HIV/AIDS SITUATION IN NEPAL: TRANSITION TO WOMEN
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Masters Thesis
HIV/AIDS SITUATION IN NEPAL: TRANSITION TO WOMEN

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In Partial Fulfillment of Requirements for the Degree of Master in Health and Society and Dynamics of Health and Welfare

Under the supervision of Sam Willner, Linköping University, Sweden
Patrice Bourdelais, Ecole des Hautes Etudes en Sciences Sociales Paris

June, 2008
DEDICATION

To my dedicated father Mr Nani Ram Karki, mother Mrs Saraswati Karki, my husband Major Prakash Deuja and my brother Dr Sanjaya Karki. I have come this far by all your support, encouragement, dedication and love. To my little daughter Saibasri Singh Deuja, for your sacrifice being away from my cuddle. I say God bless you all!
ACKNOWLEDGEMENTS

I can believe the fact the God through his wisdom and guidance made it possible for me to complete my studies successfully.

I wish to express my sincere gratitude to my supervisor, Associate Professor Sam Willner, for his constant guidance, advices throughout the thesis. I am greatly indebted to Professor Jan Sundin, for his advices, attention, and support during all the hours. I would like to state thanks to co-advisor Patrice Bourdelais; Professor and Director of the Masters Sante, Population et Politiques Sociales in Ecole Des Hautes Etudes en Sciences Socialeles during my third semester in France, Paris. I express particular thanks to Mrs. Bhim Kumari Pariyar; Program Assistant, Monitoring and Evaluation, Surveillance and Research, National Center for AIDS and STD Control (NCASC), Ministry of Health and Population, Nepal, for providing me the data for completion of this research. I pay much fervent gratitude to Britt Marie Nyberg and Kjell Nyberg for their hospitality, concern and companionships they provided during my stay in Linkoping, Sweden. I am deeply grateful, no words to express, and have heartfelt acknowledgement, to my father Mr Nani Ram Karki, mother Mrs Saraswati Karki, husband Major Prakash Deuja and my brother Dr Sanjaya Karki for their unfailing encouragement, inspiration, continuous support; who patiently put up with all stresses associate with me. This thesis would not have been possible without support and love from my husband; he also provided great help with the collection of literature, books and data for this thesis. I humbly respect your role. My soul also goes to my little daughter Saibasri Singh Deuja.
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<table>
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<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>ANC</td>
<td>Ante Natal Care</td>
</tr>
<tr>
<td>CREHPA</td>
<td>Center for Research on Environment, Health and Population Activities</td>
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<tr>
<td>CSW</td>
<td>Commercial Sex Worker</td>
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<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
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<tr>
<td>FHI</td>
<td>Family Health and International</td>
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<td>FSMN</td>
<td>Federation of Safe Motherhood Network</td>
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<tr>
<td>FSWs</td>
<td>Female Sex Workers</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<tr>
<td>HSS</td>
<td>HIV Sentinel Surveillance</td>
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<tr>
<td>IBBS</td>
<td>Integrated Biological Behavioral Survey</td>
</tr>
<tr>
<td>INGO</td>
<td>International Non Governmental Organization</td>
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<tr>
<td>IDUs</td>
<td>Intravenous Drug Users</td>
</tr>
<tr>
<td>LGBT</td>
<td>Lesbian Gay Bisexual and Transgender</td>
</tr>
<tr>
<td>MSM</td>
<td>Men Sex with Men</td>
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<tr>
<td>NACO</td>
<td>National AIDS Control Organization</td>
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<tr>
<td>NAPC</td>
<td>National AIDS Prevention and Control</td>
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<tr>
<td>NCASC</td>
<td>National Center for AIDS and STD control</td>
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<tr>
<td>NDHS</td>
<td>Nepal Demography and Health Survey</td>
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<tr>
<td>NGO</td>
<td>Non Governmental Organization</td>
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<tr>
<td>Abbreviation</td>
<td>Full Form</td>
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<tr>
<td>SACTS</td>
<td>STD/AIDS Counseling and Training Services</td>
</tr>
<tr>
<td>SCN-N</td>
<td>Save the Children Norway –Nepal</td>
</tr>
<tr>
<td>SC/US</td>
<td>Save the Children US</td>
</tr>
<tr>
<td>STD</td>
<td>Sexual Transmitted Disease</td>
</tr>
<tr>
<td>STI</td>
<td>Sexual Transmitted Infection</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>The joint United Nations Program on HIV/AIDS</td>
</tr>
<tr>
<td>UNESCO</td>
<td>United Nations Educational, Scientific Cultural Organization</td>
</tr>
<tr>
<td>UNGASS</td>
<td>United Nations General Assembly Special Session</td>
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<tr>
<td>UNICEF</td>
<td>United National International Children and Emergency Found</td>
</tr>
<tr>
<td>USA</td>
<td>United States of America</td>
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<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
</tr>
<tr>
<td>USD</td>
<td>United State Dollar</td>
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<tr>
<td>VCT</td>
<td>Voluntary Counseling and Testing</td>
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<td>WHO</td>
<td>World Health Organization</td>
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ABSTRACT

This study is about age and gender specific HIV morbidity in Nepal. The main objective of the study is to find out the factors that affect the HIV prevalence in Nepali society and the relationships of different existing socio cultural and economic factors that have led females vulnerable to HIV infection especially to housewives. Qualitative and quantitative methods were used for the data collection.

Initially, Nepal’s epidemic was driven by sex workers and drug users. Though HIV prevalence was concentrated in these groups for several years, now it has been proved that the outbreak is not limited among those groups only, the prevalence among housewives, clients of sex workers, migrants and male homosexuals are stretching up. Moreover findings have shown that the HIV epidemics is taking a devastating tool in women in Nepal, covering the more HIV prevalence number by low risk group housewives among the HIV affected female population. Lack of fully inclusive knowledge of HIV/AIDS; lack of knowledge of proper use of condom, negligence, and risky sexual behavior have compelled maximum risk for HIV contraction in society.

Socio economic and cultural structures and the consequences of its correlation aggravated the HIV prevalence among people, especially have affected women. Discrimination of women is entrenched in Nepali society. Due to disparity and discrimination women are not able to get formal education that deprives them from any opportunity for the employment that leads poverty on them. Living under poverty often stems them to engage in high risk situations and likely to adopt risky sexual behaviors which in turn render them vulnerable to HIV infection. The masculinity of the society, and women’s less power for the decision making process have made females heavily dependent on males, and this constraint them from entering into negotiating for protective sex which put them in HIV infection. The study further revealed the triggering effect of powerlessness of housewives and risky sexual behavior of men to HIV infection to low risk group housewives. If the same trends go on, the time is not so far for the Nepali women to take up the higher number of HIV prevalence, and the low risk group housewives will be highly vulnerable. It is already urgent to activate the plans and intervention program for the prevention of HIV prevalence which is stretching towards women especially to low risk group housewives. Based on the findings, conclusions and recommendations are drawn.
CHAPTER ONE: INTRODUCTION

1.1 INTRODUCTION TO STUDY AREA

Human Immunodeficiency Virus (HIV) invade the blood stream through anal, vaginal, or oral sex; blood transfusion, sharing of intravenous drug injecting equipment and through mother to child during prior to birth across the placenta or during birth, or via breast feeding.

The presence of HIV in the blood stream does not mean that a person has Acquired Immune Deficiency Syndrome (AIDS). HIV once enter the blood stream and start to attack the body’s immune system, which provide the natural defense against disease and infection. Suppressing the immune system makes individual vulnerable to many serious illness, almost any symptoms may occur in this process of HIV infection. The term Acquired Immune Deficiency Syndrome (AIDS) is used to describe the latter stages of HIV, when the immune system stops working and develops specific infections, which indicate the end stage of immune system breakdown. HIV leads to Acquired Immune Deficiency Syndrome (AIDS), though the time scale is variable, and depends upon the various factors, including; treatment regimes and infections to which the person is exposed. This is an incurable disease, but the medical cares extend the life span of the HIV infected individuals. Once people get infected with AIDS, a large proportion of those infected die within 5-10 years.1

The origination of HIV became a subject of intense debate and caused countless arguments in its earlier stages for about two decades. AIDS was identified in America in 1981 for the first time when numbers of gay men started to develop life threatening opportunistic infections like pneumonia, tuberculosis and cancers that were stubbornly resistant to treatment in all the HIV affected patients. Until that time, HIV did not yet have its name. It was soon realized that all the men were suffering from common syndromes. This eventually led to the discovery of HIV that causes AIDS.2
The first known instance of HIV infection among the three earliest instances was in the plasma sample from an adult man of Congo of 1959, the second was in the tissue sample of an American teenager who died in 1969, and the third was in the tissue sample from a Norwegian sailor who died around 1976. Though AIDS was introduced in 1981, a 1998 analysis of the plasma sample from 1959 stated that HIV was introduced into human world around 1940s or in early 1950s or much earlier. However, because the numbers of infected individuals were small and the virus was undetectable prior to 1981, a pattern of disease went unrecognized and widely speeded before 1981.

Now AIDS has become a global problem and has spread all around the world. The latest statistics of the world epidemics of HIV/AIDS estimated 33.2 million people were living with HIV/AIDS by the end of 2007, and women accounted the 15.4 million living with HIV in the world. Its main concentration is in Africa as the largest numbers of HIV/AIDS cases are found. HIV/AIDS has reached alarming proportions in Asia which are following to outpace Africa in terms of HIV/AIDS cases. South Asia has more than 20 per cent of the world’s population facing an HIV epidemic with an estimated 5.5 to 6 million people have been HIV infected. It is likely to be the region of the largest number of people infected with HIV/AIDS in the near future unless some drastic measures were introduced in combating HIV/AIDS. At least 60% of HIV positive people in Asia live in India alone. This figure is particularly significant because India is the country with the second largest number of people with HIV in the world. New infections are increasing rapidly throughout Asia with the population growth and if current trends continue, India will soon have more people living with this killer disease than any other country. Nepal bordering with India has been experiencing the second highest number of HIV prevalence in the South Asian region.
1.2 RATIONALE OF STUDY

United Nations program on HIV/AIDS (UNAIDS) at the end of 2007 estimated that out of the 30.8 million adults world wide living with HIV, 50% of those adults living with HIV were women. It is suggested that 98% of these women are living in developing world.\textsuperscript{10} In recent years epidemiological evidences have shown that the HIV infections are increasing fastest among women. Especially women are interconnected with HIV infection and the vulnerability due to traditional cultural and sexual roles.

A number of studies have examined the role of gender inequalities on women’s risk and vulnerability to HIV/AIDS.\textsuperscript{11} According to Carol Bellamy, the Executive Director of UNICEF, pervasive gender inequality, and the violations of the rights of women that accompany it, is one of the most important forces propelling the spread of HIV amongst women. Inequality is apparent in laws that treat women as second-class citizens, in social norms and customs that deprive them of knowledge about their own bodies and strip them of the power to make independent decisions, in endemic and widely sanctioned patterns of violence and abuse, in inadequate access to health care, in the disproportionate burden women bear in caring for the sick and in holding ravaged families together.\textsuperscript{12} Also writing on this, Campbell posits that women are physiologically more susceptible than men to the transmission of HIV/STIs because male- to-female transmission occurs more efficiently than vice versa.\textsuperscript{13} Such societal and biological circumstances along with, where heterosexual contact remains predominant for HIV transmission accelerate the HIV prevalence in society especially to women.

In Sub-Saharan Africa the number of HIV infection were roughly half a million in men as well as half a million in women in 1985. Since then the number of women living with HIV has increased every year. In 2005 in the interval of two decades, HIV positive women were 13 million compared to 9 million men.\textsuperscript{14} Recent estimations by UNAIDS at the end of 2007
reported that 61% of women were infected by HIV in Sub-Saharan Africa. UNAIDS and the National AIDS Control Organization (NACO) estimated that 2.5 million people are living with HIV/AIDS in India in 2007, 39.3% of these were women. Heterosexual contact is the predominant modes of infection in both South Africa and in India. Women’s vulnerability to HIV infection in India has been attributed to their low social and economic status. India is facing HIV epidemic from high risk population groups to low risk population groups, spreading parallel with the increasing rural prevalence, and with the trends of large numbers of new HIV infections occurring in married women being infected by their husbands. Nepal has similar socio cultural and economic situation as the neighboring country, India. The HIV/AIDS situation in Nepal is not confined to specific groups or any regions. There are already evidences that HIV incidence is growing up significantly in rural parts of Nepal. Data in Nepal are not striking primarily to the male population. The gap of HIV epidemics between men and women seems to be closer. The HIV/AIDS epidemic is increasing steadily, spreading rapidly to wider population along with low risk population in monogamous married women.

Given the high prevalence of HIV among the female sex workers and returning migrant laborers, transition of HIV from high risk behavior groups to low risk behavior groups like house wives can’t be neglected following HIV infection from mother to children. Children are the future man power of the nation. HIV/AIDS lead to severe consequences which effects the development of mind as well as the health of children causes the direct loss of national economy in the country. Regarding the issues, I realized that it is essential to know about the HIV prevalence in Nepal and to identify the situation; which are the major factors and how the social, cultural and economical factors are correlated in the spread of HIV among men and women and especially to housewives.
1.3 STATEMENT OF THE OBJECTIVES

Generally the study seeks to examine the women’s level of HIV prevalence in Nepal. Specially, I will

- Analyze the gender and age specific HIV morbidity in Nepal, and to specify HIV prevalence for gender in different groups over time
- Identify the societal factors that induce the HIV prevalence
- Discuss the relationships between the societal structure and women’s vulnerability to HIV
- Identify the major factors that are influencing HIV prevalence in the society
- Identify specific factors that are contributing HIV prevalence among housewives
- Some recommendations to control HIV prevalence
CHAPTER TWO: RESEARCH METHODOLOGY

2.1 RESEARCH DESIGN

The present study is basically of a descriptive nature with both qualitative and quantitative data.

2.2 CHOICE OF METHODOLOGY

The qualitative research methodology contextualizes human behaviors and life styles in its real world from different angles through immersing in their socio cultural status or in situation and investigates the underlying attitudes, knowledge, reactions, behaviors and preferences. But some types of information require quantitative methods to detect the measurable difference in knowledge, behavior and morbidity pattern to complete the object of the research. Integration of such research methods help in order for decisions making. Viewing the fact, I employed both qualitative and quantitative data to reflect a more complete picture of issues that is being addressed.

2.3 SECONDARY DATA SOURCES

Secondary data means information that has already been collected by someone else and, which is available for, researcher. I gathered information from secondary sources. This research is primarily based on HIV infected population in Nepal, reported by the Ministry of Health and Population, the National Center for AIDS and STD control, Kathmandu Nepal (NCASC). NCASC Kathmandu Nepal provides reports of HIV and AIDS every month. The sources of information for NCASC are various Voluntary Counseling and Testing (VCT) centers
located in different parts of the country. For the data collection purpose, I requested to my family to make contact with the staff of NCASC, then the researcher made an approach to the concerned people and collection of data was possible via electronic media, and made the series of contact further to understand the data. To make it uniform pattern and to cover the total HIV affected people of that year, data was collected of the last month of those respective years.

I also used secondary data such as Nepal Demography and Health Surveys (NDHS) in order to get data regarding the over all situation of Nepal. The 2006 Nepal Demography Health Survey (NDHS 2006) is a nationally representative survey of people in Nepal as the part of the world wide Demography and Health Surveys (DHS) Project. The 2006 NDHS enumerated a total of 41,947 persons, enumerating of 53% females.

I also sought data from the internet sources, journals, articles, newsletters, leaflets magazines and other published or unpublished books. Similarly published journal, documents, from WHO and UNAIDS helped me to understand the HIV situation among the population of Nepal. It also listed research articles where additional information on HIV/AIDS and Sexual Transmitted Infections (STIs) are presented and regularly updated. After collecting data, collected data were carefully studied. The information was categorized and sub categorized in the tabulation form to make more clear and scientific. The HIV incidence of a particular year is derived from the difference of reported number of HIV cases in between two consecutive years, of the same year and the previous year. That then the data in tabulation form interpreted using of figure.

2.4 LIMITATIONS OF THE STUDY

Systematic and continuous surveillance systems are not yet institutionalized in Nepal. Low reporting rates are common due to weakness in health care and epidemiological systems.
NCASC provides reports of HIV and AIDS every month collecting from VCT centers only. VCT centers are not well phased all across the country. Only very few persons turn for VCT services, so it is clear that the total HIV prevalence number of Nepal are not included in this data. There are great variations in data from NCASC and other national and international organization so statistics of WHO/ UNAIDS and these numbers represent only the pin point. Due to the limited resources of data and updated was only available in NCASC; this study was carried out only by the reported data by NCASC and other relevant data published by different organizations. I remained in limitation to cover and to explain the different aspects of HIV situation in Nepal due to lack of data available. The result of this study does not cover the exact number of HIV positive people in Nepal. Comparison over the time is problematic because coverage of the data has probably changed over time. When calculating the reported cases of HIV for different groups or years, we have no information regarding the risk population, so we can only calculate absolute numbers, not prevalence and incidence rate; which strongly limit the possibilities of meaningful comparisons. I had difficult time to be clear in some parts of their derivation .I had to make several communications with NCASC staff. Since there was no proper research in Nepal it was difficult to get the data in the web page too. In Sweden, I was not able to get the publications written about HIV/AIDS situation of Nepal .I collected the different books, journals and published papers directly from the different organizations who are working with HIV/AIDS in Nepal, with the help of my family.
CHAPTER THREE: BACKGROUND OF STUDY AREA

3.1 BRIEF DESCRIPTION OF NEPAL, POSITION AND SIZE

Nepal is a South Asian independent landlocked country with a total land area of 1,47181 square kilometers. The country is bordered by the People’s Republic of China to the north and the Republic of India in three sides – east, west and south. The northern region of Nepal has various ranges of mountain peaks, where as east, west and south is surrounded by West Bengal, Bihar, and other northern states of India. Nepal is rectangular in shape and stretches 885 Km east to west and 193 km in width – north to south. Nepal witnesses the rich in three different broad physiographic areas; the Mountain region, the Hill region, and the Terai region. All three regions are parallel to each other, from east to west, being the continuous ecological belts and have bisected occasionally by the country’s river systems. For a small country, Nepal has the great diversity, ranging from the Terai plain situated at about 90 meters above the sea level and rising to about 1000 meters, in the south. Hill region is situated in between 1000 meters to 4000 meters above the sea level. The mountain region situated at 4000 meters to 8848 meters above the sea level in the north; this region contains eight of the world’s ten highest peaks including Mt. Everest.

3.2 CLIMATE AND VEGETATION

Nepal evidences the geographic diversity which experiences the five seasons; summer, monsoon, autumn, winter and spring. Nepal’s varieties of climatic conditions are primarily related to enormous ranges of altitudes. There are five climatic zones in Nepal broadly based on altitudes. The altitude below 1,200 meters has tropical and subtropical zone; the altitude ranges from 1,200 to 2,400 meters has the cool temperate zone; the altitude ranges from 2,400 to 3,600
meters has the cold climate zone; the sub artic climatic zone is of 3,600 to 4,400 meters in altitude; and the arctic zone is above 4,400 meters in altitude.\textsuperscript{21}

The variation of climatic nature has also great impact on the production of crops in different regions. Cultivation is very difficult in mountain areas with the limitation of human habitations and economic activities. Unavailability of transportation and due to high cost, herding and trading is common in mountain areas. Due to the climatic rhythms, herds settle to the temporary shelter. People migrate seasonally down to the low land along with their pack animals. They buy their necessities and sell their products during the period. Wheat, millet, barley, herbal medicine, spices are their products.

Agriculture is the dominant economic activities in hilly region. This region comprises Kathmandu valley which is considered as the most fertile and urbanized area. However a short growing season due to climatic influence in the region’s higher altitudes, which results the limitation of the multiple crops in some areas of hill region. This situation becomes more stress by the insufficient land to hilly dwellers which cause them poor socio economic situation. Rice, wheat, maize, corn, tea, vegetables and other cash crops are their production. People from hilly areas generally become seasonal migrants to engage in wage labor.

Terai (plain) region is the most alluvial land and richest economic region of the country in terms forest and farm. Rice, wheat, corn, sugarcane, tea, root crops, jute, tobacco, oilseeds, grains, fruits, vegetables are their products.

\textbf{3.3 POPULATION AND SETTLEMENT STRUCTURE}

The population of Nepal has increased from 23,151,423 (2001 census, Central Bureau Statistics,
2006)\textsuperscript{22}, to estimated 28,901,790 (July 2007), with the growth rate of 2.1\%.\textsuperscript{23} The density is 184 per square kilometer of total land.\textsuperscript{24} The pressure of population growth has led to fragmentation of land and depletion of forest products upon which most of the rural population depends. Growing populations leading over-exploitation of forests have made firewood and fodder extremely scarce in most areas of the country.

Table: Distribution of population in different ecological regions

<table>
<thead>
<tr>
<th>Ecological region</th>
<th>Land area of the total land</th>
<th>Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Terai region</td>
<td>23%</td>
<td>48%</td>
</tr>
<tr>
<td>Hill region</td>
<td>42%</td>
<td>44%</td>
</tr>
<tr>
<td>Mountain region</td>
<td>35%</td>
<td>7%</td>
</tr>
</tbody>
</table>


Settlement structure varies between the different ecological regions and the available facilities.\textsuperscript{25} Table above shows the largest number of the population inhabit in the smaller land area of Terai fertile land. Hill region covers the highest land area than any other region and large number of population. This region covers Kathmandu valley which has dense population and high mobility. Concentration of people in Kathmandu is high because of the opportunity, transportation, facilities and safety. Small numbers of people reside in the larger area of Mountainous region.

3.4 EDUCATION AND EMPLOYMENT

Though various campaigns are launching by the government to improve the school enrollment, one in four men and one in two women never go to school, and women are less educated than
men in Nepal showing the figure 49% women and 23% men have no education and 26% of female and 35% of male have only some or primary education (NDHS 2006). Only 48.6% of the total populations are literate of which 62% male and 34.9% female (2001 Census). Educational attainment is also related to economic status and rural-urban region. However there are significant changes in the educational attainment in both male and female, and education attainment are rising but large gender gap in education are existing.

Agriculture is the main sources of survival for three fourth of Nepali people (table below). Greater part of the gross domestic product and workforces depend in agriculture, while manufacturing industry comprises a small proportion of the gross domestic product and workforces.

<table>
<thead>
<tr>
<th>Economic sectors</th>
<th>Gross domestic products</th>
<th>Work forces</th>
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<tbody>
<tr>
<td>Agriculture</td>
<td>40%</td>
<td>76%</td>
</tr>
<tr>
<td>Services</td>
<td>41%</td>
<td>18%</td>
</tr>
<tr>
<td>Manufacturing industry</td>
<td>22%</td>
<td>6%</td>
</tr>
</tbody>
</table>


42% of the Nepalese people are unemployed in Nepal (2004). 86 % of female workers are employed in the agriculture sector. Most of them are not paid or get very minimal charge. Employment among women is inversely related with their level of education and wealth status. According to (NDHS 2006), 78% of women with no education are employed, while 48 % of women with secondary education or above are employed. Similarly, 90 % of women from poorest households are employed but only 49% wealthy women are employed. In contrast to women, 86% of men with high or basic education are employed, and 70% of men have earnings (NDHS 2006). Unemployment is a serious problem in Nepal. Millions of Nepalese people are
migrating for long or short term hoping to be employed for the better earnings.

3.5 HEALTH

Life expectancy in Nepal has improved by more than twenty years for male and female between 1971-2006. It was 42 years for males and 40 years for females in 1971. By 2006, it was 62.9 years for males and 63.7 years for females (World health report, 2005 and population projection for Nepal 2001-2021). Very recently the Federation of Safe Motherhood Network (FSMN) reported that maternal deaths are highest in Nepal in the South Asian region. Statistics point out that 281 out of 100,000 mothers die during postnatal stage, following three infant deaths every hour and one maternal death every four hours. Sexually transmitted infection is also becoming a problematic issue among the Nepalese people, especially among women. Socio economic status, lack of health care provider and health care services make difficulties for the care and treatment of sexually transmitted infection. It is necessary to understand the situation of the sexually transmitted infections in public health aspects of HIV/AIDS.

3.5.1 Sexual transmitted infections

Sexually Transmitted Infection (STI) prevalence in Nepal has been scaling up in the recent years. The STI prevalence rate in women is 4.7%. The infection with bacterial vaginosis could double a women’s susceptibility to HIV infection. STIs occur by sexual contact with the infected people, and especially with the individuals who are likely to have many sexual partners. Genital infections and bacterial sexually transmitted infections such as syphilis, gonorrhea, and chlamydia can be prevented by using condom or safer sex practices. Protection from STI means the prevention from HIV as well, as the risk of exposure and the preventive
methods for both are similar. The greater the numbers of STIs among the people are the signal of the higher chances of HIV prevalence in society.

The research conducted by Family Health and International (FHI) and United States Agency for International Development (USAID) in 2000 among truckers, 10% of truck drivers had at least one STI. STI prevalence was highest among the illiterate and informally literate trucker. Married truckers were more likely to have STI than unmarried trucker. The majority had syphilis, these groups of people are highly suspected to get HIV infection. The active syphilis correlates to the risks of HIV transmission. That would make them more vulnerable to their partners.

According to one other research, 47% of the female sex workers had at least one STI and 12.4% had more than one, 77% had untreated syphilis and 9% were HIV positive among STI patients. 68% of sex workers who had worked in Mumbai had STI, indicating that more than half of the sex workers in India were infected with at least one type of STI.
CHAPTER FOUR: BACKGROUND SITUATION TO STUDY AREA

4.1 BRIEF HISTORY ON HIV/AIDS EPIDEMICS IN NEPAL

The first case of AIDS was reported in Nepal in a foreign visitor in 1988. Since then prevalence has climbed steadily. Nepal’s National center for AIDS and STD control (NCASC) reported 10,546 HIV infections and 1,610 AIDS cases by December 2007, but the weak public health surveillance system in Nepal reveals the actual number of infection is expected to be much higher. NCASC estimated the HIV positive number to be closer to 70,000 in December 2007. In 2006 UNAIDS report revealed as many as estimated 75,000 people in Nepal were HIV infected including all age groups, among them 16,000 were women. If compared with other regions, Nepal belongs to the countries with low HIV/AIDS prevalence but the prevalence is increasing rapidly. Less than one percent of Nepal’s adult populations are estimated to be HIV positive. The major mode of HIV infection in Nepal is heterosexual contact, although some transmissions are reported through intravenous drug use, homosexual contact, and prenatal transmission and blood products.

HIV Sentinel Surveillance (HSS) survey scattered in Nepal in November 1991 for the first time and conducted a series of surveys. Surveys covered different sites of Nepal and blood specimens were collected from sex workers, STI patients, injecting drug users, ANC women and tuberculosis patients. 1.7% (1 among 60) of FSWs from Nuwakot and 10% (4 among 40) of FSWs from Dharan and Morang districts were reported to be HIV positive. The second round of HSS survey that took place on April/May 1992 detected 0.7% HIV positive among female sex workers and 0.5% HIV positive in STI patients, and latter in the same year in the third round of HSS survey showed an increase to 1.2% among female sex workers and 0.7% among STI patients. The fourth HSS survey carried out in May/June 1993 showed that slightly decrease of HIV Seroprevalence among the FSWs by 1.1% and increase in STI patients by 1.1%. This
fourth round 1993 survey for the first time showed the HIV prevalence in the general population in low risk group from Ante Natal Care (ANC). Following the fifth and sixth round of HSS survey in 1994 July and in 1995, HIV prevalence stood in the same position. In 1993, HIV prevalence in sex workers were estimated 1.3% outside major urban areas and 0.97% in major urban areas. HIV prevalence was mostly limited only in sex workers during those years.

A survey conducted in Kathmandu in 1997 revealed 2.7% of sex workers and was increased to 17% in 2000. The prevalence of HIV among street based sex workers in Kathmandu was 15.7% in 2001 compare to 2.1% 2004 and 1.4% in 2006. HIV prevalence among sex workers in high way street also decreased significantly since 1999 from 3.2% to 1.5% in 2006.

HIV infection increased among Intravenous Drug Users (IDUs) markedly from 1995-1998. NCASC in 1998 estimated about 20000 IDUs and 48% HIV positive among them further suggested one third of HIV prevalence was among them. Research conducted in 1999 reported about 40% HIV prevalence on national level among IDUs and 68 % in Kathmandu. Similar observation was observed in 2004. In 2005, FHI reported a decreased prevalence from 68 % to 52% among estimated 5000-6500 IDU in Kathmandu. Integrated Bio Behavioral Survey in 2007 showed the highest HIV prevalence range from 6.8% to 34% among IDUs depending upon the location including Kathmandu.

With the estimation of about 7000-20000 MSM in Kathmandu, HIV prevalence for the first time recorded was 3.9% in 2005 that was 2 out of 53 in Kathmandu valley.

FHI in 2005 stated that nearly 23% of migrants who were seeking service to Voluntary Counseling and Testing (VCT) center were found to be HIV positive. According to NCASC 2007 estimations, 41% of HIV cases in labor migrants and 21% among housewives or their
partners. HIV prevalence varies by location in Nepal. According to NCASC 2007 estimation; 49.7% of HIV in Terai region, 16% in Far western region and 15.7% in Kathmandu. The review of HIV epidemics in Nepal clearly pictured the HIV prevalence was spreading among sex workers and STI patients in the earlier stage, and now prevalence rates are increasing among high risk group population such as sex workers along with injecting drug users, men who have sex with men and migrant workers.

UNAIDS/WHO:47 “Some countries have avoided HIV epidemics for many years despite significant levels of injecting drug use, commercial sex and infrequent condom use. However once HIV establishes a firm enough presence in at risk population groups, it can spread extensively among and beyond them as several Asian countries have discovered.”

According to the statement above by UNAIDS/WHO, it can be understood that HIV has already been established a firm in several risk groups in Nepal. The HIV prevalence has established a firm and aggravated also because it was impossible to regard a problem of HIV interventions aggressively during the transition period of country’s social development, civil war and political turmoil. Now there are high chances of extensive spread among and beyond them. The prevalence of HIV in general population is indicating that HIV infection is rapidly increasing in housewives.

4.2 RISK GROUPS AND HIV VULNERABILITY

Risk groups and HIV prevalence are not uniformly distributed within a particular ecological region in Nepal. It varies between the different rural and urban areas. It is also associated with the extension of high ways, urbanization and mobility status of those particular regions. Commercial female sex workers, client of sex workers, migrants, intravenous drugs users, and
homosexual men are considered as high risk groups in Nepal.

4.2.1 Female sex workers

Different surveys and reports have confirmed the stabilization of the HIV prevalence among FSWs. It is suggested that the sex workers largely contribute to increase the HIV prevalence in Nepal. Surprisingly, HIV epidemic among FSWs in Kathmandu valley in 2001 was 16 %, higher than the figure among India- Karnataka´s female sex worker in 2004.

An average of nearly 20 female children a day trafficked to India and Middle East from Nepal. US experts stated that 40% of Nepali sex workers were found to have HIV positive on their return to home from India, but Nepali experts stated the number could be up to 90% as they are not sent home unless at first they are known as infected. The girls are yet to reach the sexual maturity at the age of around fourteen or younger are involving in sex trade in India. The longer the captivation in brothels and in the younger age the higher chances of HIV contraction in individuals. Harvard researcher explains the popularity of fairer featured younger Nepalese girls in Indian brothels result the captivity for longer periods and the greater chance of HIV contraction to them. Nepalese girls are more often considered as virgin than any other racial girls, are commonly perceived by Indian men and highly prized in India’s sex trade following the virgin myth “unprotected sex with them will cure HIV/AIDS ” as younger are less likely being infected by HIV.

Once drawn into the web of trafficking and sexual abuse, trafficked girls have significant chances of contracting HIV/AIDS, because they have no ability to control their bodies. But they are submissive, and engage in extremely risky sexual behaviors.

A study of sex workers in Nepal’s Terai region found 4% of sex workers were affected by HIV.
among the 17% sex workers who worked in Indian brothels. Research has also shown that almost 40% of women and female children who have been rescued from brothels have tested positive for HIV. Maiti Nepal an NGO, focus on the prevention of girls trafficking; rescues about 60 girls and women each year from India and confirms that 30% to 60% HIV infection among them. The greater chances of HIV contraction in sex workers have been signified by the experience of one of the victim’s experiences who rescued by Maiti Nepal; among 70 sex workers 40 were Nepali in the brothel where she was working. They had to have sex with many as 40 men some days and at least 15 clients per day. Sometimes they had to suffer with gang rape. Pregnancy, sickness, infections and infrequent use of condom were mostly common as clients visiting to brothel refuse condom.

4.2.2 Clients of female sex workers

Estimation of the number of clients of sex workers and to find out which categories of professions those are more likely to be the clients of sex workers and get into prostitution is more difficult to find, than to estimate about the female sex workers. The migrant workers, wage labors, transport workers, highway drivers, army, and police usually become the clients of sex workers. One study showed that the proportion of having sex with female sex workers increased by 20% for each group (42% to 62% for transport workers and from 10% to 30% for migrant workers within one year period of time (2000-2001). Similarly one cross sectional study reported that only 60% of transport workers and 45% of migrant workers used condom consistently.
4.2.3 Intravenous drug users

Drugs named as Heroin entered in Nepal for the very first time in 1960s. Latter in 1990s, Tidigeic (brand name) replaced Heroin in cheaper price. IDUs are widely spread in different parts of the country, mostly in Kathmandu, Pokhara, and Terai region which are nearer to India like; Biratnagar, Dharan, and Jhapa. Drugs are imported from bordering towns of India. IDUs pose high risk by using same drug equipment, and by unsafe sex practices. 60

4.2.4 Men sex with men

Men sex with men (MSM) is out of norm among the population in Nepal. Homosexuality is illegal in Nepal under a code of unnatural sex. Nepal Supreme Court recently ordered government to end discrimination against Lesbian, Gay, Bisexual and Transgender (LGBT) and to treat the same rights as other heterosexual citizens.

The exact figure of homosexual men and the HIV prevalence number among them in Nepal has not been registered. About 40000 LGBT have been recorded in Nepal. 61 On estimation on the basis of their nature of high risk behaviors suggest that HIV prevalence must be high in MSM community. There are also reports among this group who had been to Indian brothels and was infected with HIV by unprotected sex. 62 Men of these groups are also married with children and have numbers of sexual partners. 63 Dance bars and restaurants in Nepal, especially in Kathmandu are the common location of commercial male to male sex. Both Nepalese and foreigners seem in these places. 64
4.3 AWARENESS AMONG PEOPLE TO PREVENT FROM HIV INFECTION

4.3.1 Knowledge of HIV/AIDS

According to the findings of NDHS 2006, knowledge of HIV/AIDS is broadly spread in Nepal and the level of knowledge among the population has increased from 72% in 2001 to 87% in 2006. 69% rural women have heard of AIDS compared to 91% urban women. People of ages 15-24 have relatively good knowledge of HIV/AIDS compared to other age groups (NDHS 2006). Married men and women are less aware than their unmarried counterparts, and married women have lowest knowledge of HIV/AIDS. Men have high level of HIV/AIDS knowledge compared to women. The knowledge, awareness of HIV/AIDS in Nepal is not uniform across the country. Knowledge of HIV/AIDS, its modes of transmission, and how its infection could be avoided is greatly associated in their background characteristics like rural/urban dwellers, wealth status, and educational attainment. Knowledge of HIV/AIDS is also inadequate among MSM. However the attitude, knowledge of HIV/AIDS and sexual behavior of street children are not known properly. It seems that this group is stretching towards the high risk group as they are vulnerable to sexual abuse, unprotected sex, and drugs use. Research conducted by UNESCO/CREHPA 2005, showed that 75% of street children have heard of HIV/AIDS. The research found that only 9% to 29% street children use condom among the total respondents. Similarly anal sex was reported in 29% among them. Two independent test conducted by NGO in Katmandu showed that 31% of street children were infected by HIV, and 16 out of 32 (50%) high risk children were HIV positive. NDHS findings also have shown the wide spread misconceptions in Nepalese people that HIV can be transmitted from mosquito bites.
4.3.2 Knowledge of condom

Condom is only the best preventive method to perform the safer sex to prevent HIV infection. The knowledge of using condom and their advantages in preventing HIV transmission and control of HIV/AIDS is less among women than man that is 58% of women and 84 % of men respectively. Education has a great impact on knowledge of use of condom .Women with education have knowledge of condom compared to uneducated women .Migration also plays positive impact on knowledge of condom. NDHS 2006 shows people who remained way from home are more likely to have the knowledge of condom .Also, the Men who Sex with Men perform risky behavior not using condom or inconsistently use. Similarly, most of the street children do not use condom though they have heard about HIV/AIDS.68Save the Children US in 2002 observed that, the majority of respondents had ever heard of condom. Some never used condom and considered as a means of contraception, rather than protection from STI/HIV/AIDS.69
CHAPTER FIVE: SOCIETAL NORMS AND PERCEPTIONS AND ITS VULNERABILITY

In order to understand the spread of HIV/AIDS it is imperative to address economic, social, and cultural and political issues that impact on HIV spread in society and HIV infection in women. Socio economic factors and its relations, including those related to education, employment, occupation and sustenance link the phenomenon of women’s vulnerability in HIV/AIDS.

5.1 SOCIO CULTURAL CONDITIONS

Girls and boys are socialized according to the prevailing culture and tradition from their early life. Nepali culture has internalized the norms and virtues derived from the Hindu tradition. Women have played crucial roles in Nepali societies. They perform mostly all domestic tasks; they bear children, look after the needs of the family and obey the parents and male households. Hard work like fetching water and sources of fuel for cooking are part of their work of all age groups of women especially in rural region. Girls have fewer opportunities for education and training; they are attracted to household chores such as catering, sewing, parlor, if they think of the vocational training. These norms tend to make women uneducated and therefore they cannot generate the attitudes of improving their lives.

Societies always concentrate to make girls skilled on household affairs, try to train them to be a good housewife to serve husband and her children. Girls are seen as a burden to their families and are married off at an early age. However the early marriage is a violation of human rights, it is just becoming the theory in the air. Nepalese people are not following the rules and practising for the early marriage. Usually Nepalese girls have arranged marriage at their early age.
Family, relatives, elders mostly decide for their marriage; when to marry, to whom to marry. This custom is dominant in Nepalese society, and strongly emphasis on virginity. After marriage her prime duty is to please in-laws and husband.

Traditionally men and women play different roles in society. Women work harder and longer than men, for the most part of the time they are expected to stay at home, are supposed to be in kitchen and remain subservient to their husband. While men for the household earnings, discuss the important issues concern in the home and in society, and in decision making process.

Socio-cultural norms prevent both women and men from obtaining critical information about sex, sexuality and HIV/AIDS/STI. For instance, Nepali people are bounded by the culture of silence around sexual matters. Cultural value such as shyness prevents open discussion and education on sexuality and reproduction thus leaving adolescents to acquire HIV related information from their informed peers. People feel odd to listen and discuss in such subjects among the family members. This can be illustrated by the experience of a radio program in Nepal, called “Chatting with my best friend,” that spread the knowledge and awareness of HIV/AIDS. According to program producer, “program initially received many letters complaining against the discussion on use of condoms, sex and sexual organs”. 71

5.1.1 Gender issues

There are greater differences at the level of gender in social, cultural and economic aspects. These differences rise from biology, sexual behavior, and socially constructed gender-differences in roles and responsibilities, and decision-making power. Although the government states that “all citizens are equal before law, no discrimination against any citizen on grounds of
sex”. Despite the principle, son preference starts from birth; the differing ways of rearing a girl and a boy child, wedding grace for newly married couple is to give the birth of ‘son’. In such son preference society male member of the house eat earlier than female member. There is vast parity gap of participation of girls in educational attainment compare to boys although there is the theory the equal access to educational opportunity for both boys and girls. Education for girls is often regarded as a wasted investment demanding every girl will be married and leave the family. Women have fewer opportunities of education and less access to health care. Many women have to obtain permission from their husband or relatives to access health care or reproductive health services. Women have played only limited roles in family decision-making. Women have particularly no rights for pregnancy. Husband and in-laws usually decide to about when, how many and how often to get pregnant. Traditionally high son preference has extra pressure for the women, giving birth to daughters only increase the chances of her husband to get associated with other women.

Notions of masculinity are associated with pride, machismo that emphasizes multiple sex partners and taken as normal for men, are embedded in Nepali society. However men show the promiscuous behavior, it would be never accepted in women. Women’s lack of sexual autonomy and male sexual freedom is in imbalance in power in gender relation between men and women that possess vulnerability in HIV. Many female do not refuse sex in order to avoid physical abuse and maintain the stability of the relationships. Abuse, rejection, threats are the result of refusal of sex. She also has fear of facing being divorced or separated; or her husband would accept other woman. Even economically empowered women not only have their own share problems in relationships, but also face the same barriers in bed room as non working women. Two thirds of the seven hundred girls expressed their experience of discrimination at school, at home or in community; their further view to that of boys as such for discrimination are as their ability to earn, support parents and bring dowry.
5. 1. 2 Stigma and discrimination

Nepal is monogamous society. Extramarital sex is strictly out of norm and unaccepted for both sexes. Traditionally it is marked by social evil. However those norms do not apply to men and women equally. Females violate the norms are harshly criticized. It is regarded as normal for men in society like indulging pleasure. But women are always adhered to be careful and virtuous, get HIV would be a shock for the families and society and would be hard to accept.

On the other side HIV/AIDS has been associated with prostitution and concerned with promiscuity. Religious or moral beliefs lead people to believe that HIV/AIDS is the result of moral fault such as “promiscuity or deviant sex” and is considered as bad person’s disease and the result of bad deeds in early life so they are deserved to be punished.

Prostitution and drugs use are against the moral and traditional customs. For the reasons HIV/AIDS are highly stigmatized and discriminated. On the other hand men sex with men are also stigmatized and discriminated in the society as this is against the nature, which leads to double stigmatization, being the MSM or drugs users along with HIV positive make them their situation more worse.

Fear of stigmatization and discrimination prevent people from accessing testing and treatments services and make them vulnerable to HIV/AIDS infection. The self stigma and hostility in the people living with HIV/AIDS inhibit people from disclosing their HIV status, not to seek medical assistances or advices and remain in shadows, passing the infection to others.
Divorce also has a social stigma; it is not accepted in society. Divorced women face difficulties to remarry, and have to attempt to establish independent household. A divorced woman often returns to her family, but is not wholeheartedly welcomed.

5.1.3 Religion

Nepal is a Hindu country. More than 80% of people are Hindus followed by Buddhists, Muslims, Kirats, Christians. Nepali people are religiously conservative. Nepalese are “profoundly and incurably a believer” and religion impregnates the entire texture of Nepali life. Nepalese mostly in these communities are governed by traditional cultural values and religion. In many ways, these stand as a barrier in the holistic development of Nepali women.

Religiously women remain fast for a whole day without water in a special festival called ‘Teej’, and they drink water from husband’s toes at the end of ceremony for their long life and prosperity. They keep light oil lamp and stay up all night. Unmarried girls also celebrate the festival with the hope that will get married to a good husband.

Custom such as Sati Pratha (widow burning) – (burn herself alive into the funeral pyre of her deceased husband), that had been practiced for a long time in Nepal, however that is not existing now. Both the points clearly reflect that Nepalese have been in a society where women are of utmost respect.

They consider their husband as their deity. Women are highly dependent to their husband. Faithful, loyal, spirituality, emotionally and physically, sacrificing, devotion are their notions; such are the model of the Hindu women.

Female virginity is highly valued in Nepali society. Parents tend to marry their daughters at an early age to avoid premarital sex and pregnancy. Religiously marriage is encouraged to the necessity of ‘pure bride’, so early marriage has been embedded in religious belief, eventually
resulting in the child marriage in vogue. Traditionally social and religious values believe in the marriage before puberty, before menstruation starts.\textsuperscript{74}

5.2 ECONOMIC ISSUES

Nepal’s social indicators remain below the average among the South Asian region. Nearly 32% of the populations live below the poverty line.\textsuperscript{75} Internal conflict, political instability, ineffective policies are weakening the country’s economy drastically. The country’s situation and its consequences like unemployment, high market price make poor life more stressful. Those situations drag a rapid growth of internal sex trade, women trafficking into commercial sex and huge migration to sustain the life.

Poverty means having little or no voice, no power in decision-making processes. It also translates to vulnerable to abuse, violence and dependent on risky means of survival. Poverty is also associated with poor education, health, nutrition and lack of opportunities.

5.2.1 Sex trafficking

There were common customs to sell or present beautiful girls to the palace to serve as concubines and maids in late 1951.\textsuperscript{76} That kind of trafficking has ceased but has been placed by ‘cross border trafficking’ these days. Girls currently trafficked to India and other destinations are abducted by traffickers; they are selling by their own parents, husband, relatives of their husband, or friends of their kin.\textsuperscript{77}

Some parents indulging in poverty sell their daughter as a source of family income for little as only in US $ 200 to an agent. Then they transport across the porous border. Brothels usually pay
$1,700 USD for a beautiful Nepali woman. Sex work is becoming the phenomenon of economy that has become the main source of income for survival in some parts of Nepal. Remittances from them provide many rural families with a relatively high living standard. Poverty usually is the main stem forces to dive into sex trade. Findings have shown that those girls are usually pressured by poverty and dire economic circumstances. Sex trade has become the best option to less privileged and uneducated women as it is higher paid than any other unskilled labor. The numbers of commercial male sex workers are also increasing in Nepal. Male sex workers report the earning of Rupee 10 to Rupee 50 from their work. They also work in restaurants and massage parlors where they can earn up to several thousand Rupees.

5.2.2 Migration

Nepal is the least developed country in South Asia. About 85% of the populations subsist from agriculture. Poverty, unemployment, declining natural resources, and political turmoil are the major reasons for long or short term labor migration that has become the source of income. Moreover the conflict and the political violence have accelerated the traditional economic migration from rural and hills to urban centers of Nepal and India.

Nepal and India share an open border. Nepalese and Indian can travel and work across the border and are treated at par as the native citizens. Especially rural Nepalese people, who have been suffering from poverty, unemployment civil war and political turmoil, have been migrating to India in thousands every year. The 1991 Census of Nepal recorded that 89% of the total migrants had been to India. Nepalese people, whether they are women laborer, children, or men laborer, they cross the Indian border for work. Migrant people in India, work as Indian government servants, watchmen, factory workers, domestic helpers, restaurant workers, drivers, porters, sex workers. Around 8000 people crossed the border every week at the end of 2002.
Similarly Indian Embassy officials reported that some 120000 displaced Nepalese crossed India during January 2003. Save the children Norway Nepal (SCN-N) reported that some 16,871 children entered India for safety and search for opportunity during three months span 4 July -4 October in 2004. Though there are not official reports of migration in India, because of the open border, but it is estimated that about 1.3 to 3 million Nepalese migrants live in India and numbers are rising continuously.

Nepalese people have also been migrating to other countries as well, like the gulf countries. Skilled migrants who have enough resources and literate have been migrating to the USA and Europe. According to report of the US embassy in Kathmandu; Nepal came among the top twenty countries and became the 19th leading country of origin for international students in USA.80 Other groups who have some resources and are not much skilled go to South East Asian countries, mainly to Singapore, Malaysia, and the Middle East. But the first choice for a majority of illiterate or lowly literate, unskilled and marginal population of Nepal has been migrating to India. Recently Nepal’s minister for labor reported that the number of Nepali workers leaving for overseas jobs during five months from ending December 2007 increased by 35 %.81 Nevertheless internal migration is also more in practiced. There are millions of people who enter urban area in search for opportunities. The Nepal government’s National Health Research Council found out that the most Nepalese migrants have more than one home, the city/town/village where they originally came from and city/town where they work.

5.3 CONFLICT AND POLITICAL SITUATION

The civil war in Nepal started in 13th February 1996 by Maoists and it ended with an agreement signed on 21st November 2006. During the civil war, the Maoists dominated the rural areas of almost all around the country and the government was limited in main city areas. Health posts,
schools, village councils, civilians, NGOs, INGOs, police booths, army barracks were targeted by the Maoists when the insurgency started. There were indefinite numbers of traffic ban on the roads in different districts and in regions. In addition of halt of vehicular movement and blockade of the main high way, they looted the imported food on the way that made the food shortage in the market. The Maoists announced blockade of the capital city in 2004 and unrest reached on its peak. And intense situation and unrest continued into 2005 with the numerous deaths. Land mine explosions, bombs and ambushes were common in different sensitive places and on the roads and streets. Abductions and disappearances raised in the country making people frightened for everyday lives.

Nepal had already a low economic growth rate and a high inflation. The conflict and unstable politics further deteriorated the economy of the country. The economy of Nepal was adversely affected by the unstable politics and the Maoist insurgency since 2001. The GDP was declined from 3.5% in previous years to 2.3 % during the year 2004-2005. Agriculture that supports 40% of country’s GDP was badly hampered by the Maoist insurgency. Lots of people migrated internally and externally to escape from violence, seeking for employment and safety. Estimated about 200000 to 500000 at least were internally displaced and more than 400000 people crossed into India. Though the Maoist movement ended up officially in paper, the political situation has not been improved. The present situation has not been settled with ongoing unrest. Violence, strikes, threat, looting, abductions, attacks, clashes, thrashes and bomb blasts are still going on making people’s daily lives intense.

5.4 LEGAL SITUATION

In Nepal, women are lacking legal resources, and experience discrimination in legal rights and protection. Many systems of law favor male ownership of property or assets. Women are
discriminated by law in the inheritance of property rights. Men can divorce their wives or can take a second wife without divorcing if she has not produced a son by 10 years or not giving birth to any children after the marriage date. Legal systems do not protect victims against sexual violence between intimate partners. There are not any specific laws to deal with domestic violence against women. There is very limited time to file the rape case or such sexual violence. Women have to wait for years for any justice.
CHAPTER SIX: RESULTS

6.1 GENDER AND AGE SPECIFIC HIV MORBIDITY

Government of Nepal NCASC reported a total of 10546 HIV positive people by December 2007. Among the total reported cases, 31% were females and 68% were males as of December 2007.

Figure 1: Reported HIV incidence by gender and year of diagnosis

Source: Appendix1, Table 3; NCASC report.

Fig 1 above based on the reported cases shows that HIV positive cases in females have been increasing since HIV prevalence started in Nepal. Though there were no constant rising of HIV reported cases in female in previous years; that reported only 19 % in 1997, but seems rising in recent years from 24 % in 2000 that reached up to 35 % in 2006 and 39% in 2007. The figure 1 above shows the new HIV positive cases in male were 65% in 2006 and 61 % in 2007 among all the reported cases.
Figure 2: Reported total HIV infection in different sub groups in 2007

According to NCASC report of HIV prevalence in different sub groups; figure 2 above shows that clients of sex workers pose the highest number of HIV infection among all sub groups following by housewives, injecting drug users and female sex workers that shows the 46 %, 21 %, 19 % and 6 % respectively as of December 2007.

Source: Appendix1 Table 4; NCASC report
Housewives and sex workers have higher proportion of HIV incidence among the HIV affected female population. Though HIV infection in women started from its early epidemics, gradual increase of HIV infection in housewives started from 1992 only, with the minimal number till 1996. The new reported HIV cases in housewives among all the HIV females are constantly increasing, that was 65% in 2005 then reached up to 87% in 2006 and 78% in 2007, fig 3. The proportion of HIV prevalence in housewives is increasing rapidly and about ¾ of the total infected women are housewives.

Source: Appendix1, table 5; NCASC report
Female sex workers have the second highest HIV reported cases among HIV affected female population. The fig 4 above shows the gradual decreases of HIV cases in female sex workers from 61 % in 2001 to 15 % in 2004 and 4 % in 2006 then shows the increase projection to 8% in 2007.

Source: Appendix 1 table 6; NCASC report

Figure 5: Reported HIV incidence among male sub groups by year of diagnosis

Source: Appendix 1, table 7; NCASC report
Clients of sex workers and IDUs have the highest proportion of HIV incidence among reported HIV affected male population in Nepal. Fig 5 above illustrates the new HIV reported cases in clients of sex workers in 2001 were 83% and declined to 50% in 2004; in 2007 the new HIV reported cases were 61% among all reported male cases. Proportion of HIV incidence among IDUs were moderate compare to clients of sex workers; the new HIV reported cases in IDUs were increased from 16 % in 2001 to 48 % in 2004 and then had declined to 24 % in 2007.

**Figure 6: Reported HIV incidence among female age groups and year of diagnosis**

Source: Appendix 1, table 8; NCASC report
Figure 7: Reported HIV incidence among male age groups and year of diagnosis

Fig 7 and 8 illustrate that HIV reported cases in both male and female children of age group up to 9 were 4% from 2004 to 2007, among all age groups. The most affected age groups were 30-39 for both male and female. Among female, 31% of all infected by HIV in 2004 were in the age group 30-39 then raised continuously up to 38% in 2007; and 41% of all HIV infected male were 30-39 age in 2004 that rose up to 43% in 2007. This age group is followed by 25-29 and 20-24 in both male and female.

Overall it is here clear that the growing and continuing challenge of HIV/AIDS prevalence is becoming concentrated in women in Nepal especially in low risk group housewives. The number of new HIV reported cases of females were 19% in 1997 and 39% in 2007 among the affected population. While new HIV reported cases of housewives were 33% in 1997 and 78% in 2007 among the total affected women.

Source: Appendix 1, table 9; NCASC report
6.2 SOCIETAL FACTORS THAT ARE INFLUENCING HIV VULNERABILITY

6.2.1 Socio cultural factors

Gender dimension has deeply entrenched in Nepali society. Gender dimension is there, because women and men experience differently and unequally in society. Women nearly half of the population in Nepal are the victims of the inequality, disparity, discrimination. Gender dimensions along with the cultural and religious justifications are making the girls marrying at early age that deprive them from the educational opportunities and knowledge. These increase the HIV vulnerability to women in Nepal.

However the age at marriage has risen up over the years, early marriage is practising in Nepali society especially more in rural areas. According to UNICEF 7% of marriages take place below ten years old in Nepal, while 40% of marriages take place below 15 years following 52.2% percent marriage take place in age at 16. The more the younger the more they are vulnerable as the younger are physically and sexually immature. The research in developing country showed that the majority of girls of age 15-19 are married and they are more likely to have HIV infection than their sexually active unmarried peers.

Culture of Nepali does not permit a female to make her choice in marriage and without influence or the permission of parents or the relatives. Kinships practices are vary across the different ethnic groups. Some ethnic groups of the Himalayan region practice polyandry (a woman is married to all the brothers in the family). Some ethnic groups married to her brother in law in her husband’s death. Such fragility of the marriage contributes the risk of HIV infection in women. In such marriage women’s fidelity may not protect her from HIV contraction; her husband’s risky sexual behavior during marriage may put her at risk for HIV
infection.

Separation and divorce are like a social misfit in the society and are highly stigmatization in society. Nepali societies that feel divorce is never being an option, regardless of how abusive or adulterous the husband may. Women always feel fear that they will be abandoned by their husbands or supporting partners if they try to exert control over how and when to have sex and whether to use condom, which adds the women in greater risk in HIV.

Men take the role to decide for the number of children to give birth to, and the child spacing. Moreover the son preference in the society and in the family those make women for high susceptibility to HIV infection as these limit to control the safer sex.

6.2.2 Socio economic factors

There seems to be a big gender gap between males and females in school enrollment process though government’s effort to make more female educated .The drop out rate is higher for girls. Education and employment are closely related to each other .Education and employment level in the society among men is higher than women, so the males have higher income earning power. Low level of education among female results the high level of unemployment and low earning power. Lack of education and training drag them to more vulnerable to poverty and women with low or no income may be prone to HIV infection as they force to undertake sexual risk .This situation has serious implication for the spread of HIV among Nepali women.

The social status also influences the people’s ability to acquire and to improve their economic situation, their position in the society determines their ability to acquire and mobilize the resources. As there is the gender dimension in the society, females show less educational
attainment and less opportunity to be employed so less capability to earn a living. Most of the Nepali women are primarily limited in the farming is assured that they have not acquired education or training. Some women with some years of education continue to work in low paid jobs such as cabin restaurants, message parlors, discos, dance restaurants, factories, and business offices and get nominal salaries; their low incomes, low status and lack of alternatives make vulnerable to abuse. While some are employed in the formal sector often occupy supporting positions, and as a result are subjected to sexual exploitation by men due to their low social status.

Nepali women’s economic positions are marginalized, dependence to others, even eroded leading to increasing vulnerability. Low economic status women coupled with the inadequate health facilities prevent women from the treatment of the STIs, for instance one in five Nepali women died from pregnancy related causes (NDHS 2006). This contributes to the worsening of women’s health and facilitates that induce the spread of HIV.

Women are marginalized or left out especially in decision making process and are deprived from facilities such as schools, health care center, police stations. These result increase the migration which leads to the HIV risk among women. This coupled with cultural factors including lack of opportunities for women, especially in inheritance systems that compel them more to migrate and survive by selling sex.

6.2.3 Political factors

Political imbalances along with the conflict deteriorate the country’s situation badly. People search the alternative sources for survival of life and seek safe places to escape from the violence. They may loose their job and the rises of market values make their life difficult. Lack of available employment opportunities and income sources force both male and female to
migrate in order to sustain the lives. The migrant workers leave away from their spouses and visit after some interval of time and their risk behavior in their working place will lead them HIV infection. If that agent contracts HIV/AIDS their spouse also becomes infected. The effect of migration is significant in the transmission of HIV/AIDS in both male and female.

6.2.4 Physical factors

Nepal is a country which has the evidences of different geographical situations and variations. Environmental degradations normally due to monsoonal flooding that may have the potential displacement from their land, rural homes, and livelihoods. Rural people depend upon the agriculture for their livelihoods. People depend upon natural rainfall for farming and irrigation. Their high level of dependency on the agriculture results in greater shock in the unfavorable environment; lack of rain, drought, flooding or landslide. That increase the rural poverty and affect their livelihoods. This compels hundreds of men and women to migrate to urban or neighboring country in search of wage labor to subsist, that prompt the HIV infection in the society.

6.3 RELATION OF SOCIETAL STRUCTURES AND VULNERABILITY OF HIV AMONG PEOPLE ESPECIALLY WOMEN

According to NDHS 2006, sex paid is considered as ‘high risk sex’ is more prevalent in urban areas among the men who have secondary and higher education. One out of five men reported sex with some other than spouse or cohabiting partner; 3% of men of age 15-49 reported sex with two or more sexual partners; higher risk behaviors also reported from the age group 15-49 (NDHS 2006). Payment for sex is slightly higher among men who have been away from home
or men of wealthy background. Around 1% of men were reported for sex paid in Nepal (NDHS 2006). A study conducted in 2006 found that 27% of migrant men engaged in high sexual behavior, those frequently visited sex worker while in India in their working place. It has also been suggested the several thousands of Nepalese are migrating to urban areas within the country or in abroad in search of jobs and for the better earnings. On the other hand women’s low level of status makes them unemployed or to work in low paid jobs in agricultural sector or in non-agricultural sector; inside or outside the country. Female unable to accesses basic necessities of life due to lack of money. Such female in society tend to develop different survival strategies such as exchanging sex for money. Widespread poverty drives women into sex industry (Population Bulletin 2002). Such women may take maximum risk of engaging in unprotected sexual intercourse for financial favor. Due to financial favor by men or material dependence on them mean women cannot be in controlled when, with whom, and in what circumstances they have sex (UNAIDS 1999). They tolerate unsafe sex by exposing her to HIV infection to gain money or favor. This then, they make themselves vulnerable for HIV infection in the society.

“This correlation of men with cash and power in hand while women in the same ground needing and seeking for their subsistence, make risk at HIV prevalence in women.”

The above phenomenon coincides with the increases prevalence of HIV among clients of sex workers, migrant workers along with the sex workers in Nepal. Fig. 2 shows that the proportion of HIV prevalence was 46% in clients of sex workers as of 2007. Fig. 5 explains the increasing pattern of new HIV cases among clients of sex workers reached up to 61 % in 2007. NCASC in 2007 estimation reported the 41% of HIV among the labor migrants in Nepal.

“These actions in the ground and the phenomenon coupled with ‘risky sexual behaviors of male’ aggravate more HIV prevalence in the society.”
Intravenous drugs users show the second highest HIV cases among the male population. Fig 2 shows the proportion of HIV prevalence was 20% in IDUs by December 2007. Fig 5 shows the new HIV positive cases among IDUs was 24% in 2007. Study found out that one in three IDUs had sex with at least one female sex worker in the past 12 months of survey, and 70% of those had sex with more than two female sex workers (FHI and NCASC 2002; FHI, New Era, and SACTS 2003). Similarly a study conducted by FHI in 2005 has showed the risky behavior among IDUs, 93% IDUs were men, having sex with female partners and majority did not use condom and further showed that the infrequent use of condom with regular and non regular partner.

The proportion of HIV incidence among homosexual men is also rising steadily. Fig 5 explains the new HIV reported cases of MSM among all infected male in 2006 was 0.57% and 2.09% in 2007. Though the figure seems lower, UNAIDS have warned these groups that have shown high risk behavior. Their risk behavior can be illustrated by the given account:

“I had anal sex for more than one hour. I also had bleeding. I also had feeling of itching. I take medicine when I have such problem nowadays. After that I had anal sex with a lot of people, not less than 500 times.”

The research found 3.9% (2 out of 53) HIV prevalence among MSM, further reported only 63% used condom with their non commercial partner in Kathmandu. Homosexual men perform sex with male partner or female partner or with female sex worker coupled with anal sex and inconsistency condom use, such risky behaviors make vulnerable for STI/HIVAIDS among them and their wives. The prevalence of inconsistent condom use is more likely to present the biggest threat of HIV infection in the society.
“I know very well about condom. I know that it prevents the transmission of STI. I know how to put this on. I don’t use condom with my regular partners but I always use condom with my new partner.”

6.4 MAJOR FACTORS FOR HIV PREVALENCE AMONG MALE AND FEMALE

6.4.1 Lack of comprehensive knowledge of HIV

Men’s risk sexual behavior along with inadequate knowledge make more vulnerable for HIV infection in the society. Knowledge of HIV/AIDS is higher among educated and wealthiest households compared to no education and poorest households. Though knowledge of AIDS is widespread that 73% of women and 92% of men have heard of AIDS, but only 20% women and 36% men have comprehensive knowledge of HIV/AIDS transmission that is they know both condom use and limiting sex partner to one uninfected partner are preventive methods for HIV (NDHS 2006). Evidences for those urban youngsters do not know the comprehensive knowledge for HIV infection and transmission.

Khem Bhadur Bodathoki, 22, seller, Kathmandu, Thamel, one of the busiest city and popular for tourist area states, “It is transferred by blood or sexual contact.” His friend of same aged, Krishna Thakuri shows less understanding, “people get AIDS from drugs. I am not at risk,” he asserted.

With the very different than the above response,
Shamu Shahi, 30, street vender, “I don’t know too much about HIV/AIDS because I don’t use drugs, people get HIV/AIDS by using drugs and visiting wrong women,” referring to the city’s now thriving CSW (commercial sex worker) scene. “I have no interest in these women – there are enough tourists around for that,” he laughed.

Comprehensive knowledge of HIV/AIDS varies in different population groups. Migrants and female sex workers have lowest level of HIV knowledge than clients of sex worker.94

6.4.2 Lack of knowledge of proper use of condom

58 % of women and 84% of men have the knowledge of condom and the role that they can play in preventing the transmission of HIV (NDHS). Having the knowledge of condom and HIV infection do not mean that they all know the proper way to use condom to prevent from HIV incidence; people are lacking the knowledge of proper use of condom. The evidence, that people do not know the proper use of condom from the survey conducted by SC/ US.95;

One rickshaw puller admitted, “I did not know how to use condom, but my girlfriend assisted in putting on condom by herself”.

6.4.3 Negligence in sexual practices

Some people even who have the knowledge about HIV/AIDS don’t use condom. Negligence
about the HIV infection, absence of condom use couple with extra marital sexual partners put them much risk for HIV contraction among them and transmit to their wives and partners.

The clear evident for 96; The day laborer admitted having as many as three extramarital sexual partners a week –often without condom –but knew little about HIV/AIDS, or the risk of infecting himself, his wife and others, and asserted, “I am always on top-you cannot get infected that way.”

6.5 SPECIFIC FACTORS FOR HIV PREVALENCE AMONG HOUSEWIVES

6.5.1 Powerlessness of housewives and risky behaviors of men

It is here straight forward that housewives are more susceptible for HIV prevalence as these groups are victimized by their husbands especially who belongs to the risky sexual behaviors.

Women can not negotiate safer sex if they feel powerlessness . A survey conducted by (NDHS
2006) found out, 23% of women justified in beating his wife for refusing to have sexual intercourse with her husband, and 83% of women justified in refusing to have sexual intercourse if she knows that her husband has STD or if she knows that her husband has sexual intercourse with other women. It is also the subject of mistrust to each other for demanding condom within marriages. It has been reported that condom is unacceptable in marriages.\(^97\) Importantly the knowledge about HIV prevention and transmission and condom use are of little use for women if they feel powerlessness. For the reason, even they have knowledge about HIV transmission and prevention that make them more risk for HIV transmission from risky sexual behavioral husband, which is clear to understand by given behavior.\(^98\)

As dusk falls in Ratna park, a popular cruising area for men who have sex with men in Nepalese capital, Katmandu. The MSM who is married and has child, said; “I can always find someone here,” bragged Pradip, 23, while his friend prompt him to tell more. “He has been married for four years and has two children, but his wife knows little of his evening activities, or would she dare ask” she knows his place,” he said.

Research conducted in 2006 had found that one in ten migrants use condom with their spouses\(^99\), these “risky behaviors of husband and women’s powerlessness” are making housewives more vulnerable for HIV contraction.
CHAPTER SEVEN: DISCUSSION

7.1 DISCUSSION AND SCOPE

Findings have shown decreases in the HIV prevalence in some groups, like sex workers and in IDUs in recent years. The survey conducted in 2000 in Katmandu showed an increase of HIV prevalence among sex workers by 17% from 2.7% in 1997.\textsuperscript{100} While in 2001 HIV prevalence in sex workers in Kathmandu was recorded 15.7%, 2.1% in 2004 and 1.4% in 2006.\textsuperscript{101} The reported data from NCASC, in fig 4 above shows the decline proportion of HIV incidence among sex workers recorded 61% in 2001, 15% in 2004 and 4% in 2006 then 8% in 2007.

Research conducted in 1999 reported about 40% HIV among IDUs national wide and 68% in Katmandu, and the similar observations showed 38.4% HIV among IDUs in 2004 national wide and 68% in Katmandu.\textsuperscript{102} FHI in 2005 showed the decreases prevalence of HIV among IDUs from 68% to 52% in Kathmandu.\textsuperscript{103} Integrated Bio Behavioral survey in 2007 showed the highest HIV prevalence range from 6.8% to 34% depending upon the location.\textsuperscript{104} Fig 5 above shows that increase projection of new HIV cases among IDUs reported from 16% in 2001 to 48% in 2004, then decline to 24% in 2007.

However the decrease projection in certain groups like sex workers, overall new reported HIV infections in females have been increasing as it was recorded 39% in 2007, among the total HIV affected population, while proportion of HIV incidence among female was only 19% in 1997.

The slow down figure of HIV in certain groups are probably the results of the bloody confrontation during the period in the country. The conflict in the country limited the freedom of movement, worst security situation, and travel and trade were halted. That made people’s everyday life insecure and frightened. It also may be due to collapse health system that may
subject to people failure to report.

The conflict and its link to HIV prevalence are also complex and have several ways to increase the HIV exposure, In Sierra Leon’s decade long civil war made high HIV prevalence among sex workers rose from 27% to 71%, also confirmed that 11% of Nigeria’s peacemakers were HIV resulted from conflict, and that might be sexual violence, rape, human rights abuse.

Here in the case of Nepal, the proportion of HIV incidence case has increased to housewives. Fig 3 shows that new reported number of HIV infection in housewives are constantly increasing that was recorded 87% in 2006 and 78% in 2007 among total HIV affected reported female. This probably is the result of heavy displacement and migration in that period and those migratory people might have transmitted HIV among them.

The reality of increase of HIV prevalence and the mass population displacement due to conflict has been documented in Bosnia- Herzegovina, Democratic Republic of Congo, Liberia and Rwanda.

The increase incidences of housewives have intersected with the increase projection of HIV incidences in clients of sex workers and migrants. The increase number of HIV positive cases in clients of sex workers and migrants may have played the role for HIV infection in housewives; as these both groups have direct link to housewives. NCASC 2007 estimated about 41% of HIV prevalence among labor migrants. The proportion of HIV prevalence among clients of sex workers were also increasing gradually with some up and down trends. Fig 5 shows that the 83% of HIV cases were reported in clients of sex workers in 2001, then showed 50% in 2004 and increased to 61% in 2007 among total HIV affected male population.

There is yet high chances of expansion of HIV epidemics in Nepal as it is suggested that the
greatest threat of HIV transmission can occur during the period of peace following the conflict. Return of the migrant people and freedom that might play the role of HIV prevalence. Migration itself seems the complex phenomenon in the study of HIV prevalence, men and women are equally susceptible for the HIV contraction in this process.

Now it is more vulnerable in case of Nepal as millions of people are migrating to its bordering town India. India is the country which has the greatest threat of HIV in South Asia. FHI 2004 estimated 50% of Nepalese sex workers in Mumbai brothels are found to be HIV positive and about 7.7% of migrant people from Mumbai India were found to be HIV infective. World Bank has sited that trafficking Nepali women and girls to India as a risk factor for HIV transmission in the region.

Prevalence of HIV seems expanding in Nepal that also can be understood from the nature of STI prevalence. The scenario of increasing STI prevalence is the alarming indication HIV prevalence. It has been suggested that the 200,000 STIs are estimated annually and prevalence is highest belongs to the group 30-39 age groups. The above fig 6 and fig 7 shows that the overall HIV recorded cases are highest in 30-39 age groups. The prevalence of STI has the direct relation to the prevalence of HIV. The preventive methods for STIs and HIV are similar. STI prevalence is the signal of high risk sexual behavior and increases the chance of HIV infection. The risk of HIV infection increases for people who have other sexually transmitted infections. Research has shown that some untreated STI in either partner can increase the risk of HIV transmission as much as tenfold. This especially significant for women because many STI cases in women go untreated. Women’s symptoms are often latent or difficult to see, and many women who have been diagnosed with STI do not receive medical treatment because of poor health facilities in Nepal.
7.2 FUTURE RESEARCH

I would be interested to generate the consequences of using family planning method and the prevention of HIV in Nepali society. Findings of (NDHS 2006) shows that the uses of injectables are more than doubled and use of female sterilization increased by 49% over the last 10 years. Permanent and injectables methods are more popular among high parity women. Female sterilizations and injectables are most popular methods among all women who have less than higher secondary education and who have no education. The finding of NDHS shows that 71% were sterilized before age of 30, with 29% sterilized before age of 25. The median age at sterilization is 27 (for women sterilized before age 40). Thus female sterilization in Nepal occurs in their early reproductive lives. In general, as women level of education increases they are more likely to use modern spacing method, especially condoms. Only about 16% of women who have completed higher secondary education have used condom (NDHS 2006).

It has been showed that the majority of women in Nepal are using the injectables or the female sterilization, which clearly reflect that women mostly are using the long term family planning methods from their early age. Use of sterilization and the injectables also reflect that Nepali women seek for the methods that work for long run and to be confident for the longer period. Data from NDHS shows the idea to use the modern contraceptive has increased over the decade from 26% to 70%; the desire to stop child bearing increased from 59% in 2001 to 76% in 2006. The sign of declining fertility rate in Nepal is the indication of awareness of the women for the number of child to bear and spacing of child.

But in the society, majority of females are uneducated, indulging in poverty, having less power, and in around the discrimination and stigma. The only means of preventive method of HIV infection ‘condom’ is under the control on men. Meanwhile, women are not able to negotiate
safer sex. For the moment, let’s suppose, women may able negotiate safer sex in the excuse of child spacing process; but in the case, if she has had already used any means of family planning method: do they negotiate for the safer sex practices to save from HIV contraction? Is this possible to negotiate for safer sex for Nepali housewives if they are already sterilized or using family planning?

Do these women in this society are conscious for the dual protection, and the use condom to safe from HIV risk?

Are these consequences making our Nepali housewives more vulnerable for HIV prevalence?

So it is urgently needed to know, how these housewives who are using family planning methods rather than condom for limiting birth or the child spacing are coping with such instances, to prevent from the HIV prevalence.
CHAPTER EIGHT: CONCLUSION

8.1 INTRODUCTION

This chapter comprises the research findings and presents conclusion drawn from study in general. Some suggested recommendations, based on the count of the study in general are made.

8.2 SUMMARY

The research has been dealing with the gender and age specific HIV prevalence in Nepal. It examines the causing factors, and examining the relationships of existing societal status of Nepal that are making HIV risk to male and female population. The quantitative data was qualitatively analyzed and was supported with information from extensive literature search. The first specific objective was to analyze the gender and age specific HIV morbidity in different groups in Nepal. We have to be careful drawing conclusions based on the reported yearly data from NCASC. But we may at least think it strongly indicates.

*Nepal experiences the increasing HIV prevalence. Clients of sex workers, intravenous drugs users, homo sexual men are the most at risk group among the male population where as the female sex workers and housewives reported significant rises of HIV prevalence in absolute numbers, among females. Among both males and females, the 30-39 age groups were most affected by HIV, followed by the 25-29 age groups. Overall the reported number of HIV infection in women is increasing. The reported HIV cases in female was 19% in 1997 that reached up to 39% in 2007 among the total HIV affected population. The number of HIV cases is highest in housewives among reported HIV positive females. HIV cases in housewives are increasing continuously that was reported 33 % in 1997, and was 78% in 2007.*
Second objective was to find out the societal factors that make HIV prevalence among male and female population in society. *Existing socio cultural, socio economic, physical and political status coupled with the migration and displacement are responsible for HIV prevalence among male and female in Nepal.*

Third objective was to access the relationships between societal structures and the vulnerability of HIV infection among women. *Women are the victims of the society. Inequality, disparity, and discrimination are attributed to women. Gender dimensions along with the cultural and religious justifications make less access to education, unemployment; and are the reasons cause poverty. Lack of income earning, disparity in property inheritance, and gender disparities which existed with respect to access to and to control of range of resources are identified as the major causes of poverty and force to depend upon others; living under the poverty has stem women engage in high risk behavior which thrive them into HIV contraction.*

*Although females are employed in different service sector, they are only able to engage in below the standard with low payment and in petty trading. In such situation they then exchange sex for money in order to survive and increase risk to tolerance to HIV, these conditions put these females at risk of contracting HIV. These kinds of women may also have high anticipation for help or any favor from the men, which put them risk for HIV.*

HIV risk goes in peak among male and female in society if their clients or their partner expose high “*risky sexual behaviors*”. Those then multiply the HIV prevalence forming big network transmitting to their clients, sex partners, and husband and to their wives.

The fourth objective was to identify the major factors of HIV prevalence in existing societal structure. Even though the majority of people know and heard of HIV/AIDS, people are not aware for the “*fully inclusive knowledge of HIV/AIDS*”; that is they don’t know the both
‘condom use’ and ‘limiting sexual partner to one uninfected partner’ for the prevention of HIV infection and transmission. People, who know about the condom that is only the method to prevent the HIV transmission, do not mean that they all know the “proper way of using condom”. Some people do neglect for HIV infection even they are aware of the knowledge of HIV and condom, and are in risk to HIV infection of their “negligence”. Such factors make excess risk for HIV contraction in society.

Fifth specific objective was to access the specific factors of contracting HIV to housewives. Societal and cultural construction including its norms and values such as marginalize (discrimination), patriarchal structures (preference for male), early marriage predispose them powerlessness. As societal constructs such preference for males put women in position which have made develop a low self esteem and made them over dependent on husband. Such conditions make housewives develop risk taking behavior as they can not negotiate safe sex with their husband. “Power relation” or “powerlessness” with in the society is the fact that women can not negotiate safe sex with their ‘risky behavioral husband’ hence making them prone to HIV infection.

Finally the current research has concluded that the HIV prevalence among women in Nepal is gradually accelerating upward, especially low risk groups ‘housewives’. In contrast to African epidemics, Nepal’s epidemic is not as advanced, and currently HIV prevalence is higher in men than women, but it is the characteristics of the epidemics in women and at its early stage; we can presume.

Vigorous action should be taken against the health promotion program to employ into the HIV intervention in time, and as soon as possible; otherwise HIV epidemics among women in Nepal would be vulnerable in near future. And HIV/AIDS could be the leading cause of death if the current rate of infection continues to increase.
8.3 RECOMMENDATIONS

In sum, from the above study, it can be concluded that ‘HIV awareness in the society’ including the ‘fully inclusive knowledge’; ‘limiting the risky sexual behavior in men’ and ‘empowering to women’ can prevent HIV incidence in Nepal.

- Awareness of HIV/AIDS in the society plays the key role for the prevention of HIV/AIDS. There is an urgent need to increase the awareness of HIV/AIDS to make people aware from the comprehensive knowledge for the prevention of HIV/AIDS.

- Extensive use of print as well as electronic media should be used for the promotion of HIV/AIDS awareness and the use of condom. Media should focus to all the people belonging to the different socio economic status; and to highly literate, moderately literate and illiterate people across the country. Media should target to illiterate people by using all members of mass media, education and communication. Activities should use local folk media in local language that must be easily understandable and effective.

- Knowledge of condom and the availability should not target only the general population, but also the people at higher risk of HIV exposure; especially women, young people, sex workers and their clients, injecting drug users.

- Promotion of the concept of the condom as only one method for dual protection against transmission of HIV/STI as well as unintended pregnancy, alone or in the combination with other methods of contraception.

- Conduction of intensive education campaigns to change attitudes of men towards high risk sexual behavior, and the image of condom as a sign of caring of health. It should be advocated strictly that condoms are under the control of men, and they may play the role of HIV transmission to their sex partners and to wives.
• Condom campaign should focus the information and counseling for the correct use of condom and consistent use.
• Good quality condom must be readily available, regularly at any time. Condom should be distributed freely or at a normal fee in traditional outlets such as pharmacies, medical shops, and in non-traditional outlets such as tea shops, tobacco shops, grocery shops, liquor shops, bars, kiosks, hotels, petrol pumps. These non-traditional outlets open for the longer period where more people are socialized.

Certain conditions like socio-cultural and economic structures in the society normally bound to women and put them at risk for HIV infection, so only knowledge among them may not work for the HIV prevention.

• Empowering women should be the first step to prevent from HIV incidence among female.
• Developing and enforcing policies should be employed regarding the provision of education to women. School enrollment campaign for girls should be strongly emerged in all parts of the country. Education is the root that makes women empowered, help to acquire rights and can defend from the discrimination, and help to be employed that break the cycle of poverty among them.
• Policy for the job security and employment should be employed that benefit to reduce the HIV prevalence situation in women in Nepal.
• Gender sensitizing program should be mobilized intensively. Women will remain highly vulnerable to HIV exposure, until men and women share equal rights in the decision making process.
• Government should provide the full rights for the property inheritances to women and strong laws to protect the victims against sexual or domestic violence on time.
Women should be aware about their sexual and reproductive rights. There is need to change the social barriers which create the favorable environment for women, so that they can negotiate for safer sex practices. They should have rights to decide freely the number of and spacing of children. They should have rights to marry with her free and full consent.

Commercial sex worker is high risk group for HIV infection because of their numerous sexual partners, and because they often have other Sexual Transmitted Disease (STD), that enhances HIV transmission. Stopping prostitution seems impossible. Since it has no legal status, there are no regulations in the sex industry in the country. Legalized prostitution seems the effective way for HIV prevention to sex workers and their linked populations. Legalization would help them to be screened in every interval of time; sex workers would gain rights to negotiate condom use. It allows government to monitor and regulate the sex trade.

Integration of HIV/AIDS programs in other services for internal or external migrants.
Advocate the public policy for migrant’s fundamental rights to health services.
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WHO, Country health system profile, Nepal
Available: http://www.searo.who.int/en/Section313/Section1523_6868.htm
YOUANDAIDS, The HIV/AIDS portal for Asia Pacific
## APPENDICES

### APPENDIX: 1

Table 1: Reported cumulative number of HIV infection in different subgroups in males and females

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Table 3: Reported HIV incidence by gender and year of diagnosis

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Source: Ministry of health and population. National Center for AIDS and STD control Teku, Kathmandu, Nepal;

Year wise detection of HIV/AIDS in Nepal (1988-2006) and Table 1. New HIV incidence of males and females from the year 2001-2007 derived from the difference of that group of that particular year and the previous year.
**Table 4: Reported total HIV infection in different subgroups in 2007**

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Source: Table 1
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Source: Ministry of health and population National center for AIDS and STD control Teku Kathmandu, Nepal; Year wise detection of HIV and AIDS situation and table 1. HIV incidence in housewives among the total female from the year 2001 to 2007 derived from the difference of that group of that particular year and the previous year.
### Table 6: Reported HIV incidence among female subgroups by year of diagnosis

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<td>2005</td>
<td>214</td>
<td>47</td>
<td>41</td>
<td>7</td>
<td>0</td>
<td>20</td>
<td>0</td>
<td>329</td>
</tr>
<tr>
<td>2006</td>
<td>807</td>
<td>41</td>
<td>1</td>
<td>9</td>
<td>3</td>
<td>70</td>
<td>0</td>
<td>931</td>
</tr>
<tr>
<td>2007</td>
<td>620</td>
<td>66</td>
<td>1</td>
<td>9</td>
<td>1</td>
<td>84</td>
<td>17</td>
<td>798</td>
</tr>
</tbody>
</table>

Source: Table 1 Calculation: HIV incidence of each subgroups of the particular year is derived from the difference of that group of that particular year and the previous year.

### Table 7: Reported HIV incidence among male subgroups by year of diagnosis

<table>
<thead>
<tr>
<th>Subgroups</th>
<th>Clients of sex worker</th>
<th>IDUS</th>
<th>Men having sex with men</th>
<th>Blood transfusion</th>
<th>Children</th>
<th>History not available</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>206</td>
<td>39</td>
<td>NA</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>246</td>
</tr>
<tr>
<td>2002</td>
<td>284</td>
<td>77</td>
<td>NA</td>
<td>2</td>
<td>8</td>
<td>7</td>
<td>378</td>
</tr>
<tr>
<td>2003</td>
<td>386</td>
<td>110</td>
<td>NA</td>
<td>1</td>
<td>15</td>
<td>-7</td>
<td>505</td>
</tr>
<tr>
<td>2004</td>
<td>467</td>
<td>451</td>
<td>NA</td>
<td>2</td>
<td>23</td>
<td>0</td>
<td>943</td>
</tr>
<tr>
<td>2005</td>
<td>553</td>
<td>321</td>
<td>NA</td>
<td>0</td>
<td>32</td>
<td>0</td>
<td>906</td>
</tr>
<tr>
<td>2006</td>
<td>1043</td>
<td>559</td>
<td>10</td>
<td>9</td>
<td>129</td>
<td>0</td>
<td>1750</td>
</tr>
<tr>
<td>2007</td>
<td>753</td>
<td>298</td>
<td>26</td>
<td>2</td>
<td>110</td>
<td>50</td>
<td>1239</td>
</tr>
</tbody>
</table>

Source: Table 1 Calculation: HIV incidence number of each sub groups of the particular year is derived from the difference of that group of that particular year and the previous year.
Table 8: Reported HIV incidence among female age groups and year of diagnosis

<table>
<thead>
<tr>
<th>Years</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age group</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-4</td>
<td>6</td>
<td>4</td>
<td>24</td>
<td>29</td>
</tr>
<tr>
<td>5-9</td>
<td>6</td>
<td>14</td>
<td>33</td>
<td>42</td>
</tr>
<tr>
<td>10-14</td>
<td>1</td>
<td>3</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>15-19</td>
<td>12</td>
<td>11</td>
<td>29</td>
<td>18</td>
</tr>
<tr>
<td>20-24</td>
<td>61</td>
<td>45</td>
<td>137</td>
<td>118</td>
</tr>
<tr>
<td>25-29</td>
<td>97</td>
<td>87</td>
<td>234</td>
<td>182</td>
</tr>
<tr>
<td>30-39</td>
<td>106</td>
<td>122</td>
<td>348</td>
<td>304</td>
</tr>
<tr>
<td>40-49</td>
<td>42</td>
<td>36</td>
<td>92</td>
<td>76</td>
</tr>
<tr>
<td>50 +</td>
<td>7</td>
<td>7</td>
<td>22</td>
<td>17</td>
</tr>
<tr>
<td>Total</td>
<td>338</td>
<td>329</td>
<td>931</td>
<td>798</td>
</tr>
</tbody>
</table>

Source: Table 2 Calculation: HIV incidence number of each age groups of the particular year is derived from the difference of that group of that particular year and the previous year.

Table 9: Reported HIV incidence among male age groups and year of diagnosis

<table>
<thead>
<tr>
<th>Years</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age group</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-4</td>
<td>13</td>
<td>9</td>
<td>49</td>
<td>42</td>
</tr>
<tr>
<td>5-9</td>
<td>8</td>
<td>13</td>
<td>71</td>
<td>55</td>
</tr>
<tr>
<td>10-14</td>
<td>4</td>
<td>11</td>
<td>10</td>
<td>13</td>
</tr>
<tr>
<td>15-19</td>
<td>31</td>
<td>9</td>
<td>28</td>
<td>11</td>
</tr>
<tr>
<td>20-24</td>
<td>149</td>
<td>119</td>
<td>176</td>
<td>96</td>
</tr>
<tr>
<td>25-29</td>
<td>218</td>
<td>207</td>
<td>385</td>
<td>253</td>
</tr>
<tr>
<td>30-39</td>
<td>390</td>
<td>403</td>
<td>794</td>
<td>529</td>
</tr>
<tr>
<td>40-49</td>
<td>106</td>
<td>116</td>
<td>194</td>
<td>189</td>
</tr>
<tr>
<td></td>
<td>50+</td>
<td>24</td>
<td>19</td>
<td>43</td>
</tr>
<tr>
<td>-----</td>
<td>------</td>
<td>------</td>
<td>------</td>
<td>------</td>
</tr>
<tr>
<td>Total</td>
<td>943</td>
<td>906</td>
<td>1750</td>
<td>1239</td>
</tr>
</tbody>
</table>

Source: Table 2
Calculation: The HIV incidence number of each age groups of the particular year is derived from the difference of that group of that particular year and the previous year.
APPENDIX: 2

Map: South Asia
Map: Nepal
End notes


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