting drug users (LALS, 1995; sexual pattern (Gurubacharya and Subedi, 1992) ; knowledge, attitude and practices (KAP) studies); and NGOs involvement in HIV/. Similarly there has been growing coverage of women trafficking, sexual exploitation and cases and HIV/AIDS and STDs victims in newspapers and media.

The Nepal Family Health Survey (NFHS), 1996, has studied knowledge of AIDS among its respondents. Its findings show that there is substantial difference in the

knowledge of AIDS by women's place of residence and educational level. More urban women (67%) than rural women (23%) have heard about AIDS. 9 out of 10 women, who have passed SLC, have heard of AIDS, only 17% of the women with no education are found to be aware of AIDS. The report also says that one-fifth (22%) of the respondents who have heard of AIDS are unaware of how to avoid the disease and one in ten women has misconceptions about the disease could be prevented. This implies the widespread lack of awareness and misconceptions about AIDS in Nepal.

The study of commercial sex workers (CSWs) in Kathmandu Valley by Bhatta and et al conducted in 1993 among 373 CSWs found that over 50% of them have secondary and higher level of education. Their findings indicate that CSWs are not necessarily from illiterate or from poor family backgrounds, although economic factors appear to be the major driving force for the majority of these women. This study found that the prevalence of STDs is a serious problem among the CSWs and over 40% of them are reported to have never used condoms. This implies that they are at risk of transmitting STDs and HIV. The study does not have much to say about the clients and the way these CSWs suffer, get exploited and lack medical facilities.

The assessment study of sexual network of five urban areas (Mahendranagar, Dhangadi, Birgunj, Bhairawa and Biratnagar) by Cox and Subedi (1994) has more socio-cultural insights into the CSWs and their clients. They have studied the social context of prostitution of Badi and non-Badi CSWs and suggest how this affects their knowledge about AIDS and its prevention. Badi women were found to have more knowledge about AIDS and have been highly successful in adopting protective behaviors where as the non-Badis CSWs have very low level of AIDS knowledge and its preventive measures making them more vulnerable to HIV infection. This study shows that majority of the clients of the surveyed CSWs were drivers and conductors who are reported to be high risk groups.

The National Center for AIDS and STD Control (NCASC) conducted research in 1995 in Nuwakot District, focusing only on high risk groups. The NCASC research

focused on HIV/AIDS symptoms and treatment, and did not asked about people's general knowledge. Schilling and Parajuli (1996) studied knowledge, attitude and practice on HIV /AIDS and sexual behaviour among students in Pokhara Nepal. The study population comprised of 7075 students. The finding of this study was that almost all students had heard about AIDS and the overall knowledge about HIV/AIDS was sufficient. Some misconceptions regarding knowledge about casual social contacts and other specific transmission routes were reported. Variables associated with high knowledge about AIDS were male sex, age over 20 years, good SLC results, high TV exposure and a few others. The study also highlights the sexual practices among the students and says that almost a quarter of the students (only 2.5% of them were female) reported to have had sexual relationships outside marriage and more than 50% of them with two or more different partners. This behaviour was independently associated with male sex, urban upbringing, having been abroad, liberal attitude towards premarital sex and good knowledge of AIDS. Their findings suggest that only knowledge is not sufficient for behaviour change and even the college students have some misconceptions about HIV/AIDS. So one might easily guess what might be the conditions of those rural areas, which are cut off from easy access to health services, communication, and above all high level of illiteracy.

Similarly there are other studies related with HIV/AIDS. Many of such studies focus on some specific high-risk groups like injecting drug users (LALS, 1994) and commercial sex workers and the land transportation route (New Era, 1995). Researches of this kind should not be limited to only a specific group of people, but should look at their beliefs and expanse of different kinds of people in different places. Such studies have not paid much attention to rural areas of Nepal like Myagdi. The research had taken three different areas of rural Myagdi. This research worked to identify the ideas and knowledge of people from three different areas, as well as reflect the beliefs, knowledge and practices of people of the different castes and ethnic groups regarding HIV/AIDS and STDs. The study tries to address the social context of vulnerability that might help for the potential spread of HIVIAIDS in the district.

The principal behavioural components that affect the rate of sexual transmission of HIV in a given unit of time are the frequency of sexual intercourse, types of sexual acts, number of partners and rate of partner change (Anderson, 1972: 71).

In a research conducted by CREHPA_in five-boarder town of Nepal, about one-fourth of men were found to have casual sex and a large proportion of them did not use condom during casual sex. (CREHPA, 1998).

A Survey by Family Health International in 1999 among FSWs and truckers along the highway routes in the Terai of Nepal showed that 75% of the truckers had had sex with a sex worker and that only 70% of the truckers had used a condom at the last sexual encounter. The survey showed that the STD prevalence among the truckers was 10.2% whereas the HIV prevalence was 1.5%.

As regards FSWs, 69% of clients were truckers and 51 % migrant workers. Only 40% had used a condom at the last sexual encounter. Overall, HIV prevalence among sex workers was 4%, but 50% among sex workers who had previously worked in Mumbai (India).

A study done by WHO shows that among married women with HIV positive in South Asia, 90% are monogamous and have had sex partners throughout their lives. Studies on STDs in Nepalgunj have also pointed out that a lot of time when a housewife is infected with STDs; she is blamed for "sleeping around with other men". In actuality, a lot of time, her husband transmits her. In this sense, there is a gap again, in perception and realities on this issue. Some housewives are already infected with HIV/AIDS, others with STDs that may increase their risk of HIV infection A vast majority of housewives are illiterate and do not have access to services that would protect them from HIV/AIDS.

In a sero-prevalence survey done by SACTS in Katmandu in 2000, 52 out of 300 FSWs (17%) were HIV positive. A mere four years ago, in 1996, HIV prevalence among Katmandu FSWs was 2.7 %. These data also suggest a strong link between HIV and

STDs Among the 300 FSWs in this study, 58 women (over 19%) had untreated syphilis. Of these 58 women with untreated syphilis, 15 (25.8%) were HIV positive. Of the 242 women negative for untreated syphilis, only 37 (8.9%) were HIV positive. The total estimated number of FSWs in the Katmandu valley is between 7,500 and 10,000.

Incidence of HIV/AIDS in specific subgroups of population - Clients of sex workers with sexually transmitted disease (STD), female sex workers (FSWs), and injecting drug users (IDUs) - has reached a stage of concentrated epidemics'. Unless efforts are made to be at a significant scale to control further spread within these vulnerable, groups as well as to insulate the spread to the general population, the situation is likely to get out of hand soon_ It is estimated that by the end of next decade HIV/AIDS will be leading cause of deaths among the adult population of Nepal: (NCASC, Situation Analysis, 2000).

Among all IDUs in Nepal (estimated number 30,000), approximately 40% are HIV positive and among IDUs in Katmandu (estimated 15-20,000) the rate increases to around 50 %(NCASC, 1999). In addition the most recent survey of 300 female Katmandu sex workers revealed that 15 FSWs self-reported ever having injected drugs, representing 5% of the total sample. However, of these 15 women, 11 were found to be HOV positive (SACTS, 2000).

Among a sample of 400 FSWs in Terai, 16 (3.9%) were HIV positive and 77(18.8`%) had treated syphilis. Two statistically significant correlates for HIV infection were having worked in India, especially Mumbai, and having untreated syphilis. Of 16 women who reported working in Mumbai, half 8, were HIV positive. Among the 400 FSWs in this study 9 out of the 77 (11. 7%) women with untreated syphilis were HIV positive. Only 3% or 4 out of 333 women without untreated syphilis were HIV positive (New Era / FHI, 2000).

A similar behavioral surveillance survey covering 16 districts was done in September/October 2001 by New Era and FHI with a total number of 1400 (400

FSWs, 400 Male transport workers and 600 industrial workers, police and rickshaw waalas).

This survey confirms that condom use as reported by the FSWs and the male groups, has markedly increased both in terms of 'last time use' and 'consistent use'. 60% of transport workers report that they use condoms consistently with sex workers, while few labourers (45%) report the same. Furthermore, more men are reporting sex with sex workers. After years of decrease, the percentage of men in both sub-population groups who report having sex with FSWs in the past year has dramatically increased- from 42% of transport workers in 2000 to 61 % in 2001 and 10% labourers in 200 to 30% in 2001.

Another study conducted for FHI/Nepal by New ERA showed that HIV prevalence in Kathmandu among male IDUs was 68% and among female IDUs it was 16% (New ERA, 2002). Yet another study carried by SACTS (2001), also sponsored by FHI/Nepal, put HIV prevalence among Kathmandu FSWs at 17%. In 1998, HIV prevalence rate among sex workers was 2.7% (SACTS, 1998). And, among a sample of 410 FSWs in the eastern Terai highway route, 16 (3.9%) were found to be HIV positive (New ERA, 1999). These data are a strong indication if the rapidly increasing trend of HIV prevalence among the high-risk groups in Nepal (New ERA, 2003).

In 2003, a behavioural study was done in six districts in the Western and Far--Western Sector of the Mahendra Highway of Nepal' . The 407 FSWs interviewed reported that the three most frequent clients were transport workers (53.8%), wage workers (47.2%) and police/military (43.7%). Almost 80% of the FSWs reported use of condoms during their last intercourse however, only 68% of the FSWs who had frequently visiting clients reported to have used condoms. 52% of the FSWs reported to have used condoms consistently within the last 12 months.
Similarly, New ERA carried out a survey called ‘Behavioural *Surveillance Survey of FSWs and Clients in Kathmandu Valley: Round I’*. A total of 4000 FSWs were sampled. This survey was carried out to measure risk behaviour associated with

the risk of HIV infection, such as condom use, sexual behaviours, knowledge of HIV/AIDS, reported cases of STI and their treatment behaviour, and drugs Habits. It was revealed that 'the medial age of FSWs was 21, with 69% of the sample being under 25 years; a majority (92%) of FSWs had sex before the age of 19 years; knowledge of condom is universal i.e. 92% of them said that they used condom during the last sex act with the client; and they had poor knowledge about STI, for instance, only 6% of FSWs mentioned syphilis or gonorrhoea or their common names Furthermore, about 40% of FSWs consumed alcoholic beverages and 1.3% had tried injecting drugs.(New ERA, 2003).

The survey conducted by SACTS (2004) ' *STI/HIV Prevalence and Risk Behavioural Study Among FSWs and Truckers Along the Terai Highway routes of Covering 22 Districts of Nepal'* revealed that the median age of the FSWs was 26 years with the age range 13-50.Half of the FSWs had their first sexual experience at the age of 15, with the youngest being nine years old. The average amount of money charged per client is Rs. 400. Reported ever use of condom among the sex workers was 72%, however condom use with the first client was 53% only. Only 23% of the FSWs reported to use condom every time they have sex with their clients. HIV prevalence among FSWs was 2% and the FSWs who had worked in India were associated with HIV and STI. (SACTS, 2004).

Thus it is obvious from the literature review that taking up the profession of female sex workers is largely a compulsion of poverty. Poverty and ignorance also lead to living with HIV/AIDS without being aware of infection and passing it into others. HIV/AIDS, thus, is another face of poverty and in the long run can be controlled only through alleviation of poverty in all its manifestations. But the problem must also be tackled on priority basis immediately through specific target-group oriented measures in all fronts ranging from health related intervention to education, awareness building and rehabilitation. If not, the social and economical negative consequence will be immense. A concerted and coordinated effort would be necessary to have meaningful and effective impact.

CHAPTER THREE

Research Methods

This chapter describes how the information necessary for the study was collected and how the data will be analyzed. It encompasses sources of data, research design, data collection tools, modes of data analysis and constrains in data collection

3.1 Rationale for the Site Selection

Kathmandu metropolitan City has been selected as the site of the present study area. Kathmandu is the Capital city where migration of people from different parts of Nepal for employment is supposed to be high. There has been a steady increase in the number of cabin, dance, disco and normal restaurants as well as massage parlours which is the main cause of promoting this profession. Various previous researches have shown the increase of sex trade in the city and high prevalence of HIV/AIDS among the FSWs. In the light of these factors Kathmandu metropolitan City has been selected for the study.

3.2 Research Design

The researcher employed qualitative and quantities research designs. The explorative design was applied to investigate FSWs knowledge and attitude towards HIV/AIDS, and to ascertain their sexual practices and behaviour. Similarly, the descriptive design was employed to describe socio-cultural and socio-economic conditions, and to explain to contextual factors leading them to become sex workers.

3.3 Nature and Source of Data

Both primary and secondary data were used to fulfil the research objectives and to answer the research questions. Preference was given to primary data which was collected with the help structured interview. Various publications, books, journals, articles, research reports were used as secondary sources of data in this study.

3.4 Universe, Sample Size, Sampling Procedure

The term FSWs here in this study refers to girls/women who acknowledge themselves as having currently engaged in sex business. As no census of the FSWs has been taken in Kathmandu the exact number of FSW is not known. However, there has been rapid increase in the number of these FSWs in Kathmandu because of the increase of hotels, cabins, dance restaurants and other areas where prostitutes are usually found.

To achieve the set objectives the researcher has employed purposive/judgmental sampling procedure which is based on the judgment of the researcher as to who can provide the best information. The researcher purposively sampled 40 female sex workers working in different massage centres and cabin restaurants of Kathmandu.

3.5 Data Collection Technique

3.5.1 Structure Interview

Interviews were carried out to collect primary data through structured questionnaires. Information regarding socio-demographic characteristics of the FSWs, and Knowledge and use of condoms, sources of condoms, their knowledge of STDs and HIV/AIDS, its symptoms, modes of transmissions and ways of prevention were collected by this method.

3.5.2 Case Studies

Case studies are the major factors to acquire detailed information in any research. So the researcher conducted three case studies to supplement information of the past and at present. It helps to understand the factors that lead them to enter the profession. Some case studies were conducted in their rented rooms and some at their working place like restaurant, hotels, etc. All the names used in the case study are pseudonyms.

3.5.3 Observation

This method was used to find out more about their sexual activities. The researcher also observed their living conditions, behaviours with clients, their working environment, their apartment or rented rooms and so on. The research also recorded data in the hotels, restaurants, and their rented rooms.

3.6 Methods of Data Processing and Analysis

The collected data is processed and tabulated manually and the tabulated data is interpreted and presented quantitatively as well as descriptively. The processed data is presented using table, graphs, etc.

3.7 Reliability and Validity of the Data

The researcher faced many hardship while collection the primary data because most of the informants didn't want to provide their personal information. So the researcher had to assure them that the information provided by them will not be revealed to any other third parties. The researcher also visited their apartments or rented rooms to collect the dada because the informants felt relaxed and secure while providing their personal information in their living place rather than at the place where they worked.

3.8 Limitation of the Study

This study has the following limitations:

- This study has cover only the FSWs working in cabin restaurants and massage parlours of Kathmandu Metropolitan City.
- This study only covers 40 FSWs.

CHAPTER FOUR

Analysis and Interpretation of the Data

4.1 Socio-Demographic Characteristics

Female Sex Workers' age, marital status, number of depend members of their family, and their relations with their husbands are shown in the Table 1 given below.

The table 1 below shows socio-demographic characteristics of the FSWs. The average age of the FSWs was 22 years, the majority 14(35%)of the FSWs fell in the age group 20-24, 11(27.5%) were in the age group 25-29, 9(22.5) belonged to 15-19 age group and only one FSW was over forty years old. Thus, the vast majority belong to the most productive period of life.

Similarly, Table 2 shows more than half of the FSWs (52.5%) were never married and 47.5% of the FSWs were married. The FSWs were characterized by a divorced/separated ratio of 5/40 or 12.5% among once married workers. Another characteristic of FSWs was that a number of them (36.84%) were co-wives (i.e. the husband has another wife). Likewise, 12.5% of the FSWs were living with their husband, 60% of them with friends, 27.5% of them were living alone. Forty-five percent of the FSWs had economically dependent members in their family.

Table: 1

Age Range of the FSWs

Age of FSWs	**Number of the FSWs**	**Percentage**
15-19	9	22.5
20-24	14	35
25-29	11	27.5
35-39	5	12.5
40 above	1	2.5
Total	**40**	**100.00**
Median Age	22	

(Source: Field Survey, 2007)

Fig. 1

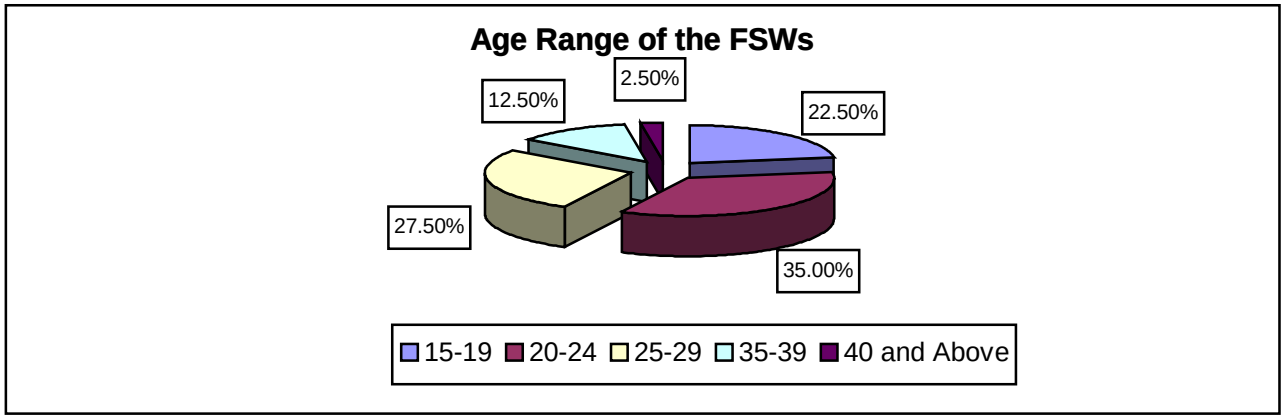
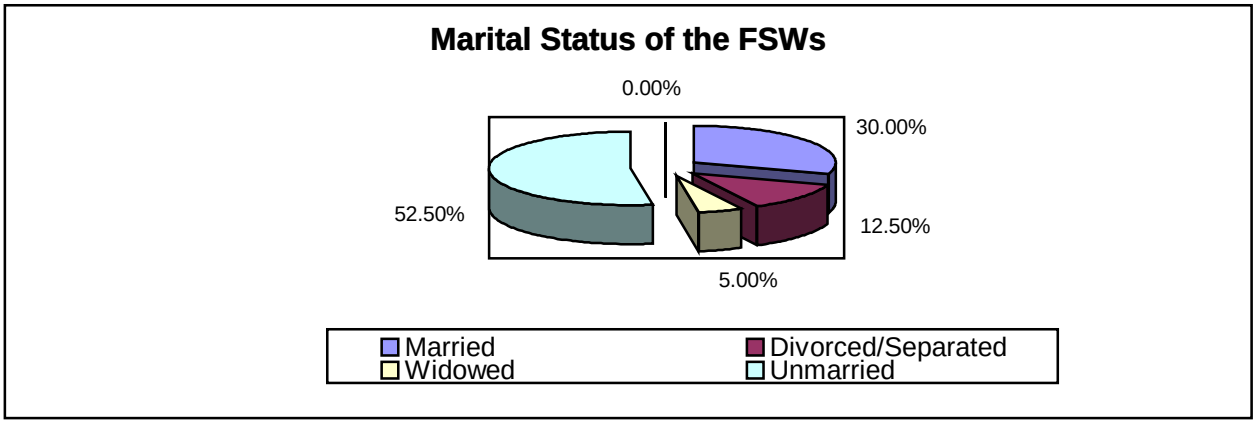


Table: 2
Marital Status of the FSWs

Marital Status	**Number of the FSWs**	**Percentage**
Married	12	30
Divorced/ Separated	5	12.5
Widowed	2	5
Never Married	21	52.5
Total	**40**	**100.00**
Sex Workers Living with Husband/Friends		
Husband	5	12.5
Friends	24	60
Alone	11	27.5
Total	**40**	**100.00**
Dependent of FSWs	**Number of the FSWs**	**Percentage**
Yes	18	45
No	22	55
Total	**40**	**100.00**
Total Number of Dependent (Adults + Children)		
One	7	38.88
2-3	6	33.34
4 and more	5	27.78
Total	**18**	**100.00**
Husband Has Co-wife		
Yes	7	36.84
No	12	63.16
Total	**19**	**100.00**

(Source: Field Survey, 2007)

Fig: 2



4.2 Social Characteristics of FSWs

The researcher tried to find out the social characteristics of the FSWs i.e the level of education they attained, their caste/ethnicity and their place of origin and so on (Table 3).

Table: 3

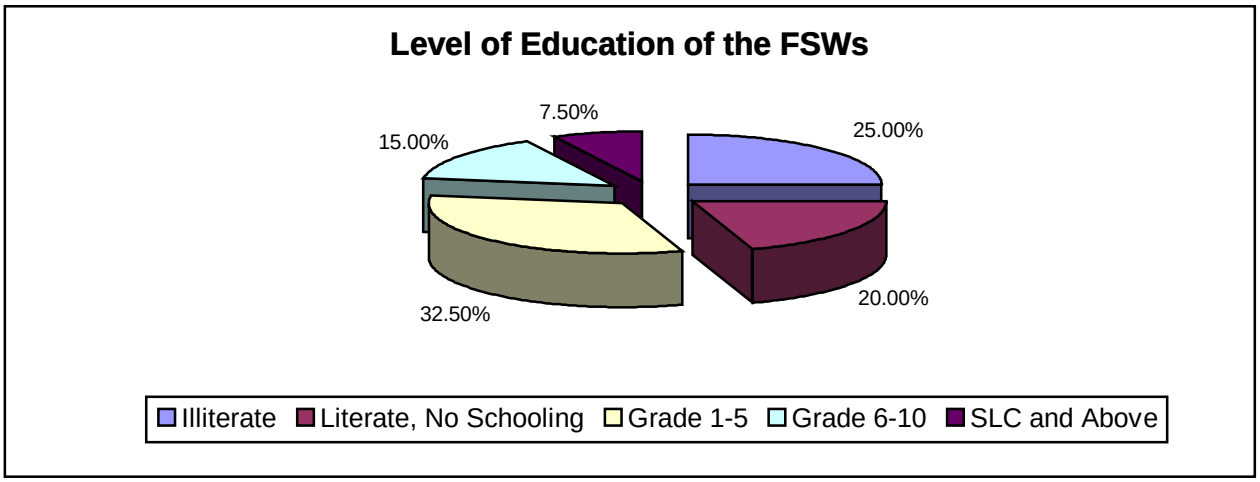
Social Characteristics of the FSWs

Education	**Number of the FSWs**	**Percentage**
Illiterate	10	25
Literate, no schooling	8	20
Grade 1-5	13	32.5
Grade 6-10	6	15
SLC and Above	3	7.5
Total	**40**	**100.00**

(Source: Field Survey, 2007)

As revealed by the study population, a majority of the FSWs were literate (75%) of which 7.5% had an educational level of SLC and above, 20% were literate with no schooling.

Fig: 3



The study also shows (Table: 4) that the three most reported ethnicity/caste of the FSWs were as follows: Tamang 25%, Chhetri 17.5%, and Brahmin 15%. Other responses are shown in table 4 below. Similarly, out of 40 respondents, the majority of the FSWs (35%) belonged to Central Development Region, 30% belonged to Western Development Region, 17.5% Eastern Development Region, 12.5 Mid-Western Development Region, and only 5% of them were from Far-Western Development Region.

Table: 4

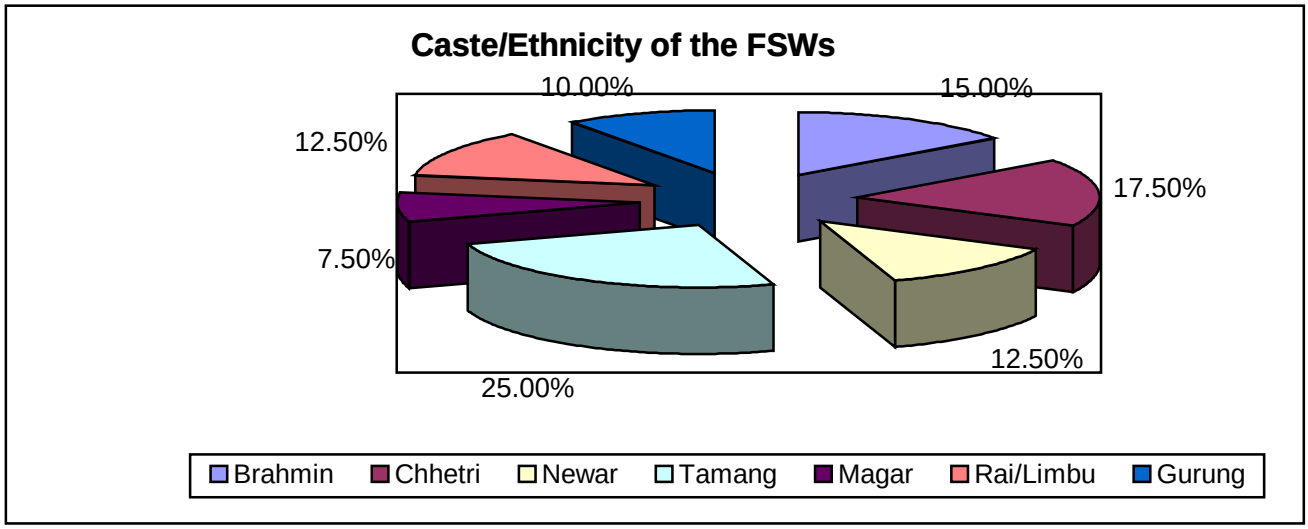
Caste/Ethnicity of the FSWs

Ethnic/Caste Group	**Number of the FSWs**	**Percentage**
Brahmin	6	15
Chhetri	7	17.5
Newar	5	12.5
Tamang	10	25
Magar	3	7.5
Rai/Limbu	5	12.5
Gurung	4	10
Total	**40**	**100.00**
Home District of FSWs		
Eastern Region of Nepal	7	17.5
Central Region of Nepal	14	35
Western Region of Nepal	12	30
Mid-Western Region of Nepal	5	12.5
Far- Western Region of Nepal	2	5
Total	**40**	**100.00**

(Source: Field Survey, 2007)

Fig: 4

Ethnicity/Caste



4.3 Sexual Behaviour of FSWs

To access the magnitude of sexual behaviour and practices of the respondents, information about their first sex, first sexual partner, age of entering this business and jobs besides sex work have been collected and analysed here.

4.3.1 Age at First Sexual Union and First Sexual Partner

The table 5 depicts the FSWs' age at their first sexual contact, types of sexual partner. The mean age at the first sexual contact was 18 years. The majority of the FSWs had their first sexual experience at the age between 17-20 years. However, two FSWs experienced first sex before the age of 14.

Table: 5

Age at First Sexual Union and First Sexual Partner

Age At First Sex	Number of the FSWs	Percentage
12-16	11	27.5
17-21	24	60
22-26	5	12.5
Total	**40**	**100.00**
Median Age At First Sex	18	
First Sexual Partner		
Boy friend	19	47.5
Husband	13	32.5
Raped	1	2.5
Client	3	7.5
Others	4	10
Total	**40**	**100.00**

(Source: Field Survey, 2007)

Fig: 5

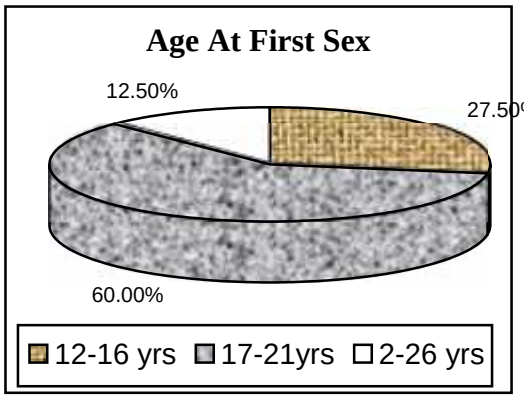
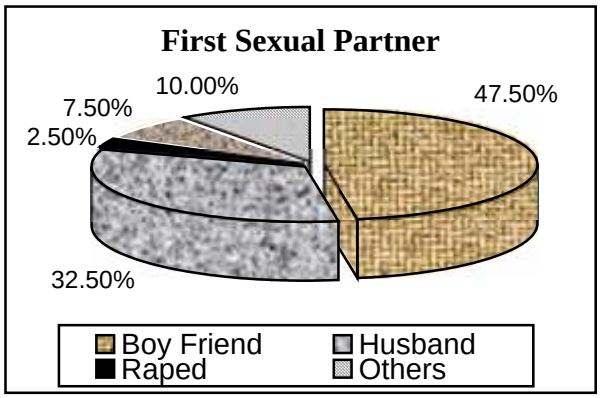


Fig:6



According to FSWs, 47.5% had their sexual contact with their boy friends (Fig:), 32.5% had their first sexual contact with their husbands, 2.5% of them were raped, and 7.5% made first sexual union with their clients. Ten percent of the FSWs had their first sexual contact with other persons like neighbours or relatives.

Table 6 shows the age of entry into commercial sex works. The majority of the FSWs (57.5%) entered the sex trade in 15-19 years. Fifteen (37.5%) of the FSWs had been in the sex work in the age of 20-24 years. However, two FSWs had entered this profession as early

as below 14 years. The majority of the FSWs (40%) had been in the sex trade for less than two years; and 12.5% of them were in this profession for more than three years.

Table: 6

Age at Entering the Sex Business

Age at Entering the Sex Business	Number of the FSWs	Percentage
<14	2	5
15-19	23	57.5
20-24	15	37.5
Total	**40**	**100.00**
Duration of Sex Work		
< 1 year	8	20
1-2 year	16	40
2-3 years	11	27.5
>3 years	5	12.5
Total	**40**	**100.00**

(Source: Field Survey, 2007)

4.3.2 Types of Jobs Besides Sex Work

The FSWs were asked about their other jobs besides sex work. More than Eighty-two percent of the FSWs do other types of work as well. Most of them worked in restaurants as waitress or dancers and others worked as masseuses in massage parlours. The main reason for working in restaurants/cabins was to have contact point to solicit clients.

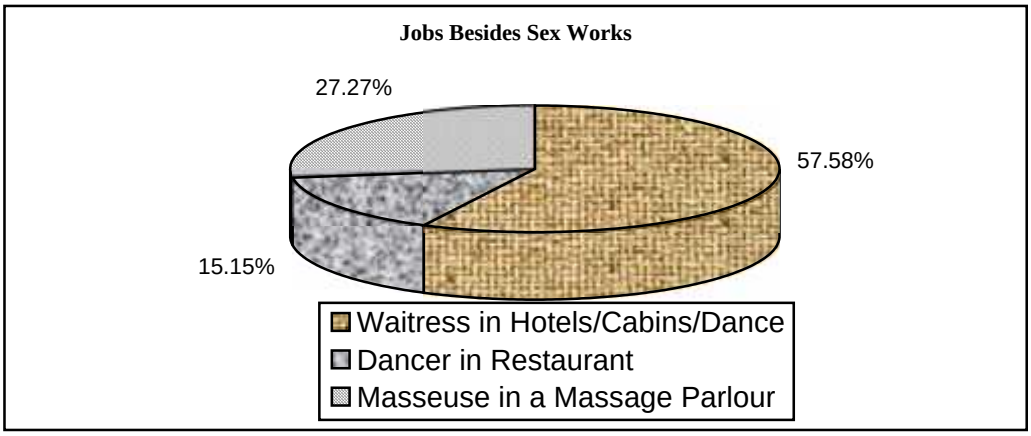
Table: 7

Types of Jobs besides Sex Work

Other Jobs Besides Sex Work	Number of the FSWs	Percentage
Have other jobs besides sex work?		
Yes	33	82.5
No	7	17.5
Types of Jobs Besides Sex Work		
Waitress in Hotels/Cabins/Dance	19	57.6
Dancer in Dance Restaurant	5	15.2
Masseuse in Massage Parlour	9	27.2
Total	**33**	**100.00**

(Source: Field Survey, 2007)

Fig: 7



4.3.3 FSWs and their Partners

The average number of clients a FSW serves varies widely. It depends upon the categories of sex workers and other characteristics. They reported that they serve 1.3 per day. It was also reported having up to 4 clients during the past week, and the number ranged from 3 to 17. Unlike in brothel situation, the FSWs in the study didn't work everyday. Nearly half of the FSWs interviewed (47.5%) had sex with one client whereas 35 had sex with two clients and 17.5% of them had more than 3 or clients on the day of sexual encounter. The majority of FSWs (42.5%) had 3-4 clients last week of interview and only 7.5% of them had 1-2 clients that week.

Table: 8

Number of Clients on a Day of Sexual Encounter and In the Past Week

Number of Clients per Day (on the day of sexual encounter)	**Number of the FSWs**	**Percentage**
1	19	47.5
2	14	35
3	7	17.5
Total	**40**	**100.00**
Mean Number of Client		
Number of Clients in the Past Week		
1-2 client(s)	3	7.5

3-4 clients	17	42.5
4-6 clients	11	27.5
6-8 clients	7	17.5
>8 clients	2	5
Total	**40**	**100.00**

(Source: Field Survey, 2007)

The types of clients as reported by the FSWs were mostly businessmen, police/army personnel, students, transport workers, people in government offices/private offices, people from rich class, Indian tourists, hotel owners, etc. Two separate questions were asked to find out the types of clients. In the fist question, the FSWs were asked about the type of clients who the most frequent visitors. And in the second question, they were asked about the occupation of the last clients. In response to both the question, the most reported types of clients were similar (Table 6). The average amount of money charged by the FSWs per client ranged from NRs. 150 to more than NRs. 500 depending upon the types of clients and time they spend with the clients for sexual works. It was reported that they charged more if they stay a night out with the clients.

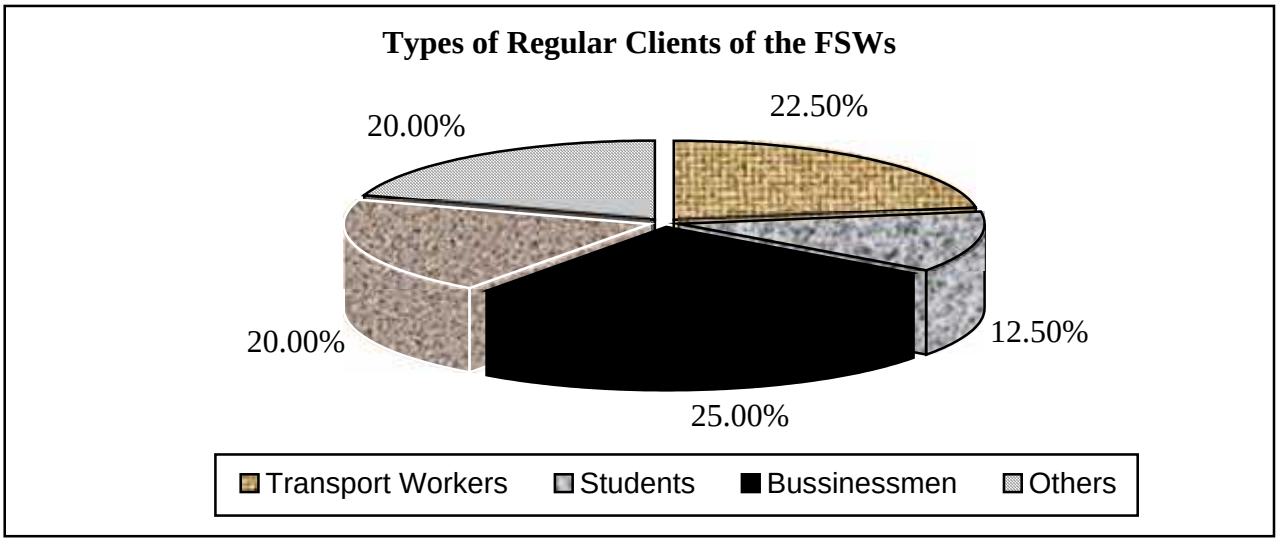
Table: 9

Sex Partners of the FSWs

Types of Regular Clients	**Number of the FSWs**	**Percentage**
Transport Workers	9	22.5
Students	5	12.5
Businessmen	10	25
Policemen/Soldiers	8	20
Others	8	20
Total	**40**	**100.00**
Amount Charged from Clients		
100-150	7	17.5
150-500	22	55
>500	11	27.5
Total	**40**	**100.00**

(Source: Field Survey, 2007)

Fig.8



4.3.4 Types of Sex Practiced By the FSWs

Many studies on sex works have reported that commercial sex workers are susceptible to violence or face undesirable situations. Some of the situation they faced put them at risk of contracting STI. Such situations could be rape, anal sex, etc. In this study the FSWs were queried if they had ever faced situations such as forceful demand for sex or demand for types of sex acts that were repugnant to them.

Table: 10

Sex Partners of the FSWs

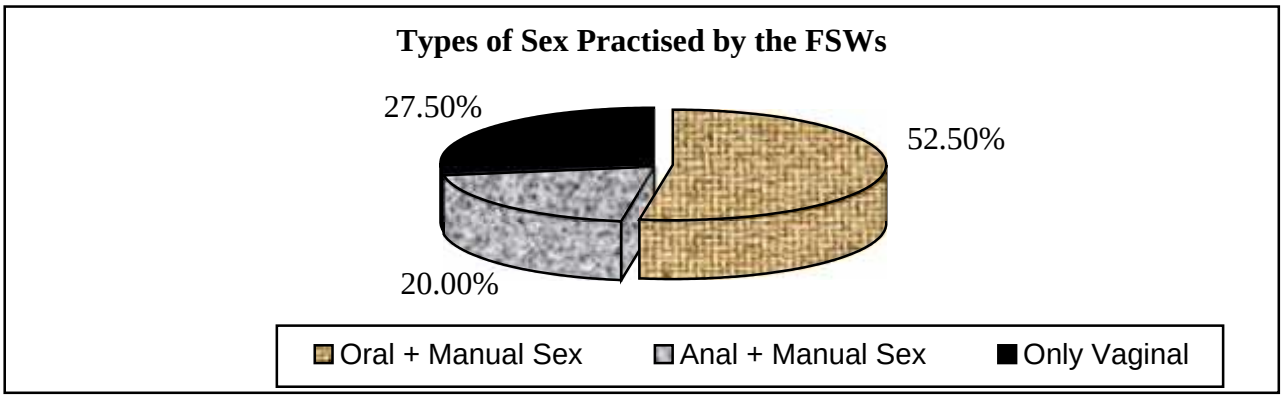
Types of Sex	Number of the FSWs	Percentage
Forced sex act demand by the client in the past year		
Yes	17	42.5
No	23	57.5
Type of sex act demand forcibly by the clients		
Rape	2	5
Anal sex	6	15
Oral sex	9	22.5
No such incidents	23	57.5
Total	**40**	**100.00**
Types of sex act in the past		

Oral sex + manual sex	21	52.5
Anal sex + manual sex	8	20
Only vaginal	11	27.5
Total	**40**	**100.00**

(Source: Field Survey, 2007)

Table 10 above shows that 42.5% of the FSWs have faced forced sex in the past year. Two cases (5%) reported that they had been raped, 15% said that clients demanded anal sex and 22.5% said that they had forcibly performed oral sex. In response to the other questions about the type of sex acts they engaged in, majority of the FSWs (52.5%) had performed oral plus manual sex, 20% admitted having anal plus manual sex, and 27.5% of them had performed vaginal sex only.

Fig: 9



4.4 Knowledge, Attitude and Sexual Behaviour of FSWs

4.4.1 Knowledge and Use of Condoms among FSWs

Condom use practice of the FSWs have been analysed in terms of ever use of condoms, consistent use of condoms, who suggested using it and places to get condoms, etc.

Table: 11

Knowledge and Use of Condoms Among FSWs

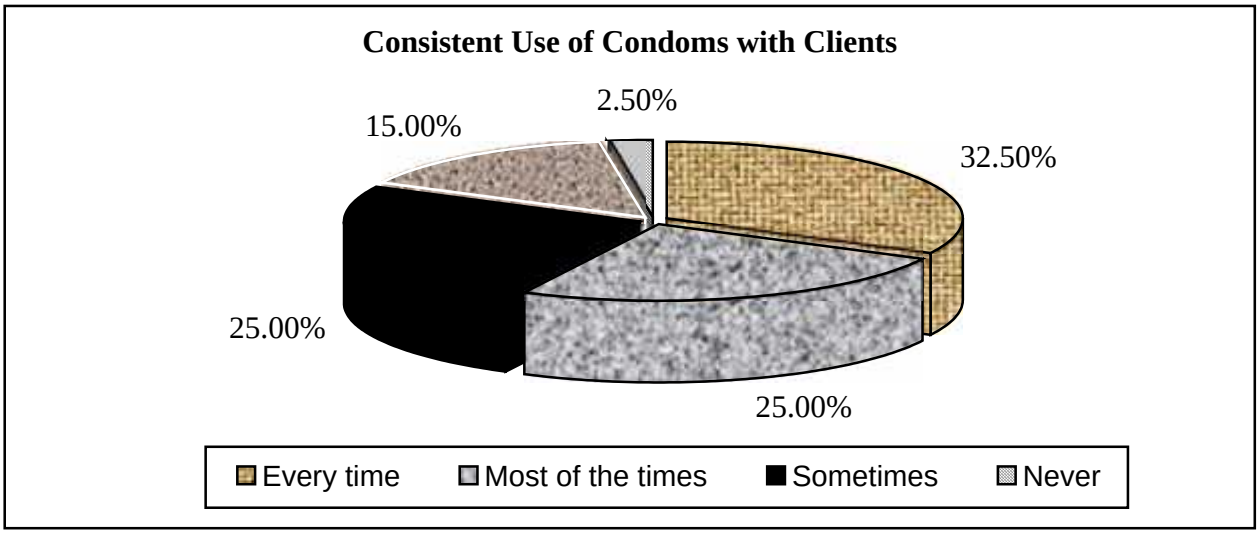
Use of Condoms and its Consistent Use	No. of FSWs	Percentage
Use of Condoms with Last Client		
Yes	33	84.6
No	6	15.4
Consistent Use of Condom with Client	**40**	**100.00**
Every time	13	32.5
Most of the times	10	25.0
Sometimes	10	25.0
Rarely	6	15.0
Never	1	2.5
Who Suggested Using a Condom?	**40**	**100.00**
Myself	15	38.4
My partner	4	10.3
Joint Decision	20	51.3
Total	**39**	**100.00**

(Source: Field Survey, 2007)

Table 11 above and figure 10 below show that the knowledge of condom is high among the female sex workers. More than 39 (97.5%) percent FSWs are reported to have used the condom and only 1 (2.5%) FSW reported that she never used the condom. She was a labour in a road construction project and came from Tamang community. It shows that, most of the FSWs were well-known with the use of the condom. These can be called the most aware group of the FSWs. They knew how to use it, and about the source of availability. However, the middle rank FSWs did not care so much about the condom. They knew about the condom but they did not know how to use it properly and the sources of availability. If the clients used it, they would accept it without hesitation. Besides, a small number of tire FSWs were quite unfamiliar with the use of the condom. They generally served the need of the low level clients.

In addition, 13 (32.5%) of the FSWs used condoms regularly during their sexual activity. Ten (25%) FSWs reported that they used the condom most of the time; 13 (32.5%) FSWs said that they rarely used the condoms and 1 (2.5%) said that she never used condoms at the time of sexual intercourse.

Fig: 10



Many FSWs tried to protect themselves from different types of STDs and HIV/AIDS. 33 (84.6%) FSWs said that they used the condom with their last client. But small number of the FSWs reported that they did not use condom with the last clients. The main reason for not using condom during the last sexual intercourse was "condom not available" and "Don't think it was necessary". Other common responses were: "No pleasure with condom", "Partner didn't like condom" and "Using other sources of contraception".

Those who had used condom during the most recent sexual encounter with their sex partners were asked who made the decision to use it. Nearly 52% of the FSWs said they made the joint decision, 38.4% said that they made the decision themselves, and 10.3% said that it was the clients' decision.

4.4.2 Places to Get Condoms

Table 12 reveals the knowledge of FSWs about the location sources where were available of condoms. According to the majority of FSWs 38 (95%), they could get a condoms from a pharmacy and 36 (90%) said they could get condoms from hospitals. Other places to get condoms were 32 (80%) private clinics, 20 (50%) retail stores, 10 (25%) NGOs/ health

worker/ volunteers, 7 (17.5%) family planning centre, 16 (40%) health centres , and 18 (45%) health posts.

Table: 12

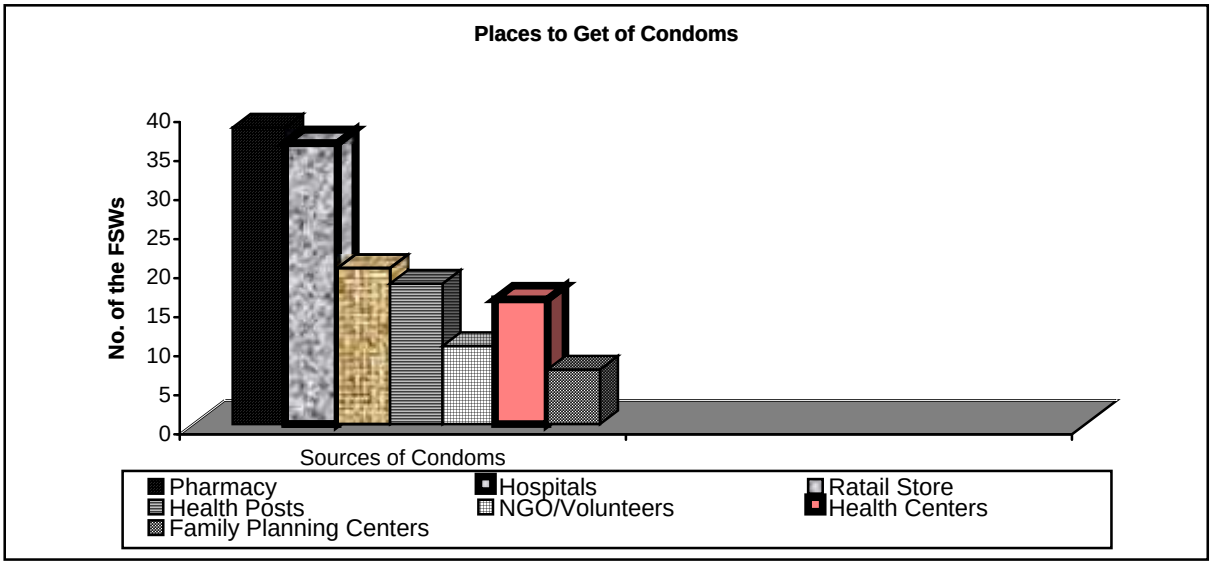
Places to Get Condoms

Places/Sources of Condoms	No. of FSWs	Percentage
Pharmacy	38	95.0
Hospitals	36	90.0
Private Clinics	32	80.0
General Ratail Store (Kirana Pasal)	20	50.0
Health Posts	18	45.0
NGO/Health Workers/Volunteers	10	25.0
Health Centres	16	40.0
Family Planning Centres	7	17.5

Multiple Response (N=40), where N= Number of FSWs. The Percentages add up to more than 100 because of multiple responses.

(Source: Field Survey, 2007)

Fig: 11



4.5 Knowledge of STDs

4.5.1 Information Sources of STDs

The knowledge of STDs among FSWs was high. Most of the FSWs 38(95%) had heard of STDs and 2 (5%) had never heard of it. Most of the FSWs reported that radio and Television

were the major sources of their knowledge of STDs. The other important sources of information were friends/relatives, cinema halls, newspapers, health workers/volunteers, etc.

Table: 13

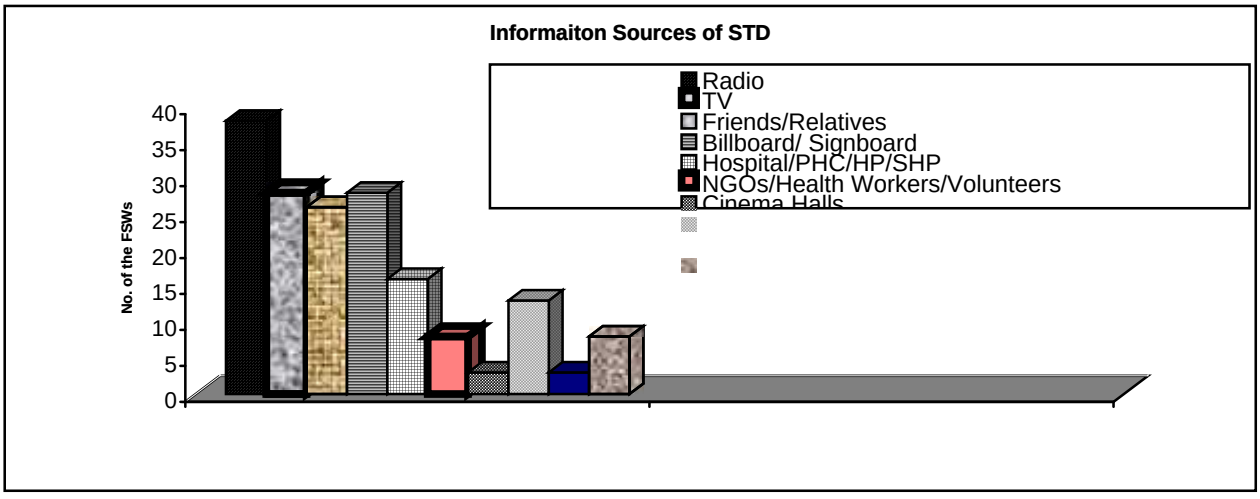
Information Sources of STDs

Heard of STDs?*	**No. of FSWs**	**Percentage**
Yes	38	95.0
No	2	5.0
Total	**40**	**100.0**
Information Sources of STDs		
Radio	38	100.0
TV	28	73.6
Friends/Relatives	26	68.4
Billboard/ Signboard	28	73.6
Hospital/PHC/HP/SHP	16	42.0
NGOs/Health Workers/Volunteers	8	21.0
Cinema Halls	3	7.8
Newspapers Book	13	34.2
Street Drama	3	7.8
Work Place	8	21.0

) Multiple Response (N=40), where N= Number of FSWs.

(Source: Field Survey, 2007)

Fig: 12



4.5.2 Knowledge of Ways of Transmission of STDs

The FSWs who had heard of STDs were asked about its mode of transmission, signs/symptoms and, its prevention. The majority of the FSWs 36 (94.4%) reported that STDs is transmitted by having sex without using a condom/unsafe sex, 33 (86.8%) said having multiple partners, infected blood transfusion 26(68.4%), and 14 (36.8%) said from infected mother to a baby. Only about 5 % of the FSWs reported that STD is transmitted by kissing.

Table: 14

Ways of STD Transmission

Knowledge of Ways of Transmission of STDs	No. of FSWs	Percentages
Unsafe sex	36	94.4
Multiple partners	33	86.8
Infected mother to a baby	14	36.8
Infected blood transfusion	26	68.4
Kissing	2	5.2

) Multiple Response (N=40), where N= Number of FSWs.

(Source: Field Survey, 2007)

4.5.3 Knowledge of Signs and Symptoms of STDs

The table 15 shows that the vast majority of FSWs had some knowledge about signs and symptoms of the STDs. About 35 (92.1%) of the FSWs said that vaginal itching is the signs/symptoms of STD, 34 (89.4%) reported that STD causes white/pus vaginal discharge, 26(68.4%) said it produces a burning sensation during urine discharge. Similarly, 23(60.5%) said that STD causes lower abdominal pain.

Table: 15

Knowledge of Signs and Symptoms of STDs

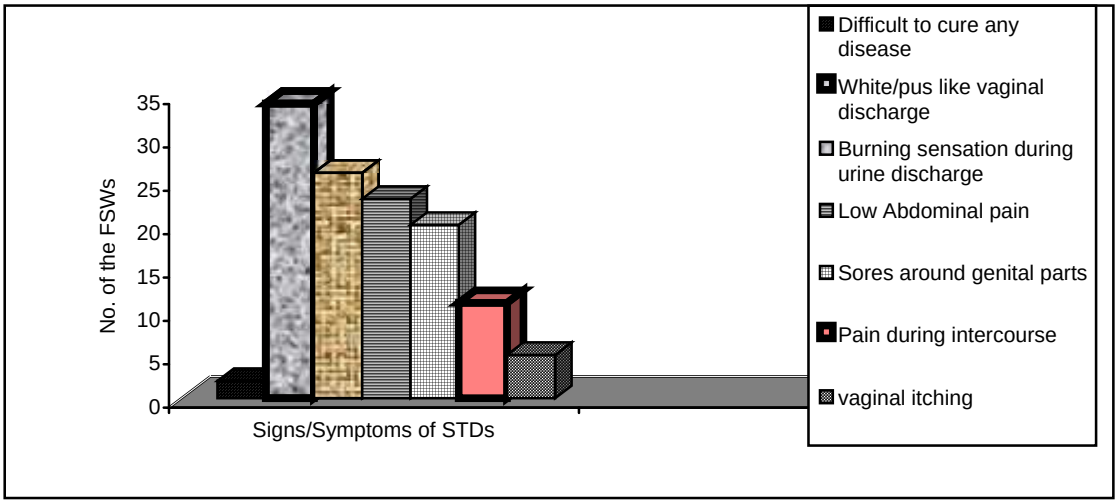
Signs and Symptoms of STDs	No. of FSWs	Percentages
Difficult to cure any disease	2	5.2
White/pus like vaginal discharge	34	89.4
Burning sensation during urine discharge	26	68.4
Low abdominal pain	23	60.5
Sores around genital parts	20	52.6

Pain during intercourse	11	28.9
Vaginal Itching	35	92.1

) Multiple Response (N=40), where N= Number of FSWs.

(Source: Field Survey, 2007)

Fig: 13



4.5.4 Knowledge of Prevention of STDs

The table 16 reveals that the Majority of the FSWs had the knowledge about the modes of STDs. More than 94 of FSWs reported that STD could be prevented by using condoms, 86.8% said that it could be prevented by avoiding multiple partners, 76.3 % said that it could be prevented by abstaining from sex, and 68.4% reported that by avoiding infected blood transfusion STDs can be prevented.

Table: 16

Prevention of STDs

Prevention of STDs	No. of FSWs	Percentages
Avoiding unsafe sex/ Always using condoms	36	94.4
Avoid multiple partners	33	86.8
Avoid infected blood transfusion	26	68.4
Abstain from Sex	29	76.3

) Multiple Response (N=40), where N= Number of FSWs.

(Source: Field Survey, 2007)

4.5.5 Possession of Condoms by the FSWs

All the FSWs were asked whether they usually carried condoms with them. More than third (35%) said that they usually carry condoms. The field interviewers requested the sex workers to show the condoms they were carrying at the moment. More than sixty percent of those who said that they carry condoms were able to show three or more condoms. This shows that most of them were aware of STDs and HIV/AIDS.

Table: 17

Possession of Condoms by the FSWs

Use of Condoms	No. of FSWs	Percentages
Do you usually carry condoms?		
Yes	14	35
No	26	65
Total	**40**	**100.00**
No. of condoms you are carrying right now?		
1	3	21.42
2	4	28.58
3-5	2	14.28
Not carrying right now	5	35.72
Total	**14**	**100.00**

(Source: Field Survey, 2007)

4.5.6 Consequences of Untreated STDS

When asked about the consequence of untreated STDs, the FSWs reported that there will be a high risk of HIV/AIDS transmission (22.5%), uterus cancer (17.5%), birth of a disable child (27.5%), infertility (7.5%), sores around genitals 25%, and so on.

Table: 18

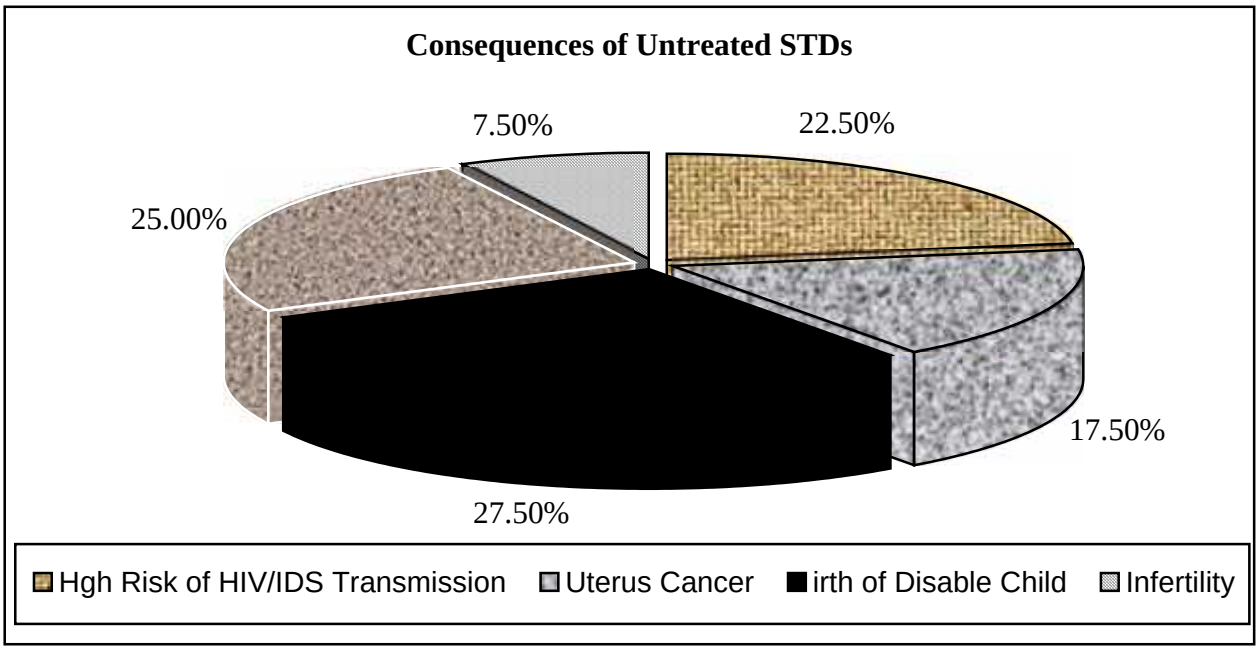
Consequences of Untreated STDS

Consequences of Untreated STDs	No. of FSWs	Percentages
High risk of HIV/AIDS transmission	9	22.5
Uterus Cancer	7	17.5
Birth of a disable child	11	27.5
Sores around genitals	10	25

Infertility	3	7.5
Total	**40**	**100.00**

(Source: Field Survey, 2007)

Fig: 14



4.6 Knowledge and Attitude towards HIV/AIDS

4.6.1 Knowledge of HIV/AIDS

AIDS is caused by human Immune Deficiency Virus (HIV) and the predominant mode of its transmission is sexual contact. Other routes of transmission include blood transfusion, use of syringe and needle, and so on. The researched asked the informants where they heard about HIV/AIDS, its symptoms, modes of transmissions and what they are doing to prevent it. The responses are analysed below.

Table: 19

Sources of Knowledge of HIV/AIDS among the FSWs

Heard of HIV/AIDS?*	**No. of FSWs**	**Percentage**
Yes	40	100.00
No	0	0.00
Total	**40**	**100.0**
Information Sources of STDs		
Radio	40	100.0
TV	40	100.00

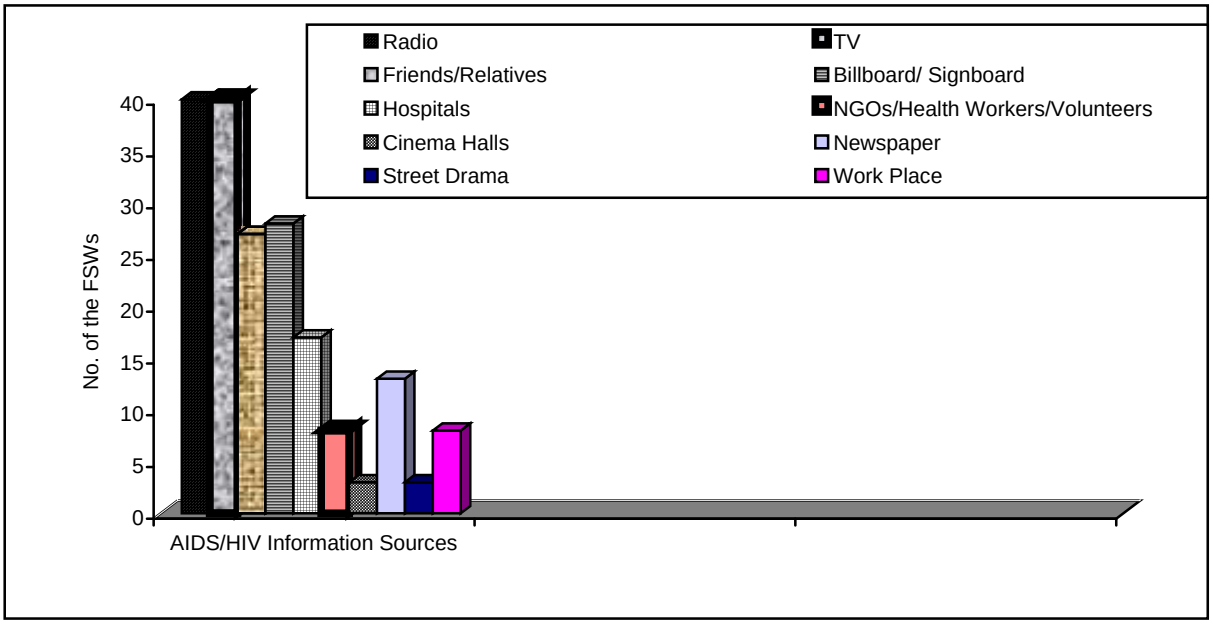
Friends/Relatives	27	67.5
Billboard/ Signboard	28	70
Hospital/PHC/HP/SHP	17	42.5
NGOs/Health Workers/Volunteers	8	20
Cinema Halls	3	7.5
Newspapers Book	13	32.5
Street Drama	3	7.5
Work Place	8	20

Multiple Response (N=40), where N= Number of FSWs.

(Source: Field Survey, 2007)

The study revealed that all of the FSWs had heard of HIV/AIDS. Most of the FSWs reported that radio and television were the major sources their knowledge of HIV/AIDS. The other important sources of information were friends/relatives, billboards, cinema halls, newspapers, health workers, street drama, work places, pamphlets and posters. Other responses are given in the table above and shown in the figure below.

Fig: 15



4.6.2 Knowledge of Transmission of HIV/AIDS

All the FSWs were asked questions regarding its transmission, prevention and its cure i.e whether there is a vaccine against HIV/ADIS. More that eighty two percent (82.5%) of them said HIV/AIDS is transmitted by having a sex without a condom, 60% said having multiple sex partners, 45% said HIV/AIDS is transmitted through blood transfusion, and 30% said by syringe/needle. Only about 10% of the FSWs reported that HIV/AIDS is transmitted from an infected mother to her baby and 32.4% said it is transmitted by having sex with the patients of HIV/AIDS.

Table: 20

Knowledge of Ways of HIV/AIDS Transmission

Ways of Transmission of STDs	**No. of FSWs**	**Percentages**
Unsafe sex/Sex without condoms	33	82.5
Multiple partners	24	60
Infected mother to a baby	4	10
Infected blood transfusion	18	45
Syringe and Needle	12	30
Sex with HIV/AIDS patients	13	32.5
Is there a vaccine that can protect person from HIV/AIDS?		
Yes	2	5
No	22	55
Don't Know	18	45
Is there any cure for HIV/AIDS?		
Yes	3	7.5
No	32	80
Don't Know	5	12.5
Total	**40**	**100.00**

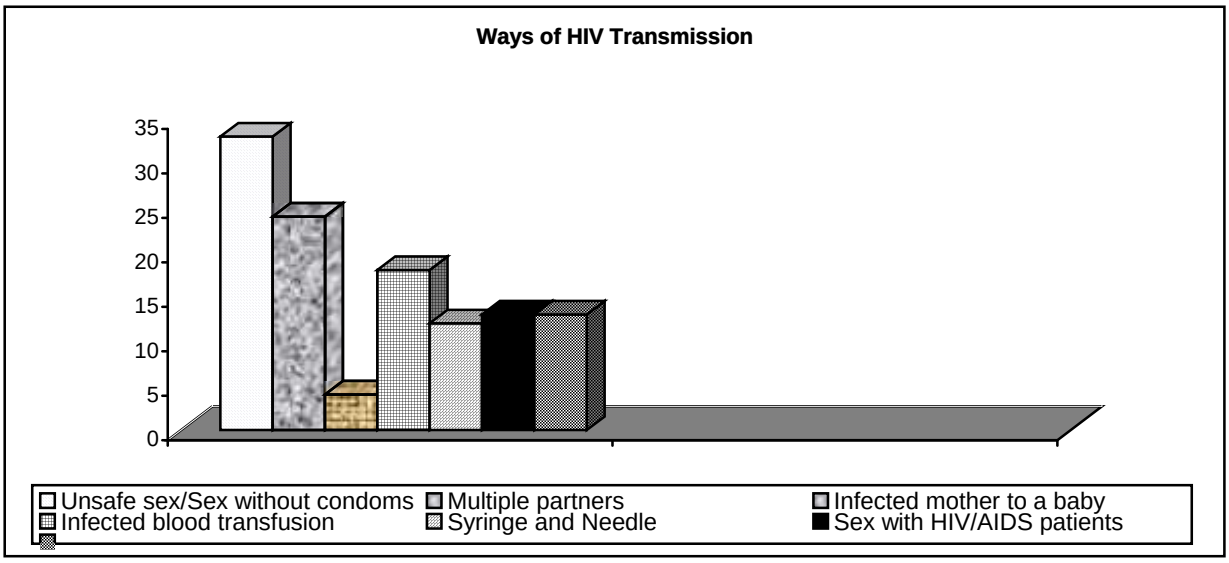
Multiple Response (N=40), where N= Number of FSWs.

(Source: Field Survey, 2007)

The FSWs were also asked whether there is a vaccine against HIV/AIDS. Some 5% thought that there is vaccine against HIV/AIDS. About 55% the FSWs said that there was no vaccine against HIV/AIDS, 45% reported that they had no knowledge about it. On the other hand, in

the FSWs were also asked whether there was a cure for HIV/AIDS, about 7.5% reported that HIV/AIDS could be cured, about 82% of them said that there is no cure for HIV/AIDS, 12.5% of the FSWs reported that they didn't have any knowledge about its cure.

Fig: 16



4.6.3 Precaution Taken Against HIV/AIDS

The table 21 shows that 82.5% of the FSWs had take precautions against HIV/AIDS. But 17.5% had not taken any precautions. The majority 63.6% had used condoms as a protective measure, 57.5% regularly had their health checked, 30.3% cleaned their genitals after sex. Other forms of the precautions taken are given in the table 18 below.

Table: 21

Precautions Taken against HIV/AIDS

Types of Precautions taken	No. of FSWs	Percentages
Ever taken precautions against HIV/AIDS?		
Yes	33	82.5
No	7	17.5
Total	**40**	**100.00**
Use condom	21	63.6
Regular Health Check up	19	57.5
Clean genitals after sex	10	30.3

Bath after sex	4	12.1
Do not have sex with Multiple partners	5	15.1
Avoid Blood Transfusion	4	12.1
Avoid using infected needle	6	15

) Multiple Response (N=40), where N= Number of FSWs.

(Source: Field Survey, 2007)

4.7 Main Reasons for involving in Commercial Sex

It is believed that the number of commercial sex workers is rising day by day. The FSWs were asked about their main reason for entering this profession. Table 19 shows the multiple responses given by the FSWs. The most important reason was related to poverty and unemployment. The table shows that 67.5% of the FSWs were involved in this profession due to poverty, and 57.5% of them were involved in sex due to unemployment. Other responses are given in the table below.

Table: 22

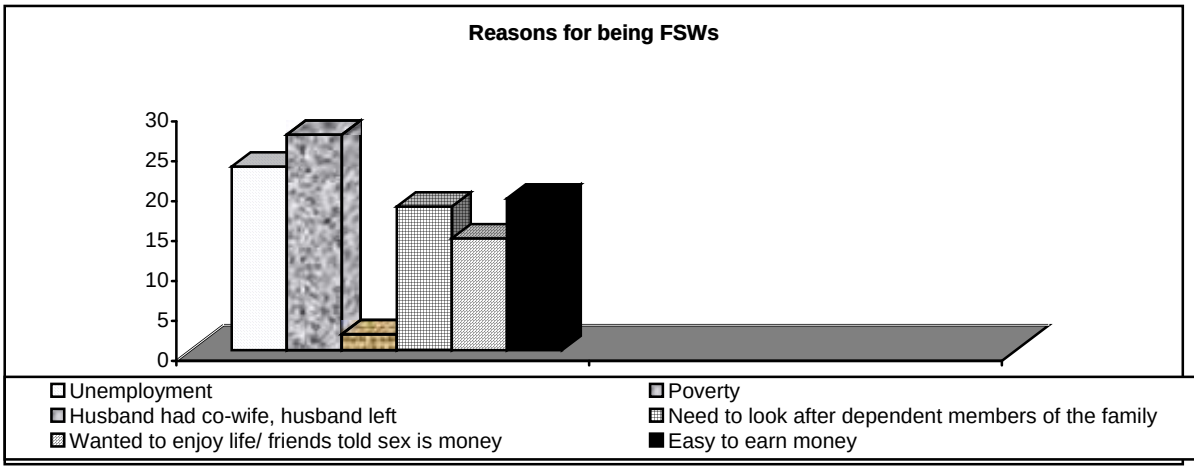
Reasons for Involving in the Commercial Sex Work

Reasons for Being FSWs	No. of FSWs	Percentages
Unemployment	23	57.5
Poverty	27	67.5
Husband had co-wife, husband left	2	5
Need to look after dependent members of the family	18	45
Wanted to enjoy life/ friends told sex is money	14	35
Easy to earn money	19	47.5

Multiple Response (N=40), where N= Number of FSWs

(Source: Field Survey, 2007)

Fig: 17



4.8 Attitude of the FSWs towards this Profession

The researcher asked all the FSWs if they were satisfied or dissatisfied with their sex business. The majority of the FSWs (47.5%) were satisfied with their work whereas 27.5% were dissatisfied with their business. However, 25% of them were indifferent about their work. .

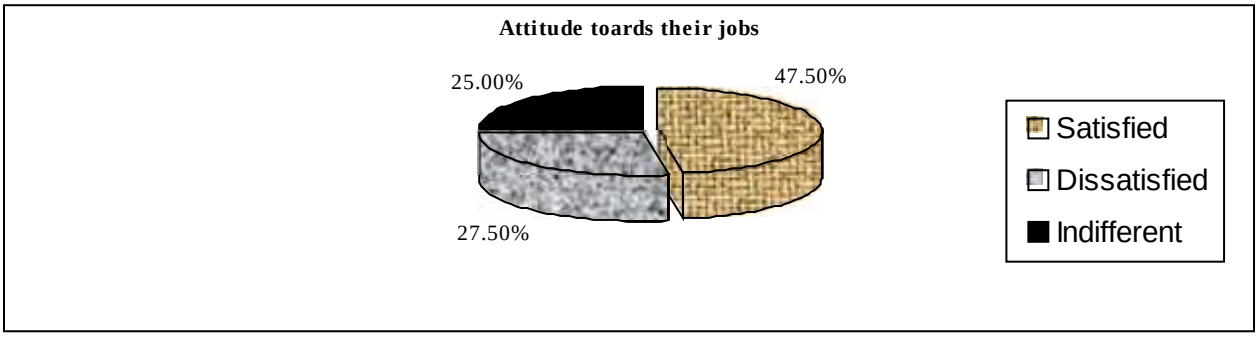
Table: 23

Attitude of the FSWs towards Commercial Sex Work

Attitude towards Their Works	No. of FSWs	Percentages
Satisfied	19	47.5
Dissatisfied	11	27.5
Indifferent	10	25
Total	**40**	**100.00**

(Source: Field Survey, 2007)

Fig: 18



4.9 The FSWs Exposure to FHI Media Message

Since Family Health International (FHI/Nepal) started intervention programmes to bring awareness about HIV/AIDS among high-risk groups, message regarding the use of condoms for the prevention of AIDS were broadcasted and put up. Different media channels were utilized. A couple of years ago, FHI started to use new message, especially in Kathmandu area. Among the new messages are *JhilkeDai Chha Chhaina Condom,* and *Condom Bata Suraksha Youn Swasthya ko Raksha.* These messages were shows on TV and broadcasted over radio. And posters depicting the message along with visual character were posted at different places, such as health posts, road sides and pharmacies.

Table: 24

Heard/Seen/ Read FHI Message in the past by the FSWs

Messages Seen/Heard/Read in the Past	No. of FSWs	Percentages
Condom Lagaaun AIDS Bhagaaun	39	
Jhilke Dai Chha Chhaina Condom	40	100
Condom Bata Suraksha Youn Swasthya ko Raksha	27	67.5
Use Condoms for Protection of HIV/AIDS and STI	25	62.5
Dhaale Dai	31	**77.7**
Guriji & Antare	40	100
Other Messages from Radio	21	52.5

(Source: Field Survey, 2007)

The study revealed that the older version of the message – *Condom Lagaaun AIDS Bhagaaun* and *Dhaale Dai* are still popular among clients. Newer message *JhilkeDai Chha Chhaina Condom (93%),* and *Condom Bata Suraksha Youn Swasthya ko Raksha(86*%,) are catching one Very fast.

4.10 CASE STUDY

The Case of Jamuna

Jamuna, (fictitious name) was born at the pension camp Pokhara, Kaski district in 2029 B.S. Now she is a 31 years old married women. Her husband left her and now she lives with her dependant two children. She spent her childhood in extreme poverty. As a child, she helped her family in working in the fields, bringing firewood, fodder and as well as grazing the cattle. She didn't get a chance to continue her study for more than grade five. One day one of her friends from Mahal village invited her on her marriage. Her bride was from lakeside, Pokhara. On the day of Marriage, she went there being bridegroom's friend (L.akhantee). She spends five days on her house. On those days she ,introduced herself with the bride's friends. At the same time she had sexual relation with a boy who was invited as a guest there too and he gave her Rs. 2000 (two thousand) to buy clothes. She was just 17 years old at that time. Later on her friend Jamuna got married other poor boy but later even he left her so she had no other easy option to earn money except to engage in sex trade. She says “being uneducated and having no other alternatives I forced myself to this job for our survival”. She wants to leave the job if she gets other opportunities.

The Case of Shanti

When Shanti Devi Tamang (fictitious name) was a 21 years old married women from Dhadingt, her family migrated to Kathmandu. They did so because of poverty in their home in Dhading district, Deurali VDC. There are six members in her family. They are her father, mother, elder sister, she and her one small child. All of them were labours. She became unable to continue her study after grade five because of extreme poverty. After that, at the age of 16 she fel in love with a man from Chhetri community and six month later she got married with him. He was a policeman. "My husband's was from higher/superior caste. They used to scold and threaten me

because of My low caste status," she told the researcher.. After a year, she left her husband. She was pregnant at that time. She started to live with her father and mother after the departure from her husband. She gave birth to a son after few months. In the meantime, she came into contact with a guy. The boy asked her to go to his hotel in Kathmandu. She kept sexual relation with him. This happened three years ago. "That guy gave me Rs 800 for the sex work," she adds. The amount given by him was equal to her ten days' earnings as a labourer. She has changed her profession now because she can get more money by this new profession. She has been in the profession for the last three years.

The Case of Rupa

Rupa (her fictitious name) is 18 years old. She comes from Ratnanagar -4, Chitwan district. There are 5 members in her family. When she was still young, her mother died and her father married another woman. Her family depended on agriculture for their livelihood. Though she was hard working and did lots of household works, her stepmother never supported her. Instead of supporting her, she used to scold her. Her father also ignored her so she left the house and went to live with one of her sisters' house who had a small *bhatti pasal*. It was in Pokhara Buspark in Narayangarh. She started to work in the same hotel. After few weeks of works in the restaurant, one of the costumers of the restaurants, a Lahure from India, raped her and compelled her to keep on the relationship. She accepted it helplessly. He bought her a pair of beautiful clothes and he gave her Rs. 1000. She had not seen that much money during her lifetime. After that she got confidence that she could earn more money from sex trade, she gave continuity to the profession, which she continues until now.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

This survey which forms the basis of this study covers 40 FSWs working in different massage centres and cabin restaurants based on Kathmandu metropolitan city. The field research was conducted in different places of Kathmandu municipality in which the samples were selected using Purposive Sampling Design. In this micro level study every effort was made to gather as much information as possible to better understand the FSWs, their knowledge and behaviour towards HIV/AIDS and STDs.

Both qualitative and quantitative methods were used to collect data. Structured interview (quantitative) was the main tool used in gaining an in-depth knowledge of the issue.

This study attempts to explore the present socio-demographic characteristics of the FSWs, their knowledge of and attitude of the FSWs towards HIV/AIDS and STDs. Furthermore, it also tries to investigate the FSWs sexual practices and behaviours, and main reasons that lead them to enter this profession.

5.1 Summary

The major findings of the Study are as follows:

The median age of the FSWs was 26 years with the age range 12 – 40 and above. More than half of the FSWs (52.5%) were never married and 47.5% of the FSWs were married. Among the once married of the FSWs, 12.5% of them were divorced/separated, and a number of them (36.84%) were co-wives. Likewise, 12.5% of the FSWs were living with their husband, 60% of them with friends, 27.5% of them were living alone. Forty-five percent of the FSWs had economically dependent members in their family.

The majority of the FSWs belonged to Tamang family (25%), followed by Chhetri (17.5%), and Brahmin (15%) respectively. Similarly, out of 40 respondents, the majority of the FSWs (35%) belonged to Central Development Region. Literacy among the FSWs, 75% of which 7.5% had an educational level of SLC and above, 20% were literate with no schooling.

The majority of the FSWs had their first sexual experience at the age between 17-20 years. However, two FSWs had experienced first sex before the age of 14. Furthermore, 47.5% had their sexual contact with their boy friends, 32.5% with their husbands, 2.5% of them were raped, and 7.5% made first sexual union with their clients.

The majority of the FSWs (57.5%) entered the sex trade in 15-19 years. Fifteen (37.5%) of the FSWs had been in the sex work in the age of 20-24 years. The majority of the FSWs (40%) had been in the sex trade for less than two years; and 12.5% of them were in this profession for more than three years.

It was also reported having up to 4 clients during the past week, and the number ranged from 3 to 17. Nearly half of the FSWs interviewed (47.5%) had sex with one client whereas 35 had sex with two clients and 17.5% of them had more than 3 or clients on the day of sexual encounter. The majority of FSWs (42.5%) had 3-4 clients the previous week of interview and only 7.5% of them had 1-2 clients that week.

The types of clients as reported by the FSWs were mostly businessmen, police/army personnel, students, transport workers, people in government offices/private offices. The average amount of money charged by the FSWs per client ranged from Rs. 150 to more than Rs 500 depending upon the types of clients and time they spend with the clients for sexual works. The average amount of money charged per client by FSWs was Rs. 325.

It was reported that the FSWs had faced situations such as forceful demand for sex or demand for types of sex acts that were repugnant to them. It was found that 42.5% of the FSWs have faced forced sex in the past year. Two cases (5%) reported that they had been

raped, 15% said that clients demanded anal sex and 22.5% said that they had forcibly performed oral sex. The majority of the FSWs (52.5%) confessed that they had performed oral plus manual sex, 20% admitted having anal plus manual sex, and 27.5% of them had performed vaginal sex only.

More than 39 (97.5%) percent FSWs are reported to have used the condom and only 1 (2.5%) FSW reported that she never used the condom. She was a labour in a road construction project and came from Tamang community.

Ever use of condom among the FSWs was 97.5%; however condom use with the last client was 84.6% only. Only 32.5% of the FSWs reported to use condom every time they have sex with clients, 25% reported using condoms most of the time and 2.5% never used condoms. The main reason for not using condom during the last sexual intercourse was "condom not available" and "Don't think it was necessary". Other common responses were: "No pleasure with condom", "Partner didn't like condom" and "Using other sources of contraception".

The majority of FSWs 38 (95%), they could get a condoms from a pharmacy and 36 (90%) said they could get condoms from hospitals.

The knowledge of STDs among FSWs was high. Most of the FSWs 38(95%) had heard of STDs and 2 (5%) had never heard of it. Most of the FSWs reported that radio and Television were the major sources of their knowledge of STDs.

The majority of the FSWs 36 (94.4%) reported that STDs is transmitted by having sex without using a condom/unsafe sex, 33 (86.8%) said having multiple partners, infected blood transfusion 26(68.4%), and 14 (36.8%) said from infected mother to a baby.

Ninety-two percent of the FSWs said that viginal itching is the signs/symptoms of STD, 89.4% reported that STD causes white/pus vaginal discharge, 68.4% said it produces a burning sensation during urine discharge. Similarly, 60.5% said that STD causes lower abdominal pain.

Majority of the FSWs had the knowledge about the modes of STDs. More than 94 of FSWs reported that STD could be prevented by using condoms, 86.8% said by avoiding multiple partners, 76.3 % said by abstaining from sex, and 68.4% reported that by avoiding infected blood transfusion STDs can be prevented. When asked about the consequence of untreated STDs, the FSWs reported that there will be a high risk of HIV/AIDS transmission (22.5%), uterus cancer (17.5%), birth of a disable child (27.5%), infertility (7.5%), sores around genitals 25%, and so on.

The study revealed that all of the FSWs had heard of HIV/AIDS. Most of the FSWs reported that radio and television were the major sources their knowledge of HIV/AIDS. The other important sources of information were friends/relatives, billboards, cinema halls, newspapers, health workers, street drama, work places, pamphlets and posters. More that eighty two percent (82.5%) of them said HIV/AIDS is transmitted by having a sex without a condom, 60% said having multiple sex partners, 45% said HIV/AIDS is transmitted through blood transfusion, and 30% said by syringe/needle. Only about 10% of the FSWs reported that HIV/AIDS is transmitted from an infected mother to her baby and 32.4% said it is transmitted by having sex with the patients of HIV/AIDS.

The study revealed that 82.5% of the FSWs had take precautions against HIV/AIDS. Some 5% thought that there is vaccine against HIV/AIDS. About 55% the FSWs said that there was no vaccine against HIV/AIDS, 45% reported that they had no knowledge about it.

It was found that most of the FSWs were involved in this profession due to poverty 67.5% and unemployment 57.5%. Similarly, the majority of the FSWs (47.5%) were satisfied with their work whereas 27.5% were dissatisfied with their business. However, 25% of them were indifferent about their work.

It was also found that most of the FSWs had heard of FHI message about condom, HIV/AIDS and STDs.

5.2 Conclusions

In Nepal, HIV/AIDS is in increasing trend across the country. Nepal is more vulnerable and in high-risk area to HIV/AIDS. The major contributing factors include grim poverty, low awareness, low level of education, stigma and discrimination, high rate of trafficking, unsafe sexual intercourse, increasing trend of commercial sex, in and out migration and poor resources to fight against this fatal disease. Time has already come for all of us to work together for the prevention and control of HIV spread.

It is a social concern that everyone should put efforts on HIV/AIDS prevention and control. There is a need of joint efforts of every individual, civil society organizations and states to have HIV/AIDS and STDS free world by joining hands in hand. We have one world. In addition, we have one hope that is AIDS free society. At present, HIV/AIDS has become a social issue rather than only health problem. From social point of view, AIDS means awareness, impartiality, determination and self-protection to save our future generations. To fight against this fatal disease we must unite together. The use of condom during sexual intercourse is considered as a best practice to prevent from HIV/AIDS/STDs.

5.3 Recommendations

UNAIDS and WHO recommend that every country should have a program for prevention and care of STD which should be integrated or closely coordinated with National AIDS programs. The services that form part of the program should always be delivered with due respect for human rights and maintenance of the dignity of persons with STD. The researcher has forwarded the following recommendations to control and prevent the spread of HIV/AIDS and STDs in the country:

HIV/AIDS/STD programs should:

- Since new girls are entering the sex trade every year, message of safe sex and HIV/AIDs awareness campaign should be focused to that vulnerable group.
- Female Sex Workers should continue to be targeted by HIV and STI control programmes.
- Deliver primary prevention activities (promotion of safer sexual behaviour, condom provision) in conjunction with National AIDS programs;
- Promote accessible, acceptable and effective case management of persons with STD through public and private health care system, including first level health care, using simple algorithms based on syndromic diagnosis;
- Include STD prevention and care services in maternal and child health, antenatal and family planning services;
- Target acceptable and effective STD care services to population identified as being particularly vulnerable to infection with STDs, including the Human Immunodeficiency Virus (HIV);
- Ongoing outreach and education programmes should emphasize STDs and HIV symptoms recognition and care seeking behaviour.
- Early STD health care-seeking behaviour should be promoted together with education related to sexual behaviour.
- In order to prevent from HIV/AIDS, massive awareness programmes should be launched by using various communication media
- AIDS and STDs educations should be included in school curriculum.
- Condoms should be made widely available and accessible for HIV/AIDS and STD prevention.
- Because of the open border with India, it is important that there is a cross-border coordination and networking with the government and NGOs to provide effective service to those that are trafficked or deceived to unsafe employment opportunities by which HIV can be regulated to some extent.
- It is necessary that HIV/AIDS/STD prevention be approached as a long term objective by policy makers/planners rather than as a combination of ad hoc programmes. Community

leadership should place sexual health as an important agenda in their development programme.

- Peer education is the most effective intervention technique to hit the goal and objective of HIV/AIDS/STDs prevention campaign.
- Rehabilitation centres should be established at various places of the country for people living with HIV/AIDS.
- Long-term political commitment and good governance is necessary to combat the HIV/AIDS epidemic in the country.

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