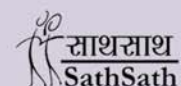
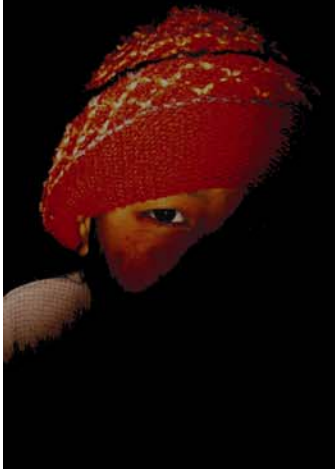




**A Study on
Knowledge, Attitudes, Practices and Beliefs
in the Context of HIV/AIDS
among Out-of-School Street-Based Children
in Kathmandu and Pokhara**





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PREFACE

The HIV/AIDS epidemic has been declared *the most formidable development challenge of our time*. Initially a medical curiosity, HIV/AIDS has evolved into a worldwide human tragedy. The epidemic is spreading rapidly and expanding to new regions, thriving on and amplifying poverty and exclusion. It strikes the poor and disadvantaged hardest, particularly where lack of education, illness, malnutrition, violence, armed conflict and discrimination are already well entrenched. Children are at risk on an unparalleled scale.

Since HIV/AIDS emerges first in groups that are socially and economically marginal, attention to the epidemic has been slow to come. General poverty and hopelessness diminish the interest in avoiding risky behaviour. Ignorance about the disease increases stigma and discrimination, making prevention much more difficult.

Most of those exposed to the virus do not have much education or access to information. Large numbers of girls and boys do not know how to protect themselves; most of those infected do not know it; and most of those affected do not adequately understand the nature and impact of the disease.

Prevention is the only way to limit the spread of HIV and education is the foundation for developing the behaviours that can reduce risk and vulnerability: it can promote awareness; empower individuals to make free and informed decisions; and develop attitudes and competencies that reduce risky behaviour.

Crucially, education is in itself a strong measure of prevention, and the push towards Education for All (EFA) targets is a key to limiting infection among young people. However, preventive education must address the culture within which they are embedded in order to generate the attitudes, provide the skills and sustain the motivation necessary for changing behaviour to reduce risk and vulnerability. Importantly, skills are not just a question of avoiding disease, but also of interacting with the infected in a considerate way.

Effective communication is needed to translate knowledge into behaviour changes and prevention education. Under UNESCO's Major Programme on Education with particular focus on Education and HIV/AIDS and "Community-Based Awareness Raising on HIV/AIDS Prevention Through Education", UNESCO Office in Kathmandu has supported SathSath and Child Welfare Scheme in the project "A Study on Knowledge, Attitude, Practice and Belief in the Context of HIV/AIDS among Out-of-School Street-Based Children in Kathmandu and Pokhara". I would like to take this opportunity to extend my sincere thanks to these two organisations for the successful completion of this very important work as well as to CREHPA for their continuous and invaluable technical support.

I trust that, though modest, this report will contribute to nurturing and using local capacity in building knowledge about needs and successes; the facilitation of learning opportunities for all to develop the knowledge, skills, competencies, values and attitudes that will limit the transmission of the pandemic, and improve prevention intervention and planning to limit the spread of and impact of HIV/AIDS.

Koto Kanno
UNESCO Representative to Nepal

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Our heartfelt thanks go to Koto Kanno, Country Representative of UNESCO Kathmandu, Douglas Maclagan, Country Representative of CWS, and Biso Bajracharya, Executive Director of SathSath for their key inputs, suggestions, and views, and to Kristin Iversen, Education Officer, UNESCO Kathmandu, for her tremendous support throughout the study.

Special thanks are due to Dr. Mahesh Puri, Associate Director, CREHPA as without his key support, advice and participation this study report would have never been appeared in this form and value. We would like to thank Ms. Moni Shrestha, Research Officer, CREHPA for her contribution in the preparation of research instruments and training of the field researchers. We would also like to thank Brian Gilligan for his advice and support throughout the study from the initial concept, for which he had advocated, to the final report.

Special thanks must be given to Ravindra Shakya and Student's Partnership Worldwide (SPW-Nepal) for their support and friendship. In particular the special contribution of SPW's ex-volunteers as professional and committed field researchers must be recognised – without them this study could not have been accomplished.

Most importantly our gratitude and respect goes to the children who participated in this study in Pokhara and Kathmandu. They set aside their research fatigue, were prepared to believe in the goal of this study and shared their views and thoughts honestly. We hope that this study and its follow-up will do them justice.

Our thanks are also due to the many individuals and organisations who collaborated in this study, for their productive support, advice and participation.

Study Team

December 2005

ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
BSS	Behavioural Surveillance Survey
CREHPA	Centre for Research on Environment, Health, and Population Activities
CSW	Commercial Sex Worker
CWS	Child Welfare Scheme
CWIN	Child Workers in Nepal Concerned Centre
FGD	Focus Group Discussion
FHI	Family Health International
FSW	Female Sex Worker
GO	Government Organisation
HIV	Human Immunodeficiency Virus
HMGN	His Majesty's Government of Nepal
IDU	Injecting Drug User
ILO	International Labour Organization
IPEC	International Program on the Elimination of Child Labour
INGO	International Non-Governmental Organisation
KAPB	Knowledge Attitudes Practices and Beliefs
MDGs	Millennium Development Goals
MSM	Men who have Sex with Men
NCASC	National Centre for AIDS and STD Control
NGO	Non-Governmental Organisation
PE	Peer Educator
SPW	Students Partnership Worldwide
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
UNICEF	United Nations Children's Fund
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNAIDS	Joint United Nations Programme on AIDS

EXECUTIVE SUMMARY

Introduction

Every minute of every day a child contracts HIV and more than 500,000 children under 15 are dying each year due to AIDS. It is estimated that worldwide 2.2 million children under 15 are currently living with HIV/AIDS.¹

The first case of HIV was reported in Nepal in 1988, and, in less than 15 years, nearly 61,000 adults and children have become infected.² HIV infection rates are rapidly increasing due to a lack of awareness among vulnerable group and due to the implications of their socially and economically marginalised situations.

Within a decade of first detection, Nepal transitioned from a “low-prevalence” country to one with a “concentrated epidemic” characterised by HIV prevalence consistently over five percent in vulnerable sub-populations such as injecting drug users and female sex workers.

HIV has now spread to other vulnerable populations which are not seen as core transmitters. It is well documented that street-based children share an environment and practices that make them vulnerable to HIV infection. This was confirmed in tests conducted by an NGO in Kathmandu in 2002 which identified 41 street-based children infected with HIV.

Street-based children are at risk to HIV/AIDS infection because of the characteristics of street life: vulnerability to sexual abuse, unprotected sex, early sexual initiation, and injecting drug use are all factors which place children at risk. Street practices encourage and reinforce risk-taking behaviours. Successful HIV prevention depends on changing these risk-taking behaviours and promoting protective behaviours.

To date there has been a lack of appropriate and systematic research to enable an effective response to the threat of HIV/AIDS among street-based children. Information has been on an ad hoc and anecdotal basis. Targeted prevention interventions have been limited: HIV/AIDS has not been mainstreamed into programming for street-based children, nor have street-based children appeared as visible target groups in HIV/AIDS programming.³

To be effective HIV prevention must be targeted, addressing the contexts in which these children live their lives and based on an understanding of their situations. If risk behaviours exist but are not recorded, the opportunity to plan risk-reducing programmes before the virus explodes through a high-risk population is lost.⁴ An in-depth and systematic understanding of the vulnerability and risk behaviours of street-based children is vital in order to develop targeted interventions.

This study, examining the Knowledge, Attitudes, Practices and Beliefs of street-based children in the context of HIV/AIDS, has been conducted to provide high quality data that can be acted upon with greater confidence to improve the appropriateness and effectiveness of programme interventions. The

¹ www.unicef.org/aids

² NSASC (2005) *National HIV/AIDS Action Plan and Budget 2005-06*

³ Street children have been included for the first time as a sub-population for targeted prevention in the National HIV/AIDS Action Plan 2005-06.

⁴ FHI and Impact (2000) *Behavioural Surveillance Surveys: Guidelines for repeated behavioural surveys in population at risk of HIV*

study jointly conducted by Child Welfare Scheme and SathSath with the technical support of CREHPA was supported by UNESCO Kathmandu.

The study which was conducted in Kathmandu Valley and Pokhara incorporated a population size estimation of street-based children, a KAPB survey conducted with a sample of 513 street-based children, and qualitative information collection through a series of focus group discussions with children.

Key Findings

This study clearly demonstrates the high vulnerability of street-based children to HIV/AIDS. The information provides a valuable understanding of the vulnerability and risk behaviours of street-based children which need to be targeted for HIV prevention. The box below presents the key findings of this study, a full discussion of which is presented in Chapter 12.

Summary of Key Findings

The majority of street-based children have a basic knowledge of HIV/AIDS:

- Most boys and girls have **heard of HIV/AIDS**
- Many **can identify that a person can get infected with HIV/AIDS from having unprotected sex** (73% and 76% of boys and girls respectively).
- The majority of boys and girls **can identify that a person can get infected with HIV/AIDS by taking injections with a used needle** (71% and 76% of boys and girls respectively).
- **Knowledge on prevention methods is more limited** but does exist among a significant percentage of boys and girls, particularly with regard to condom use for sexual intercourse.

The existence of knowledge has not resulted in the elimination of false beliefs about HIV/AIDS:

- Many boys hold the **belief that you cannot get infected with HIV/AIDS the first time you have sex**
- A significant percentage of boys and girls hold the **belief that it is not possible for a healthy-looking person to have HIV/AIDS.**

The existence of knowledge has not resulted in reduced risk-taking behaviour among street-based children:

- Among street-based children a **significant percentage are sexually active**
- **Early age of sexual initiation** among both boys and girls
- **Sexual intercourse is usually high-risk** with children involved in anal sex, sex with multiple/non-regular partners, and commercial sex
- Of those sexually active, **children below fourteen are more likely to be involved in high risk sex and less likely to use a condom**
- **Condom use is low** for all types of sexual encounters
- Despite the low number of cases reported by respondents, it is likely that there are a large number of cases of untreated STIs given the level of unprotected sex
- **High percentage of needle-sharing** among those children reporting injecting drugs

Street-based children have had limited exposure to HIV/AIDS prevention and SRH interventions:

- Although many children are frequently visited by or visit many NGOs, **a significant percentage have not had any contact with an organisation in the last year**
- In particular **street-based girls have very limited contact with organisations**
- Among all respondents, **few have discussed HIV/AIDS with someone from an organisation** (27.5% of boys and 13.7% of girls)
- There has been **limited access of street-based children to sexual and reproductive health education.**

Recommendations

This study recommends that street-based children should be recognised and prioritised by GOs, NGOs and INGOs as a sub-population highly vulnerable to HIV infection. HIV/AIDS should be mainstreamed into programming for street-based children, and street-based children should become a visible target group in prevention programming for children and young people.

Organisations working with street-based children should develop a coordinated and integrated strategy for HIV prevention, adopting a holistic approach which does not treat HIV prevention as a separate intervention but integrates HIV prevention into programmes for health, non-formal education etc. The study highlights the importance of programming which builds on children's life skills and which uses trained front line workers and peer educators to reach children in their own environment. It is also clear that awareness and prevention interventions must start at an early age with children as young as ten.

It is also recommended that this KAPB study be repeated after 2-3 years to assess the impact of interventions and monitor changes in knowledge, attitudes, practices and beliefs among the target population, as well as implementing this study in other urban areas where interventions are planned.

The full recommendations can be seen in Chapter 13.

Report Structure

This study report is presented in thirteen chapters. Chapters 1, 2 and 3 detail the background, terminology and methodology of the study. Chapter 4 describes the population size estimation process and presents the results. Chapter 5 presents data on the sample population of the KAPB survey. Chapters 6 to 9 present the data and results of the survey in relation to the vulnerability of street-based children to HIV/AIDS and as well as data identifying risk factors and risk behaviours. Chapter 10 examines the exposure of the target population to organisational interventions. Chapter 11 provides a summary of the key indicators of vulnerability and risk behaviours. Chapter 12 presents a summary and discussion of the key findings, before detailing conclusions relevant for HIV/AIDS prevention among street-based children. Chapter 13 presents the recommendations of this study based on the key findings.

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Chapter 1 INTRODUCTION

1.1 Background

The HIV/AIDS problem in Nepal is now more than a decade old. The first case of HIV was reported in Nepal in 1988, and, in less than 15 years, approximately 61,000 adults and children have become infected.⁵ HIV/AIDS infection rates are rapidly increasing due to unawareness and lack of knowledge among vulnerable groups.

Within a decade of first detection, Nepal entered into transition from a "low-prevalence" country to one with a "concentrated epidemic" with HIV prevalence consistently over five percent in some sub-populations such as injecting drug users (IDUs) and female sex workers (FSWs). For example, recent studies estimate that in 2005 the HIV prevalence among IDUs was 51.6 percent in Kathmandu Valley, 11.7 percent in western terai districts and 21.7 percent in Pokhara.⁶ HMG Nepal statistics to the end of November 2005 record cumulative totals of 5647 people infected with HIV, of whom 929 have developed AIDS, and 273 AIDS-related deaths.⁷ Out of the infected population, 53 percent were clients of FSWs, 20 percent were IDUs, 14 percent were housewives, and 7 percent were adolescents.

It is well documented that street-based children share an environment and practices that make them vulnerable to HIV infection. Furthermore, two independent tests conducted by an NGO in Kathmandu in 2002 identified the existence of HIV infection among this sub-population. In these tests 25 out of 80 (31%) street children were HIV positive, and 16 out of 32 (50%) 'high-risk' street children were HIV positive.⁸

At the same time the issue is often a low priority for these children who suffer from exclusion and discrimination in their daily lives. The threat of HIV becomes a distant reality when the immediate future is itself uncertain. In a participatory study conducted by 10 street children with 75 of their peers in Kathmandu in 2003, not one child researcher or respondent identified HIV/AIDS or STIs as an issue or problem faced. In a research conducted in Kathmandu and Dharan in 2004 with 58 street-based children over 14 years of age, HIV/AIDS, STIs and sexual abuse were ranked as 10th among the priority issues faced.⁹

Street children are at risk to HIV/AIDS infection because of the characteristics of street life. Vulnerability to sexual abuse, unprotected sex, early sexual initiation, and injecting drug use are all factors which place children at risk. Street culture encourages and reinforces risk-taking behaviour. Successful HIV prevention depends on changing these risk-taking behaviours. This includes increasing condom use, reducing the number of sexual partners, reducing needle-sharing among injecting drug-users, and delaying first intercourse among young people.¹⁰ However, the focus of HIV/AIDS prevention on the

⁵ NCASC (2005) *National HIV/AIDS Action Plan and Budget 2005-06*

⁶ See FHI/New ERA/SACTS 2001, 2003 and 2005

⁷ NCASC Statistics 2005

⁸ Tests conducted by CWIN in 2002

⁹ See Southon, J. and Dhakal, P. (2003) *A Life without Basic Services: Street Children's Say* and Save the Children Norway (2004) *Challenges in Realising the Rights of Street-Based Working Children in Nepal*. The issues faced which were identified as higher priorities were: basic needs, finding a good job, lack of education and training, bullying and fighting, police relations, health and medical issues, social discrimination, legal identity, and, exposure to criminal activities.

¹⁰ FHI and Impact (2000) *Behavioral Surveillance Surveys: Guidelines for Repeated Behavioral Surveys in Populations at Risk of HIV*.

street has often been limited to targeting injecting drug users. This has been to the detriment of prevention interventions targeting sexual risk behaviour.

To be effective HIV prevention must be targeted, addressing the contexts in which these children live their lives and based on an understanding of their psychosocial situation. If risk behaviours exist but are not recorded, the opportunity to plan risk-reducing programmes before the virus explodes through a high-risk population is lost.¹¹ An in-depth and systematic understanding of the vulnerabilities and risk behaviours of street-based children is vital in order to develop targeted interventions.

To date there has been a lack of appropriate and systematic research to enable an effective response to the threat of HIV/AIDS among street-based children. Information has been on an ad hoc and anecdotal basis. Targeted prevention interventions have been limited: neither HIV/AIDS being mainstreamed into programming for street-based children, nor street-based children appearing as a visible target group in HIV/AIDS programming. There is neither a clear strategy nor a coordinated integrated approach for HIV/AIDS within this vulnerable population.

This study, examining the Knowledge Attitudes Practices and Beliefs of street-based children in the context of HIV/AIDS, has been conducted to provide high quality data that can be acted upon with greater confidence to improve the appropriateness and effectiveness of programme interventions.

1.2 Objectives of the Study

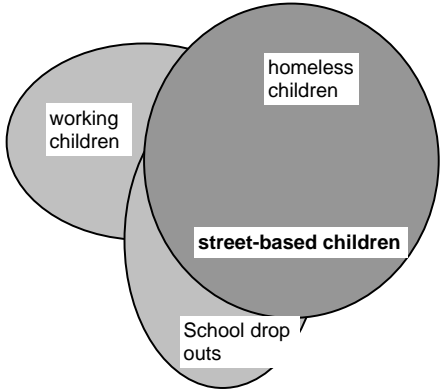
- To understand and map the HIV/AIDS vulnerability and risk factors faced by street-based children in Kathmandu Valley and Pokhara to support the development of effective interventions and to provide baseline data to monitor the impact of interventions;
- To identify recommendations to promote and facilitate the development of a coordinated strategy for HIV/AIDS prevention interventions for street-based children in Nepal;
- To develop a KAP/KAPB survey model for street-based children that can be easily replicated over time and in other geographical areas.

1.3 The Study Population

For the purposes of this study, ‘street-based children’ is understood to refer to children who transit in the street, children on the street, and children living in the street.

Fig.1 Street-based children in relation to other vulnerable groups

Adapted from Elena Volpi (2002) *Street Children: Promising Practices and Approaches*



¹¹ FHI and Impact (2000)

The street suggests a variety of places and occupations, including beggars, rag pickers, conductors, short-distance porters, street vendors, petty criminals, etc. Street-based children are understood to be children whose diverse lives have a significant relationship to the street as a space and/or a culture. Street-involved children are unaccompanied, experiencing a dysfunctional family situation, or spending most of their time outside of responsible parental or adult supervision. These children face common risk factors with regard to HIV that can be addressed through a shared programmatic approach.¹²

For the purpose of this study, a 'child' is defined as any boy or girl between the age of twelve and seventeen years. Due to the sensitive nature of the study subject it has been decided that children under the age of twelve will not be requested to participate in the study. The upper age limit (children under the age of eighteen years) has been selected in accordance with the UN Convention on the Rights of the Child (1989).¹³

1.4 Study Areas

The study was implemented in Kathmandu Valley within the ring road (Kathmandu Metropolitan City and Lalitpur Sub-Metropolitan City) and in Pokhara.



The populations of Kathmandu and Pokhara Municipalities according to 2001 Census Data were 671,846 and 156,312 respectively.

1.5 Ethical Considerations

It is not ethical to expose a child already vulnerable to any additional risk through an investigation that carries no benefit for the child. Interviews about painful subjects should be performed with the principle of 'least harm'

'Interim Statement of Intent'
Reproduced in Boyden and Ennew (1997)

¹² Based on loose definition adopted by Dr. Andrew West (2003) *At the Margins: Street Children in Asia and the Pacific*.

¹³ For the screening protocol used to identify children for KAPB Survey see Annex Three.

This study has been initiated after careful consideration of its ethical implications and the ethical challenges in undertaking a study about sensitive issues with a vulnerable and marginalized group. However, there are clearly identified benefits for the target population: this is an urgently needed study for a sub-group of children who are marginalised and at high-risk of HIV infection. The partners participating in this research are planning to implement initiatives based on the recommendations of this study as well as working to mobilise other stakeholders to work in this area.

The study received ethical approval from the Nepal Health Research Council. The project also received approval from Social Welfare Council.

Throughout the study there has been continuous priority placed on recognising ethical challenges and minimising any negative impacts. In particular the following fundamental principles have been taken into consideration:

Respect for persons

The capacity and rights of all individuals to make their own choices and decisions to participate must be recognised. In the context of this study, special protection must be given to the study population, which is marginalized and vulnerable.

Beneficence

Protection of the participant is the overriding responsibility of the researcher. Risks (physical, mental and social) must be reduced to a minimum.

Justice

There should be equitable distribution of risk and benefits among the anticipated beneficiaries.

The aim of this study is to support the development of programming strategies to protect a vulnerable group of children from HIV/AIDS. It has been acknowledged that highlighting the vulnerability of this target population may result in increased victimisation or discrimination:

Experience has shown that in the early stages of an HIV epidemic, the general public's reaction to information about HIV infection in [marginalised] sub-populations with higher risk behaviour is sometimes to call for restrictive and prohibitive measures.

Guidelines for Second Generation HIV Surveillance (UNAIDS/WHO)

It is clear in the rationale and findings of this study that the target population is not considered to be a bridging group and consideration should be taken to ensure that the target group is not presented as such.

In the absence of national guidelines for behavioural research, the research team identified the following guidelines to minimise negative impact or risk to respondents:

Age of Children

No child under the age of twelve was involved in data collection given the sensitive nature of the issues involved and the need for children to have the capacity to make an informed decision to participate based on an understanding of the study and its potential risk and benefits.

Parental Permission

Given the target population (street-based children with minimal family contact) it was not practical, and in many cases impossible, to obtain parental consent for their involvement in this study. The conditions and situation of the target population is such that parental permission is not a reasonable mechanism to protect the participants, given their neglected or abused situation.

In place of the protection that parental permission may provide for other groups of children, the study design incorporated other mechanisms for the protection of the participants. The research team was supported by front line street workers with the focus of supporting children involved in the research.

Informed Consent

Potential respondents only participated in the survey after giving verbal informed consent. It was the responsibility of the trained field researchers to ensure that potential respondents received and understood necessary information regarding the study (the nature and purposes of the study, the potential risks and benefits, and the measures to ensure confidentiality) and arrived at a decision without being subjected to coercion, undue influence, inducement or intimidation.

An informed consent form was developed in simple Nepali appropriate for the target population and read to potential respondents by the interviewers.

Non-participation

Respondents had the right and ability to refuse to participate. It was explained to respondents that they were free to skip questions during to survey and to terminate the survey at any point if they wished to. At the end of the interview respondents were given the opportunity to make comments or ask the interviewer any questions.

Discomfort

Although the issues involved in the study (sexual behaviour etc.) are sensitive issues, all care was taken to reduce discomfort for those children choosing to participate. Field researchers were fully trained to conduct interviews in a sensitive manner causing least discomfort to participants. The questionnaire also included screening questions to protect children from unnecessary distress i.e. only those children who were sexually active were asked questions regarding sexual behaviour. Given the realities of the children's situations it is also reasonable to recognise that involvement in the study was unlikely to result in increased discomfort to that encountered in their daily lives.

Confidentiality

Protecting confidentiality was essential to ensure the respondent's safety and the quality of the data. No identifiers were recorded during the survey or the population size estimation process. All researchers received strict instructions about the importance of maintaining confidentiality and this was a core component of training. Individual interviews were conducted in a private setting as far as was possible and no one but the interviewer and the respondent were present during the interview.

Information and Support

It was considered a moral obligation that while conducting the study provisions were made to address and follow-up issues raised by the respondents. It would have been inappropriate to offer information on HIV and counselling during the survey as this may have affected the data collection and the interviewer

may not have been the most appropriate person to provide this support. Therefore, at the completion of the interview, respondents were provided with contact details of a counsellor or front line worker from whom they could obtain further information and support.

1.6 Limitations

Given the urgent need for such a study to be conducted, the study is being conducted within a limited timeframe. This has resulted in some limitations to the scope of the study.

Although qualitative methods have been included in the study design, more qualitative research will need to be conducted to understand the important role of individual agency in negotiating risk environments and to understand more the protective factors that discourage risk-taking behaviour.

In particular, this study has not been able to represent adequately the issues of street-based girls in relation to their vulnerability to HIV/AIDS. Although the sample size is proportionate to the total number of street-based girls, the sample size is not large enough to be statistically significant and allow for detailed analysis. Efforts were made to include as many girls as possible in the study, while adhering to the sampling protocol, but this was limited due to their low visibility on the street, high mobility, and their limited exposure to interventions.

The study is limited to Kathmandu Valley and Pokhara and does not include other urban areas that are likely to have distinct challenges and issues in the area of HIV/AIDS prevention. It would have been unethical to conduct a study in other urban areas where there are no immediate plans of the partner organisations to implement prevention activities. It is however hoped that this study will be replicated by organisations working in other urban areas.

The population size estimation provides an estimate of the number of street-based children at a given point in time. As it is the first size estimation using this methodology it does not give an indication of whether the numbers of children are increasing, an issue of particular interest given the current social and political situation.

For ethical reasons there were no respondents below twelve years of age. This does not in any way suggest that children under the age of twelve are not at risk of HIV infection. It is hoped in the future that those organisations working with younger street-based children will be able to obtain qualitative data in a sensitive way as part of their programming.

1.7 Report Structure

Chapters 1, 2 and 3 detail the background, terminology and methodology of the study. Chapter 4 describes the population size estimation process and presents the results. Chapter 5 presents data on the sample population of the KAPB survey. Chapters 6 to 9 present the results of the survey, identifying and analysing risk factors and risk behaviours. Chapter 10 examines the exposure of the target population to organisational interventions. Chapter 11 provides a summary of the key indicators of vulnerability and risk behaviours. Chapter 12 presents a summary and discussion of the key findings, before detailing conclusions relevant for HIV/AIDS prevention among street-based children. Chapter 13 presents the recommendations of this study based on the key findings.

Chapter 2 TERMINOLOGY

2.1 General Terminology

Coerced Sex refers to sex obtained as a result of force, intimidation, pressure, blackmail, deception, or threats of abandonment or withdrawal of protection. Transactional sex often has a coercive aspect as well.

Commercial Sex in this report refers to all forms of transactional sex (money, gifts or other economic incentives) or coerced sex with girls or women who are engaged in commercial sex work.

High Risk Sex is a category employed in this report to refer to types of sexual behaviour which have high risk of HIV/AIDS transmission, therefore: anal sex, sex with non-regular partners, and commercial sex.

Kawaad is a scrap collection centre where children sell scrap. Children may also live in scrap centres and/or spend their non-working hours there.

Kathmandu/Kathmandu Valley, for the purposes of this report, refers to the area of Kathmandu Metropolitan City and Lalitpur Sub-Metropolitan City which fall inside the ring road. In many instances in the text this has been referred to as 'Kathmandu' only but it should be understood to include this whole area.

Mainstreaming refers to the integration of an issue (HIV) into strategic planning and throughout an organisation's programmes and projects.

Non-regular partner refers to a sex partner who is not the wife/husband or girlfriend/boyfriend of the respondent.

Protective Factors, in the context of this report, are factors which discourage one or more behaviours that might lead to the possibility of HIV/AIDS infection.

Resilience refers to the role of the individual in determining the impact and outcome of risk factors and risk situations.

Risk Factors, in the context of this study, are factors that encourage or are associated with one or more behaviours which might lead to the possibility of HIV/AIDS infection.

Street-based children, as described above, are understood to be children who transit in the street, children on the street, and children living in the street. This is not intended to establish or give preference to a category of children at risk, but to describe a diverse group of children who share similar risk factors in relation to HIV/AIDS and who can be reached through a single programmatic approach.

Sex/Sexual Intercourse are both employed to refer to vaginal or anal penetrative sex.

Target Population and Target Group refer to all street-based children within the study areas.

2.2 Statistical Terminology

Bias refers to influence on the sample or data collection resulting in the favour of one outcome (conclusion) over another.

Multivariate analysis is a statistical procedure to observe and analyse the relationships between variables, and in particular to identify the influence of independent variables on a given outcome (outcomes or dependent variable). For example to examine whether age has an independent influence on likelihood of condom use after controlling the effects of other factors.

A **Variable** is anything that, when measured can produce two or more different values. For example height or gender .

Predictors are independent variables which are assumed to have an influence/predict a given outcome.

Confidence Interval (CI) is the range within which the true magnitude of effect lies with a certain degree of assurance . A confidence interval of 95 per cent means that there is 5% chances that the true figure lies outside the estimated range

Odds ratio (OR) is a measure of the likelihood of an event occurring in one group against the likelihood of it happening in another group. An odds ratio of 1 indicates that the event is equally likely in both groups. An odds ratio greater than 1 indicates that the event is more likely in this group compared to reference group. An odds ratio less than 1 indicates that the event is less likely in this group compared to the reference group.

Sample and Sample Population refer to the members of the target population who participated in the survey.

Triangulation means the use of a different method to cross-check the results of the original method.

Chapter 3 Methodology

Quantitative data was acquired by utilising a Knowledge Attitudes Practices Beliefs (KAPB) survey based on Behavioral Surveillance Survey indicators. The survey systematically identified risk factors relevant to the design of programme interventions and to provide a baseline to monitor the impact of interventions over time.

Qualitative information was collected to understand the more subjective issues and the attitudes and beliefs surrounding HIV/AIDS and risk-taking behaviour as well as to validate the quantitative data. A series of Focus Group Discussions provided the opportunity for the target population to give input in the analysis of the data and to gain a more in-depth understanding of factors leading to risk-taking behaviour.

2.1 Sample Size

A good indicator for estimating a sample size for this type of study would be the proportions of the study population engaged in high-risk sexual behaviour or in high-risk injecting drug use. However, there is no up-to-date quality data (with significant sample size and/or clear sampling design) of this kind available for the chosen target population of 'street-based children'. Therefore the sample size is based on a study conducted among 100 street children by ILO in 2002.¹⁴ In this study 31 percent of the respondents reported ever having had experience of oral or anal sex. On this basis the required sample size is calculated as 513 to show a significant difference (if any) at 95 percent confidence interval with a precision level of ± 4 percent. It was decided that a sample of 400 children for Kathmandu and 113 children for Pokhara would be selected.

2.2 Sampling Design

A two stage-sampling design was used. The first stage was a selection of Primary Sampling Units (Clusters). The second stage consisted of posting researchers at the selected sites for a fixed time interval and interviewing street-based children encountered during that period.

Since there existed no reliable size estimation for the number of street-based children in Kathmandu and Pokhara a sampling frame was not readily available to draw a random sample. Therefore a mapping and population size estimation of the number of street-based children in Pokhara and Kathmandu was conducted (see Chapter 4). The list of major concentration sites of street-based children from this mapping was then used as a sampling frame for the survey. The major concentration sites (where children congregate, visit frequently or sleep) were stratified according to the locations and the number of street-based children. Those locations having less than ten children were merged with adjoining areas. Altogether 70 locations in Kathmandu and 19 locations in Pokhara were identified. The list of locations for Kathmandu and Pokhara were arranged by geographical locations from north to south. From the lists of locations, 40 Primary Sampling Units (or clusters) in Kathmandu were selected using systematic sampling with probability proportional to size. Given that the population size estimation for street-based children and the sample size needed were similar, all Primary Sampling Units were covered in Pokhara.

¹⁴ ILO (2002) *Trafficking and Sexual Abuse among Street Children in Kathmandu*

For each of the selected clusters ten street-based children were interviewed. Considering the nature of the target population, children that were present or arrived at the site between 8am to 8pm were interviewed. To allow variation in the sample respondents, interviewers were placed from morning to late evening. A screening questionnaire was used to eliminate adults and interviewing the same respondents twice.

2.3 Indicators

This survey measured knowledge, attitudes, practices, and beliefs that affect the risk of exposure of street-based children to HIV. In particular the key indicators of the survey are focused on:

- The likelihood that an uninfected person will come into contact with an infected person; and,
- The likelihood that transmission of HIV will occur if that contact comes about.

The selected indicators are based as much as possible on standardized indicators to ensure comparability over time while taking into account the distinct situation of the target group. These include condom use, onset of sexual intercourse, injecting equipment sharing behaviours, and knowledge. The full description of the standardised indicators can be found in, FHI and Impact (2000) *Behavioural Surveillance Surveys: Guidelines for Repeated Behavioural Surveys in Populations at Risk of HIV* and FHI and Impact, *Evaluating Programs for HIV/AIDS Prevention and Care in Developing Countries*.

2.4 Research Instruments

A structured questionnaire was used to collect the data. The questionnaire was based on Behavioural Surveillance Survey questionnaire for youth developed by FHI/Impact¹⁵. Necessary modifications and additions were made to suit the study population. These modifications were based on a literature review, stakeholder input and FGDs with children identifying risk-behaviours and appropriate 'street-language'.

The questionnaire included socio-demographic characteristics, drug sharing and needle sharing behaviour, sexual behaviour, use of condoms, knowledge and attitudes related to HIV/AIDS, incidence of STI symptoms, and exposure to interventions. The research instruments were developed in English and translated into Nepali. The questionnaire was pre-tested with the target population to check the meaning of the language, ability for recall with regard to research variables, and the sequence and structure of the questionnaire. Necessary changes were made.

2.5 Data Collection

The questionnaire was administered in Kathmandu and Pokhara according to the sample design by a team of field researchers. A total of 13 field researchers were selected and recruited based upon the criteria set by the technical advisor. All the field researchers had previous experience of working with children. Five days training was conducted by CREHPA and researchers were assessed again at the end of the training before being permitted to commence field data collection. During the data collection period the field researchers were supervised by an experienced field coordinator, ensuring research protocols and ethical guidelines were followed strictly and that the data collected was reliable and valid.

¹⁵ FHI and Impact (2000)

Qualitative data was collected through seven Focus Group Discussions (FGD) conducted with a total of 49 street-based children in Kathmandu and Pokhara (of which 13 were girls). These FGDs focused on the more subjective issues related to HIV knowledge, risk-taking behaviour, and exposure to interventions. The FGDs were used to validate and gain an in-depth understanding of the information from the quantitative data analysis. The FGDs lasted 60-90 minutes with the structure based on the findings of the analysed questionnaires. The FGDs were facilitated by experienced front line street workers.

2.6 Minimising Bias

Research suggests that when interviewers are well trained to discuss sensitive behaviours with respondents and make them feel at ease, respondents will provide truthful information. Interviewers should understand the importance of producing valid data and develop a sense of ownership and personal commitment to the goals of the research.

The interviewers were selected by the research team according to their ability to produce valid and reliable data in a sensitive way with respondents. They were trained and tested in interviewing skills, the research tools, research protocol, and research ethics. Training also covered rapport building, talking openly about sexual issues, and overcoming embarrassment. Attention was given to selection of interviewers in terms of age, social background, and gender. Male enumerators were assigned to interview boys and female enumerators to interview girls.

The research goals, the legitimacy, and the value of honest reporting were explained clearly to each potential respondent before s/he made a decision to participate or not. This helped to limit the possibility of respondents not answering questions honestly, especially concerning issues or behaviours that are seen as socially unacceptable. The interviews were conducted in private settings.

2.7 Data Management and Analysis

All completed questionnaires were entered into a database immediately after these had been manually edited and coded. In the case of open-ended questions, coding was done after the completion of fieldwork. Computer software dBase IV was used for data entry. Data entry validity checks were performed for all the questionnaires. After cleaning, data was analysed using STATA statistical software package. Both bivariate and multivariate data analysis techniques were used. In multivariate analysis, binary logistic regression was employed.

The textual data collected from focus group discussion was analysed manually using thematic approach. The findings from the FGDs were used to complement and triangulate with quantitative survey findings.

Chapter 4 POPULATION SIZE ESTIMATION

3.1 Methodology

In the absence of updated and reliable population estimates of street-based children in Nepal, a rapid population size estimation of street-based children in Kathmandu and Pokhara was conducted using multiple methods. Considering the nature of the study population, social mapping, capture and recapture, and triangulation methods were used to estimate the number of street-based children in both study areas. From past experience on working with hard-to-reach populations such as FSWs, IDUs and MSMs these techniques are considered reliable in identifying the important concentration sites and the population size¹⁶.

3.1.1 Contact with NGOs

A list of NGOs working with street-based children was prepared by contacting several NGOs, INGOs, the Social Welfare Council, the NGO section of the Chief District Office of Kathmandu and Pokhara and various individuals involved in relevant fields. The fifteen NGOs that were most frequently mentioned were then contacted. A letter describing the objectives and methodology of the study was circulated among all the relevant NGOs. This was followed by a brief interview with key personnel of the organisations. These organisations were contacted at the beginning of the study for two reasons: they have a great deal of first-hand knowledge about the target population i.e. their locations, characteristics, and even estimates of their numbers in particular locations; and, the outreach workers or volunteers in these NGOs could be instrumental in introducing the research team to the target group, particularly in their working areas.

Through meetings with the NGOs the research team listed areas covered by the NGOs, assessed existing mapping (if available) and discussed if and how size estimations had been conducted by them. During this process the research team collected information on how many street-based children the organisations were in contact with and through which activities. The research team then assessed whether there were any duplications and gaps in the data.

3.1.2 Research walks and key informant interviews

Following consultative meetings with concerned NGOs, the research team began "research walks" – a rapid visit of the potential sites for mapping. In the course of research walks, the research team identified local informants who were likely to have knowledge about the presence and number of street-based children in their locality. These informants could be outreach workers of NGOs, children themselves, transport workers, employees or owners of restaurants, garage staff, police, labourers etc. Informants who possessed 'rich' information about the target population that they were willing to share were selected for interview. Consequently, information gaps and areas not covered by the NGOs were identified.

3.1.3 Social mapping of street-based children

Following the assessment of existing information and identification of gaps the research team determined locations to be visited, issues to be explored or verified, and/or informants to be contacted. Subsequently, social mapping was carried out in the following stages:

¹⁶ FHI and CREHPA (2002) *A Situation Analysis of Sex Workers and Injecting Drug Users in Kathmandu Valley: A Focus Ethnographic Study*.

Stage one: Social mapping by NGO personnel

In the very first stage of the social mapping exercise all NGOs and relevant government offices were visited to compile a list of the relevant NGOs whose work is connected with street-based children. These NGOs were then requested to indicate the concentration areas of street-based children on a map and give commentaries about the activities of the children in each of the specific locations (e.g. work type, time of visit, place of sleep).

Stage two: Mapping by key informants and study team

Detailed guidelines for mapping were prepared during a two-day orientation training of the study team. Kathmandu/Patan and Pokhara were divided into several locations based on the information of the first level of mapping with NGO personnel. Each team, made up of two field researchers, then identified key informants in each area and interviewed them about the number of street-based children.

Several different approaches were employed to triangulate the collected information. Methods such as checking key informant statements by direct observation of locations, crosschecking information from at least three separate independently interviewed key informants, as well as comparing information with that collected from NGO level mapping and interviews.

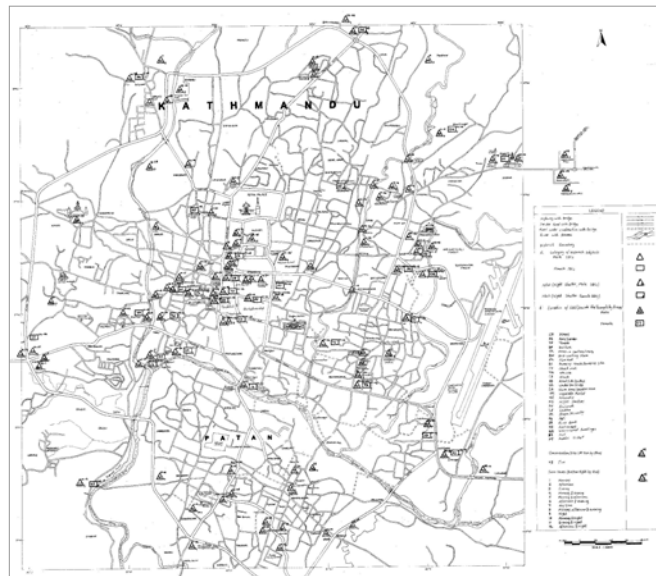
Enlarged maps and guidelines were used in each location to record the data. Information such as name of the location, type of location, number of street-based children, and time of activities were depicted. Key locations with special concentrations of street-based children were given special attention during mapping. The commentaries and descriptive interview materials about the locations on the maps were noted down in field diaries, expanded, and presented to all the members of the study team each day.

Stage three: Finalization of maps

The maps were finalized and compiled into the “main map”, separately for Kathmandu/Patan and Pokhara, with the aid of a cartographer.



Fig.1 Final Maps produced for social mapping of street-based children in Kathmandu Valley (r) and Pokhara (l)



Stage four: Capture and recapture

To triangulate the final population size estimation from mapping a "capture and recapture" method was employed. This method is used to estimate a population size, including the 'unseen' portion – for example, those who may have been missed during mapping due to their mobility. On a given day a number of the target group were 'captured' in the major concentration areas identified during the social mapping exercise (in both cities) and a red card was distributed. After three days the same process was repeated in the sample areas ('recapture'). This time a blue card was distributed and each child was asked whether they had received a red card three days before. Information on the number of both encounters and the proportion of children encountered twice was then used to calculate the total size of the population, including the 'unseen' portion.

The following formula was used to estimate the total population size at a 95 % confidence interval (CI) of the estimated number.¹⁷

$N = (\text{number in first capture} \times \text{number in second capture}) / \text{number in both captures}$

95% CI + $N \pm 1.96 \sqrt{\text{Var}(N)}$

Stage six: Verification meeting with Front Line Workers and finalization of the size estimation

At the end of size estimation process a meeting was organised with the key informants from the NGOs. The size estimation process and outputs were shared and discussed to confirm the size estimation figures.

3.2 Population Size Estimates

3.2.1 Kathmandu Valley

A total of 70 concentration sites were identified (see Annex Three) produced the following population size estimation range which was validated through capture-recapture exercise:

Male	Maximum 1833	Minimum 1402
Female	Maximum 290	Minimum 214
Combined	Maximum 2123	Minimum 1616

3.2.2 Pokhara

A total of 19 concentration sites were identified (See Annex Three) produced the following population size estimation range which was validated through capture-recapture exercise:

Male	Maximum 175	Minimum 87
Female	Maximum 40	Minimum 16
Combined	Maximum 215	Minimum 103

¹⁷ FHI (2003) *Estimating the Size of Populations at Risk for HIV: Issues and Methods*

Chapter 5 SAMPLE POPULATION

This chapter presents the background and socio-demographic data on the sample population of the KAPB survey. The survey was conducted with a total sample of 513 street-based child respondents of which 400 were in Kathmandu and 113 in Pokhara.

4.1 Profile of Respondents

Chart 1: Age distribution of respondents

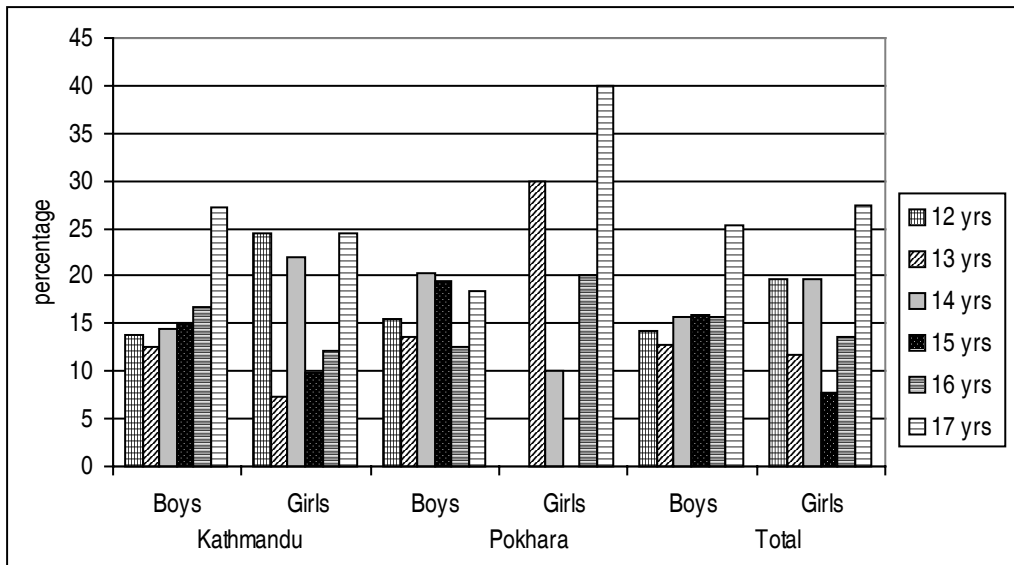
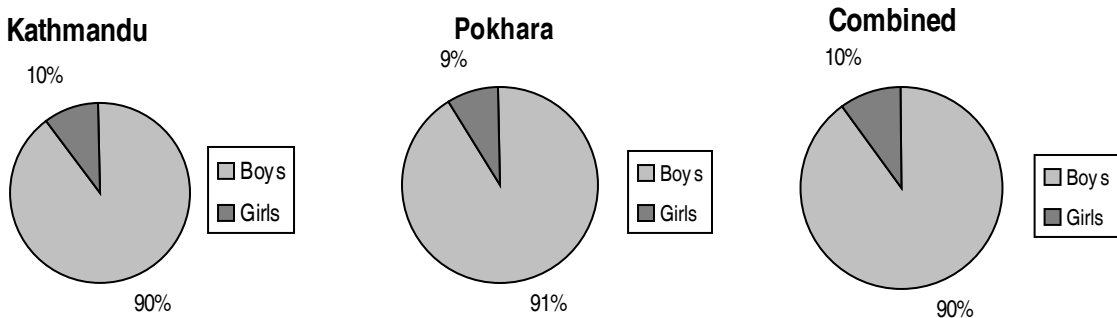


Chart 2: Gender of respondents



The questionnaire recorded the key socio-demographic characteristics of the respondents. For boys, the distribution of age was almost equally spread across the age range of 12 to 17 years (each age representing approximately 10-20 per cent of sample size). There was however a greater number of seventeen year olds participating in Kathmandu. This age therefore represented approximately 25 per cent of the total sample of Kathmandu boys.

The distribution of age of girls in both Kathmandu and Pokhara was however more uneven. Girls represented 10 per cent of the sample size in both Pokhara and Kathmandu. The population size estimation data indicates that 13-14% and 16-19% of street-based children in Kathmandu and Pokhara respectively are girls. It has already been noted that priority was given to interviewing girls wherever

possible within the sampling methodology, however due to high mobility and greater invisibility on the street this was challenging.

4.2 Adult Supervision and Living Situation

Table 3: Adult supervision and living situation

Person living with	Kathmandu		Pokhara		Total	
	Boys	Girls	Boys	Girls	Boys	Girls
Parents/Mother/Father	21.4	73.1	36.8	80.0	24.9	74.5
Other relatives	7.8	7.3	2.8	0.0	6.7	5.9
Guardians/non-relatives	3.1	2.4	1.9	20.0	2.8	5.9
Friends	56.3	2.4	46.6	0.0	54.1	1.9
On own	6.1	0.0	7.8	0.0	6.5	0.0
Husband/wife	0.8	14.6	0.9	0.0	0.9	11.8
Other	4.4	0.0	2.8	0.0	4.1	0.0
Usual place of stay at night						
Street (footpath, temple, open space, market)	36.1	0.0	24.3	0.0	33.5	0.0
Working place	5.3	7.3	2.9	10.0	4.8	7.8
Inside vehicle	4.5	0.0	9.7	0.0	5.6	0.0
Squatter house	2.2	17.1	19.4	60.0	6.1	25.5
Rented room *	41.5	73.2	33.1	30.0	39.6	64.7
Organisation	8.9	0.0	1.9	0.0	7.4	0.0
Other	1.4	2.4	8.7	0.0	3.1	1.9
Total percentage	100.0	100.0	100.0	100.0	100.0	100.0
N	359	41	103	10	462	51

* 94% of boys and 88% of girls in 'rented room' were living under adult supervision

For the sample of street-based boys in both Pokhara and Kathmandu, those living outside of adult supervision (with friends or on own) represented approximately half of all respondents (Kathmandu 62.4%, Pokhara 54.4%). The majority of the remainder lived with parents or other relatives. For girls, the majority reported that they were living with their parents (Kathmandu 73.1%, Pokhara 80%).

4.3 Caste and Ethnicity

The predominant caste/ethnicity of the sample group varied according to the location and the sex of the respondents. For Pokhara, the predominant group for boys was Damai/Kami/Sarki (45.6%), followed by Brahmin/Chhetri (28.1%) and Magar/Gurung/Tamang (21.4%). For girls the predominant groups were Magar/Gurung/Tamang and Brahmin/Chhetri (both 30%) followed by Damai/Kami/Sarki (20%). In Kathmandu, for boys the groups were Magar/Gurung/Tamang (38.4%) followed by Brahmin/Chhetri (31.0%). For female respondents, the major group was Newar (29.3%), followed by Brahmin/Chhetri (29.3%) and Magar/Gurung/Tamang (21.9%). The approximate percentages for Dalit are 15% and 10% for Kathmandu boys and girls and 47% and 30% for Pokhara boys and girls respectively.

Table 4: Caste/ethnicity

Caste/ethnicity	Kathmandu		Pokhara		Total	
	Boys	Girls	Boys	Girls	Boys	Girls
Brahmin	9.8	9.8	5.8	10.0	8.9	9.8
Chhetri	21.2	19.5	22.3	20.0	21.9	19.6
Newar	10.0	29.3	0.9	10.0	8.0	25.9
Magar/Gurung/Tamang	38.4	21.9	21.4	30.0	34.6	23.5
Damai/Kami/Sarki	10.0	7.3	45.6	20.0	18.0	9.8
Terai scheduled caste	4.5	2.4	0.9	10.0	3.7	3.9
Other Terai	5.0	9.8	2.9	0.0	4.6	7.8
Don't know	1.1	0.0	0.0	0.0	0.9	0.0
Total percentage	100.0	100.0	100.0	100.0	100.0	100.0
N	359	41	103	10	462	51

4.4 Educational Status

The majority of boys and girls reported being able to read (boys 72.7% and girls 80.4%) however this does not indicate to which level of proficiency (in many cases this may simply indicate an ability to read/write own name). A majority of the sample population had attended school at some point (74.7% boys and 84.3% girls). Of those who had ever been to school, the majority of boys (66.3%) had less than five years education, while for girls the figure was 46.5%. Of the sample group only 7.4% of boys were attending school, while 37.3% of girls were attending school.

Table 5: Educational status

Educational status	Kathmandu		Pokhara		Total	
	Boys	Girls	Boys	Girls	Boys	Girls
Can you read?						
Yes	70.7	75.6	79.6	100.0	72.7	80.4
No	29.3	24.4	20.4	-	27.3	19.6
Can you write?						
Yes	69.6	75.6	79.6	100.0	71.9	78.4
No	30.4	24.4	20.4	-	28.1	21.6
Ever been to school?						
Yes	74.1	80.5	76.7	100.0	74.7	84.3
No	25.9	19.5	23.3	0.0	25.3	15.7
Attending school?						
Yes	6.4	36.6	10.7	40.0	7.4	37.3
No	93.6	63.4	89.3	60.0	92.6	62.7
Total percentage	100.0	100.0	100.0	100.0	100.0	100.0
N	359	41	103	10	462	51
Level of education obtained						
Less than five years	63.9	48.5	74.7	40.0	66.3	46.5
5-7 years	27.8	45.4	24.0	20.0	27.0	39.5
7-10 years	8.3	6.1	1.3	40.0	6.7	14.0
Total percentage	100.0	100.0	100.0	100.0	100.0	100.0
N	266	33	79	10	345	43

For those no longer attending school, the major reason cited by over 25% of male and female participants were economically linked (could not pay school or needed to earn money). After this the major reason cited for not attending school was the distance of school from the respondent's home (29.6% of male respondents and 20.8% of girls). Notably none of the female respondents in Kathmandu cited parents not sending them to school as a reason, while 16.7% of female Pokhara respondents did report this as the reason for not going to school. Finally, a total of 5.5% of boys cited the present conflict as a reason for not attending school (i.e. 17 male respondents). None of the female respondents cited the present conflict as a reason for not attending school.

Table 6: Reason for not attending school

Reasons for not attending school	Kathmandu		Pokhara		Total	
	Boys	Girls	Boys	Girls	Boys	Girls
Parent did not send	9.9	0.0	5.9	16.7	9.0	4.8
Could not pay school	15.6	16.7	20.6	33.3	16.7	20.8
Needed to earn money	16.1	5.6	10.3	16.7	14.8	8.3
School far away	28.0	22.2	35.3	16.7	29.6	20.8
Other	11.9	44.0	5.9	16.7	10.6	37.5
Present conflict	6.6	0.0	1.5	0.0	5.5	0.0
Peer pressure	4.9	11.1	8.8	0.0	5.8	8.3
Family abuse (scolded, beaten or no care)	3.3	0.0	8.8	0.0	4.5	0.0
Death of parents	3.7	0.0	2.9	0.0	3.5	0.0
Total percentage	100.0	100.0	100.0	100.0	100.0	100.0
N	243	18	68	6	311	24

4.5 Place of Origin

The respondents originated from a large number of districts. In Kathmandu/Patan a significant percentage of girls came from Kathmandu or Lalitpur district (41.4%) and also in Pokhara 30.0% of girls originated from Kaski district. In Pokhara, 33.9% of male respondents came from Kaski district, whereas in Kathmandu although a greater proportion of boys came from surrounding districts the distribution of district of origin was much wider. The percentage of boys in Kathmandu who were from Kathmandu or Lalitpur districts was only 13.7%.

Table 7: Place of origin

Place of origin	Kathmandu		Pokhara		Total	
	Boys	Girls	Boys	Girls	Boys	Girls
Kathmandu	8.4	21.9	1.9	0.0	6.9	17.7
Ramechhap	5.0	7.3	0.0	0.0	3.9	5.9
Udayapur	3.6	0.0	0.0	0.0	2.8	0.0
Sindupalchowk	6.7	4.9	0.0	0.0	5.2	3.9
Sunsari	3.3	0.0	0.0	0.0	2.6	0.0
Dhading	5.3	0.0	1.9	0.0	4.6	0.0
Nuwakot	7.8	2.4	0.9	0.0	6.3	1.9
Lalitpur	5.3	19.5	1.9	0.0	4.6	15.7
Makawanpur	5.0	4.9	1.9	10.0	4.3	5.9
Chitwan	3.3	2.4	4.9	10.0	3.7	3.9
Kaski	1.7	0.0	33.9	30.0	8.9	5.9
Kavre	7.2	12.2	0.9	0.0	5.8	9.8
Rasuwa	1.1	0.0	0.0	0.0	0.9	0.0
Sindhuli	3.0	7.3	0.0	0.0	2.4	5.9
Dolkha	3.9	2.4	0.9	0.0	3.3	1.9
Jhapa	1.9	0.0	0.9	0.0	1.7	0.0
Mahottari	1.1	0.0	0.0	0.0	0.9	0.0
Lamjung	0.6	0.0	9.7	0.0	2.6	0.0
Sankhuwashava	0.8	0.0	0.9	0.0	0.9	0.0
Baglung	1.4	2.4	1.9	0.0	1.5	1.9
Dhankuta	0.3	0.0	2.9	0.0	0.9	0.0
Dhanusha	1.4	0.0	0.0	0.0	1.1	0.0
Rautahat	1.7	0.0	0.0	0.0	1.3	0.0
Gorkha	1.7	0.0	4.9	20.0	2.4	3.9
Okhaldungha	1.7	0.0	0.0	0.0	1.3	0.0
Morang	1.1	7.3	0.0	0.0	0.9	5.9
Myagdi	0.6	0.0	8.7	0.0	2.4	0.0
Bhaktapur	1.4	0.0	0.9	10.0	1.3	1.9
Parsa	0.6	0.0	0.9	10.0	0.7	1.9
Parbat	0.0	0.0	8.7	10.0	1.9	1.9
Other 21 districts	7.8	2.4	3.9	0.0	6.9	1.9
India	5.0	2.4	1.9	0.0	4.3	1.9
Total percentage	100.0	100.0	100.0	100.0	100.0	100.0
N	359	41	103	10	462	51

4.6 Age and reason for leaving home and duration (street-living respondents)

Table 8A: Age and reason for leaving home for first time (street-living respondents)

Age at leaving home first time	Kathmandu	Pokhara	Total
	Boys	Boys	Boys
Less than 10 years	38.3	37.3	38.1
10-12 years	33.3	38.9	34.4
13-15 years	7.4	10.2	7.9
14-17 years	20.6	13.6	19.2
Do not know	0.4	0.0	0.3
Perceived reasons of leaving home			
Domestic violence	28.0	33.3	29.0
Poor economic condition	18.1	16.7	17.8
Seeking employment	15.2	11.7	14.5
Peer pressure	7.4	11.7	8.3
Too see the city life	7.4	10.0	7.9
Influenced by peers	4.5	11.7	5.9
Present conflict	6.2	1.7	5.3
Lack of food at home	4.9	-	4.0
Death of Parents (mother/father)	3.3	3.3	3.3
Others	4.5	-	3.6
Don't know	0.4	-	0.3
Total	100.0	100.0	100.0
N	243	60	303

Of street-living respondents, the majority of who were boys, 72.5% left home at age twelve years or younger (38.1% below the age of ten years). The primary reasons reported for leaving home were domestic violence, the economic condition of the family, or the need to seek employment.

24.1% of respondents had left home in the last 6 months compared to 8.6% of respondents leaving between 6-12 months before. This may suggest a significant increase in the number of children coming to the street in the last 6 months (almost three times more) compared to one year ago, possibly reflecting the current social and political situation. It may however also be the result of organisations being successful in supporting children to move on the street within the first six months of coming to the street and therefore most children only spending a limited amount of time on the street.

Table 8B: Duration of time living on the street (street-living respondents)

Duration of time	Kathmandu	Pokhara	Total
0-6 months	26.7	13.3	24.1
7-12 year	9.1	6.7	8.6
More than one year	64.2	80.0	67.3
Total percentage	100.0	100.0	100.0
N	243	60	303

4.7 Age and reason for first spending time on street and duration (for non street-living respondents)

Of non street-living respondents, 73.7% of boys and 56.0% of girls began to spend time on the street at age twelve years or younger (41.6% of boys and 38% of girls at ten years of age or younger). It is notable that the percentages for girls and boys are not significantly different for this young age group. Economic reasons were the primary reason for spending time on the street for 63.5% of male respondents and 80.0% of female respondents. The second most reported reason was influence from peers.

Table 9A: Age and reason for first spending time on street (street-living respondents)

Age at first spending time on the street	Kathmandu		Pokhara		Total	
	Boys	Girls	Boys	Girls	Boys	Girls
Up to 10 years	42.2	42.5	39.5	20.0	41.6	38.0
11-12	27.6	17.5	44.2	20.0	32.1	18.0
13-14	18.1	25.0	14.0	40.0	17.0	28.0
15 and more	12.1	15.0	2.3	20.0	9.4	16.0
Total	100.0	100.0	100.0	100.0	100.0	100.0
N	116	40	43	10	159	50
Reasons for first spending time on the street						
Poor economic condition	61.2	75.0	69.8	100.0	63.5	80.0
Influenced by peers	15.5	20.0	14.0	-	15.1	16.0
Do not like to stay at home	8.6	-	-	-	6.3	-
Domestic violence/beaten/scolded by parents	7.8	5.0	14.0	-	9.4	4.0
Due to present conflict	3.4	-	-	-	2.5	-
Others	3.4	-	2.3	-	3.1	-
Total	100.0	100.0	100.0	100.0	100.0	100.0
N	116	40	43	10	159	50

31.9% of boys and 42.0% of girls reported spending time on the street only within the last 12 months compared to 18.1% of boys and 12.0% girls reporting having spent 1-2 years on the street. Again this may suggest an increase in the number of children coming to work on the street in comparison to two years ago, or it may suggest the success of organisations in supporting new children to move on from the street environment.

Table 9B: Duration of time spent on the street (street-living respondents)

Duration of time spent on the street	Kathmandu		Pokhara		Total	
	Boys	Girls	Boys	Girls	Boys	Girls
Less than one year	32.8	45.0	29.5	30.0	31.9	42.0
1-2 years	19.8	10.0	13.6	20.0	18.1	12.0
2-3 years	8.6	5.0	20.5	10.0	11.9	6.0
3-4 years	8.6	15.0	9.1	20.0	8.8	16.0
4-5 years	12.9	7.5	4.5	20.0	10.6	10.0
5 years and more	17.2	17.5	22.7	-	18.8	14.0
Total	100.0	100.0	100.0	100.0	100.0	100.0
N	116	40	44	10	159	50

4.8 Marital status

A total of 3.3% of all male respondents and 15.7% of female respondents reported having ever been married.

Table 10: Marital Status

Ever been married	Kathmandu		Pokhara		Total	
	Boys	Girls	Boys	Girls	Boys	Girls
Yes	3.6	19.5	1.9	0.0	3.3	15.7
No	96.4	80.5	98.1	100.0	96.7	84.3
Total percentage	100.0	100.0	100.0	100.0	100.0	100.0
N	359	41	103	10	462	51

4.9 Work type

A wide variety of work types were represented in the sample of respondents. However for boys ragpicking dominated with 46.8% as the major work type and for girls the major work type was street vending (49.0%).

Table 11: Work Type

Present work	Kathmandu		Pokhara		Total	
	Boys	Girls	Boys	Girls	Boys	Girls
Porter	9.5	0.0	0.0	0.0	7.4	0.0
Conductor/helper	11.1	0.0	20.4	0.0	13.2	0.0
Rag-picker	46.2	2.4	48.5	0.0	46.8	1.9
Beggar	3.9	2.4	0.9	0.0	3.3	1.9
Street vender	5.6	51.2	11.7	40.0	6.9	49.0
Auto mechanic/cook	2.5	0.0	0.0	0.0	1.9	0.0
Unemployed	5.3	4.9	0.0	0.0	4.1	3.9
Others	4.2	24.4	1.9	10.0	3.7	21.6
Dish washer	3.1	7.3	0.9	0.0	2.6	5.9
Hawker	2.2	0.0	0.9	0.0	1.9	0.0
Labour	4.2	7.3	14.6	50.0	6.4	15.7
Money collector	2.2	0.0	0.0	0.0	1.7	0.0
Total percentage	100.0	100.0	100.0	100.0	100.0	100.0
N	359	41	103	10	462	51

Chapter 6 SEXUAL RISK BEHAVIOUR

In one area a respondent told us that the street girls often come to sleep with them. They spend the whole night with the street boys and leave early in the morning.

In another area, the respondents reported that prostitutes often come to the kawaad and have sex with the ragpickers. They do different sexual activity, a group of people have sex with a girl and sometimes with more than one girl. Condoms are provided in the kawaad. And ragpickers are telling they have sex with their friends in same sex as well.

Field Researcher Observation

This chapter presents the results from the analysed data of the KAPB Survey regarding sexual risk behaviour of the respondents. In particular, the findings of a multivariate analysis of predictors linked with high-risk behaviour among sexually active respondents are presented.

For the purposes of this study 'sex' is defined as vaginal or anal sex. This definition is used in relation to risk level of HIV transmission. 'High-risk Sex' refers to sex with a partner involved in commercial sex work, sex with non-regular sexual partners, and/or anal sex.

5.1 Sexual Experience

Table 12: Sexual experience with a partner

Sexual experiences with a partner	Kathmandu		Pokhara		Total	
	Boys	Girls	Boys	Girls	Boys	Girls
Ever had girl/boy friend	35.1	46.3	38.8	10.0	35.9	39.2
Currently have girl/boy friend	18.9	46.3	21.4	0.0	19.5	37.2
Kissing	31.7	24.4	31.0	10.0	31.4	21.6
Fondling	34.8	24.4	29.1	0.0	33.6	19.6
Masturbation	42.6	2.4	54.4	0.0	45.2	2.0
Oral sex	4.5	0.0	3.9	0.0	4.3	0.0
Anal sex	8.4	2.4	8.7	0.0	8.4	2.0
Ever experiences of sexual intercourse (anal or vaginal)	32.3	26.8	30.1	0.0	31.8	21.6
N	341	40	101	10	442	50

A high rate of sexual activity was reported among street-based children, with the exception of girls in Pokhara. In both Pokhara and Kathmandu, a significant percentage of boys had engaged in kissing, fondling and masturbation with a partner (girl or boy). In particular, a high percentage of respondents reported masturbation with a partner (Kathmandu 42.6%, Pokhara 54.4% of all respondents). The percentage of those who had engaged in sexual intercourse (experience of anal or vaginal sex) was significant given the age group of the respondents (Kathmandu 32.3%, Pokhara 30.1% of all respondents). For girls in Kathmandu, the percentage of those who had had sexual intercourse was 26.8%. Information from FGDs suggests that this may be result of underreporting due to socio-cultural reasons. The understanding among street-based children of boy/girl friend that emerged in the FGDs was someone with whom to have sexual relations, in particular sexual intercourse. The disparity between the percentage of girls reporting having had a boyfriend (46.3%) and those reporting having had sexual intercourse (26.8%) suggests underreporting.

High sexual activity among boys can be related to two important factors. In both Pokhara and Kathmandu boys reported peer pressure from friends encouraging them to have sex (Kathmandu 40.7%, Pokhara 47.6%). Furthermore, more than half of all boys reported that half or more of their friends were sexually active (Kathmandu 54.3%, Pokhara 65%). This is significant both because of the

age of the respondents and also as perception of peer behaviour among adolescents is well documented as an important determinant of behaviour (regardless of whether this perception is correct or not).

Were you encouraged by friends to have sex?
 - Yes
 How was this?
 - I saw friends doing it then I also felt like doing it.
 - My friend paid five rupees to do it. When I saw him doing it I also paid five rupees to do it.

FGD, Boys

The data also shows early sexual initiation among street-based children, both boys and girls. Of those sexually active, the majority are active before the age of fifteen (56.9% of Kathmandu boys, 72.7% of Kathmandu girls and 77.4% of Pokhara boys reported first sex before the age of fifteen). The median age of first sex was thirteen years of age for Kathmandu boys and girls and Pokhara boys. Age of first sex ranged from as early as 7 years to 17 years. In focus group discussions many boys and girls referred to older girls proposing to younger boys to have sex.

Table 13A: Age at first sex

Age at first sex (in years)	Kathmandu		Pokhara	Total	
	Boys	Girls	Boys	Boys	Girls
Less than 15	56.9	72.7	77.4	61.2	72.7
15	24.1	0.0	6.5	20.4	0.0
16	15.5	9.1	12.9	15.0	9.1
17	3.5	18.2	3.2	3.4	18.2
Median age of first sex among sexually active	14.0	13.0	13.0	14.0	13.0
Standard deviation	2.42	2.42	2.26	2.39	3.26
Total percentage	100.0	100.0	100.0	100.0	100.0
N	116	11	31	147	11
Condom use in first sex					
Yes	25.9	9.1	29.0	26.5	9.1
No	74.1	91.9	71.0	73.5	90.1
Total percentage	100.0	100.0	100.0	100.0	100.0
N	116	11	31	147	11

Of particular concern is the low reported use of condom at first sex (Kathmandu boys 25.9%, girls only 9.1% and Pokhara boy 29.0%). This is of particular significance given that for many boys first sex was with a commercial sex partner (Kathmandu 34.5%, Pokhara 16.1%).

Most boys reported that the reason for first sex was because they wanted to have sex (Kathmandu boys 82.8% and Pokhara boys 90.3%) which contradicts an assumption that early sexual initiation (and therefore ensuing sexual activity) is the result of sexual abuse or sexual coercion. However for girls in Kathmandu 27.3% were either tricked or forced into their first experience of sex. 5.4% of Kathmandu boys and 6.4% of Pokhara boys were tricked, threatened or forced into their first experience of sex.

Table 13B: Reasons for first sex

Reasons for first sex	Kathmandu		Pokhara	Total	
	Boys	Girls	Boys	Boys	Girls
Wanted	82.8	63.6	90.3	84.3	63.6
Just happened	11.2	9.1	3.2	9.5	9.5
Tricked	0.9	9.1	-	0.7	1.3
Threatened	0.9	0.0	3.2	1.4	1.3
Forced	3.5	18.2	3.2	3.4	4.4
Peer pressure	0.9	0.0	-	0.7	0.6
Total percentage	100.0	100.0	100.0	100.0	100.0
N	116	11	31	147	11

Only 3.0% of boys and 9.8% of girls reported experiences of forced sexual intercourse by a variety of perpetrators. It must be noted that this data refers to self-perceived experiences of forced sexual

intercourse and not experience of sexual coercion or abuse. Qualitative data suggests that there are higher rates of forced or coercive sexual intercourse.

5.2 High Risk Sex

Overall 78.5% of Kathmandu boys, 36.4% of Kathmandu girls, and 54.8% of Pokhara boys who were sexually active reported having been engaged in high risk sex.

Table 14: Experience and frequency of anal sex

Ever experience of anal sex among sexually active	Kathmandu		Pokhara		Total	
	N	%	N	%	N	%
Yes	32	27.6	6	19.4	38	25.9
No	84	72.4	25	80.6	109	74.1
Total	116	100.0	31	100.0	147	100.0
Frequency of anal sex						
Very frequently	2	6.2	-		2	5.3
Frequently	2	6.2	-		2	5.3
Sometimes	28	87.6	6	100.0	34	89.4
Total	32	100.0	6	100.0	38	100.0

Among those sexually active, a significant rate of anal sex was reported by boys (Kathmandu 27.6%, Pokhara 19.4%) with the mode frequency reported as 'sometimes'. The feedback from focus group discussions suggest that in some sub-groups the rate is much higher and is both consensual and non-consensual. Anal sex was more common among younger than older boys (54% among aged 12 years, 9% among aged 17 years).

In one area we met about six boys. The boys described how one of the older ones would have anal sex with everyone. After they slept he would come and try to have anal sex forcefully as he was bigger than them. Later the boys said they all had anal sex as their enjoyment most nights. They said they don't use condoms as they are too big for them. They talked about anal sex as if it were a game for them in their group.

Field Researcher Observation

Do people have anal sex for money?

- Many sell to tourists. They give more money, give clothes, and also give food.

What does commercial sex mean?

- Prostitute

Do boys also this?

- Yes

FGD, Boys

For this study a wider definition of commercial sex was adopted, given that sex with partners who are involved in commercial sex work often does not involve a financial transaction. Children reported paying Rs.5-20 for sex with street-based girls, or giving *raksi* or tea in exchange for sex. The same question was asked to all sexually active respondents and the data does not distinguish whether the boy or girl was the receiving or giving partner.

Table 15A: Sex in exchange for money/gift

Ever had sex in exchange for money/gift of sexually active respondents	Kathmandu		Pokhara	Total	
	Boys	Girls	Boys	Boys	Girls
Yes	27.6	18.2	19.3	25.8	18.2
No	72.4	81.8	80.7	74.2	81.8
Total percentage	100.0	100.0	100.0	100.0	100.0
N	116	11	31	147	11

We found many girl vendors are offered money for sex and although they may refuse many times after some time they may accept.

Field Researcher Observation

Of those sexually active, 27.6% Kathmandu boys, 18.2% Kathmandu girls and 19.3% Pokhara boys reported having had sex in exchange for money or gift. Among the respondents reporting sex in exchange for money/gift in the last month, 34.8% of boys had done so with two or more partners. Only one girl reported that she had sex in exchange for money/gift in the last month and had had more than two partners.

Table 15B: Number of sexual partners in exchange for money/gift in the last month (among respondents reporting having had sex in exchange for money/gift in last month)

Number of person have had sex in exchange of money/gift in the last month	Boys	
	N	%
One	15	65.2
Two or more	8	34.8
Total	23	100.0

We five boys brought one prostitute here [kawaad]. We all spent an hour with her and even then we were not tired. She ended up running away.

FGD Boys

Some girls get into commercial sex. For what reason?

- *You have fun and you get money*
- *When needing to buy things for home*
- *When needing money*

FGD Girls

In FGDs respondents also indicated a significant occurrence of group sexual activities in particular with commercial sex workers.

37.1% and 32.3% of sexually-active boys in Kathmandu and Pokhara respectively reported their last sexual partner to be a commercial sex worker.

Table 16: Characteristics of last sexual partner

Characteristics of last sexual partner	Kathmandu		Pokhara	Total	
	Boys	Girls	Boys	Boys	Girls
Spouse	6.0	72.7	6.5	6.1	72.7
Commercial sex partner	37.1	0.0	32.3	36.1	0.0
Colleague	5.2	18.2	-	4.1	18.2
Boy/girlfriend	32.8	0.0	48.4	36.0	0.0
Elder street children	15.5	9.1	6.4	13.6	9.1
Others (employer, MSM, far relatives)	3.4	0.0	6.4	4.1	0.0
Total percentage	100.0	100.0	100.0	100.0	100.0
N	116	11	31	147	11

The majority of sexual active boys in Kathmandu had had sex with non-regular partners (72.4%). For girls in Kathmandu the percentage was 36.4% and for boys in Pokhara 45.2%. For most of these respondents this had occurred within the last 12 months. Of those respondents reported sex with non-regular partner, Kathmandu 40.5%, Kathmandu girls 27.3%, and Pokhara boys 22.6% reported sex with non-regular partner in the last month. For 34.1%, 33.3% and 28.6% of Kathmandu boys, Kathmandu girls and Pokhara boys reporting sex with non-regular partner in the last month respectively this has occurred with two or more partners.

Table 17: Sexual intercourse with non-regular partner (sexually active respondents)

Sexual practice	Kathmandu		Pokhara	Total	
	Boys	Girls	Boys	Boys	Girls
Ever sex with non-regular partner	72.4 (116)	36.4 (11)	45.2 (31)	66.7 (147)	36.4 (11)
Sex with non-regular sex partner in last 12 months	68.1	36.4	45.2	63.3	36.4
Sex with non-regular sex partner in last month	40.5	27.3	22.6	36.7	27.2
Number of non-regular partner in the last 12 months					
1 partner	27.9	25.0	28.6	28.0	25.0
2 or more partners	69.6	50.0	64.3	68.8	50.0
Do not know	2.5	25.0	7.1	3.2	25.0
Total percentage	100.0	100.0	100.0	100.0	100.0
N	79	4	14	93	4
Number of non-regular partner in last month					
1 partner	63.8	33.3	42.9	61.1	33.3
2 or more partners	34.1	33.3	28.6	33.3	33.3
Don't know	2.1	33.3	28.5	5.6	33.3
Total percentage	100.0	100.0	100.0	100.0	100.0
N	47	3	7	54	3

Note: Denominators in parenthesis.

The data from the survey and FGDs highlight widespread and normalised occurrence of sexual activity among street-based children. It also indicates the high level of fluidity between the different types of sexual behaviour for boys. Partners were usually non-regular and commercial, although there was not necessarily a financial transaction. Children were sometimes forced into sex while at other times they coerced others into sex. Sometimes they paid for sex and sometimes they earned money through sex. Sometimes their partners were street-based peers, older youth, MSMs, or tourists, and sometimes their partners were street-based girls, street-based sex workers, or cabin sex workers. Sometimes sex was a group activity and sometimes a personal activity.

When you have sex do you have to pay or not?
 - sometimes you have to pay, sometimes you don't
 - the first times you have to pay but later you don't
 Why not later?
 - sometimes when you drink raksi (alcohol) together you can do it
 - if you give food girls will also do it
 Do you have group sex?
 - yes
 How does this happen?
 - the first does it then we take turns
 Do older boys then encourage younger boys to do it?
 - yes

FGD Boys

Multivariate Analysis for High Risk Sexual Behaviour

A multivariate analysis of predictors linked with high-risk behaviour among sexually active respondents was conducted. In the multivariate analysis, logistic regression model was used to assess the net effect of each of the selected socio-demographic and other conceptually important predictors on key variables such as high risk behaviours and condom use. During the process of analysis, multicollinearity between the variables was assessed and the least important variables were removed from the logistic model. The results are presented in Tables 18 and 24.

With regard to high-risk behaviour, the following estimated odds ratios of having high risk sexual behaviour among those sexually active respondents deserve highlighting:

- Sexually active boys in the age group 12-14 years are three times more likely to be engaged in high risk sexual behaviour than the age group 15-17 years (statistically significant at 90% confidence interval);
- Sexually active boys who have not been married are approximately seven times more likely to be engaged in high risk sexual behaviour than those who have ever been married (99% confidence interval);
- Ragpickers who are sexually active are more than three times less likely to be engaged in high risk sexual behaviour than other work types (95% confidence interval);
- Street-based children who reported having had sex while under the influence of drugs or alcohol are four times more likely to be engaged in high risk sexual behaviour than those who have not had sex under the influence of drugs or alcohol (99% confidence interval). Although not statistically significant the data seems to support the hypothesis that those engaged in substance use are more likely to be involved in high risk sexual behaviour.

Table 18: Estimated odds ratios (and 95 percent confidence interval) for having high risk behaviour among sexually active respondents by selected predictors

Characteristics	Boys		All respondents	
	OR	95% CI	OR	95% CI
Current age				
12-14 years (ref)	1.00	-	1.00	-
15-17 years	0.31*	0.09-1.04	0.39*	0.13-1.16
Marital status				
Ever married (ref)	1.00	-	1.00	-
Never married	7.52***	1.90-29.69	7.79***	2.15-28.17
Literacy				
Illiterate (ref)	1.00	-	1.00	-
Literate	0.54	0.19-1.50	0.51	0.19-1.35
Whether or not living with family				
No living with family (ref)	1.00	-	1.00	-
Living with family	1.66	0.56-4.78	1.69	0.62-4.59
Types of current work				
Rag-picker (ref)	1.00	-	1.00	-
Other	3.62**	1.23-10.63	3.34**	1.20-9.24
Adult supervision				
No (ref)	1.00	-	1.00	-
Yes	0.72	0.13-3.97	0.91	0.21-3.96
Currently using any substances				
Yes (ref)	1.00	-	1.00	-
No	0.59	0.16-2.23	0.65	0.20-2.09
Ever visited to any organisation				
Yes (ref)	1.00	-	1.00	-
No	0.40	0.13-1.25	0.38*	0.13-1.10
Frequency of contact by any person from an organisation to discuss about how to protect from HIV/AIDS				
Never visited (ref)	1.00	-	1.00	-
Very often/often	0.39	0.11-1.38	0.42	0.13-1.45
Sometimes	2.55	0.78-8.33	2.24	0.73-6.90
Ever had sex while under the influence of drugs or alcohol				
Yes (ref)	1.00	-	1.00	-
No	0.24***	0.09-0.66	0.22***	0.08-0.59
<i>N</i>	147		158	
<i>LR chi2</i>	34.2		43.58	
<i>Prob>ch2</i>	0.0003		0.000	
<i>Pseudo R2</i>	0.2013		0.2286	

*, ** and *** denote statistically significant at 90%, 95% and 99% percent confidence interval respectively

Chapter 7 USE of CONDOMS

This chapter first examines knowledge of and attitudes towards condoms before presenting data on condom use for different types of sexual intercourse and reported reasons for non-use of condoms.

<p><i>Do you prefer to use a condom for sex?</i></p> <ul style="list-style-type: none"> - <i>I feel lazy to wear a condom</i> - <i>It's not fun, and the condom does not fit.</i> <p><i>Who decides whether or not to use a condom?</i></p> <ul style="list-style-type: none"> - <i>Girls decide and so do boys</i> - <i>Girls try to encourage you to use a condom</i> <p><i>Is there a problem because of the size of the condom?</i></p> <ul style="list-style-type: none"> - <i>Yes, there is no feeling and it is not enjoyable. It's like if you wear a plastic bag on your tongue when eating vegetables, there's no taste.</i> <p style="text-align: right; margin-top: 20px;"><i>FGD Boys</i></p>

6.1 Knowledge of and Attitude to Condoms

Most boys and girls had heard about condoms (Kathmandu Boys and Girls 90.8% and 78.1% respectively, Pokhara Boys and Girls 91.3% and 100.0% respectively). However those reporting knowledge about correct use about condoms was much lower (Kathmandu boys 40.8%, Kathmandu girls 18.7%, Pokhara boys 53.2%, Pokhara girls 60.0%). Real knowledge on correct use should be understood to be much lower than this as can be seen in Table 19. Only 30.6% of male respondents and 16.7% of female respondents identified 'squeezing end' of condom as an important thing to do when using condom.

<p><i>Why don't you use a condom?</i></p> <ul style="list-style-type: none"> - <i>I like to have sex without condom</i> <p><i>Do you know the consequences of having sex without a condom?</i></p> <ul style="list-style-type: none"> - <i>I know. You catch AIDS and STIs.</i> <p style="text-align: right; margin-top: 20px;"><i>FGD, Boys</i></p>
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Table 19: Awareness about condoms (among all respondents)

Ever heard of condoms	Kathmandu		Pokhara		Total	
	Boys	Girls	Boys	Girls	Boys	Girls
Yes	90.8	78.1	91.3	100.0	90.9	82.3
No	9.2	21.9	8.7	0.0	9.1	17.3
Total percentage	100.0	100.0	100.0	100.0	100.0	100.0
N	359	41	103	10	462	51
Knowledge about correct use of condoms						
Yes	40.8	18.7	53.2	60.0	43.6	28.6
No	59.2	81.3	46.8	40.0	56.4	71.4
Total percentage	100.0	100.0	100.0	100.0	100.0	100.0
N	326	32	94	10	420	42
Important things to do using condom						
Open wrapper carefully	60.2	16.7	58.0	100.0	59.6	58.3
Unroll on erect penis	45.9	-	30.0	66.7	41.5	33.3
Use new one very time	12.8	83.3	-	-	9.3	41.7
Check expiration date	6.8	-	-	-	4.9	-
Hold base when withdrawing after ejaculation	16.5	16.7	16.0	-	16.4	8.3
Squeeze end	30.1	33.3	32.0	-	30.6	16.7
Should be attentive, condom may break	3.8	-	8.0	-	4.9	-
Others	6.0	-	6.0	16.7	6.0	8.3
Don't know	21.1	16.7	24.0	-	21.9	8.3
N	133	6	50	6	183	12

* Percentage total may exceed one hundred due to multiple responses

When reporting the perceived advantages of condoms only 23.6% of boys and 38.1% of girls mentioned STI prevention. With regard to HIV/AIDS, 34.3% and 33.1% of boys mentioned AIDS prevention only or AIDS and pregnancy prevention respectively. For girls the percentages were lower at 23.8% and 16.7% respectively. A total of 17.1% of boys and 21.4% of girls did not report any advantages to condom use.

Table 20: Opinion on advantages of condom use (unprompted among all respondents who have heard of condom)

Advantages of condom	Kathmandu		Pokhara		Total	
	Boys	Girls	Boys	Girls	Boys	Girls
STD and pregnancy prevention	23.6	31.3	23.4	60.0	23.6	38.1
AIDS and pregnancy prevention	32.5	9.4	35.1	40.0	33.1	16.7
Pregnancy prevention only	11.0	18.8	7.4	20.0	10.2	19.0
Feel safer/protected	6.1	-	5.3	20.0	6.0	4.8
Less worry	2.1	3.1	-	10.0	1.7	4.8
AIDS prevention only	35.3	31.3	30.9	-	34.3	23.8
No advantages	0.6	3.1	2.1	-	1.0	2.4
Others	3.4	-	-	20.0	2.6	4.8
Don't know	18.4	25.0	12.8	10.0	17.1	21.4
N	326	32	94	10	420	42

* Percentage total may exceed one hundred due to multiple responses

A low percentage of both male and female respondents identified casual sex, multiple sex partners and sex with prostitutes as situations where they might use a condom. A total of 20.7% of boys and 26.2% of girls could not identify a situation where they might use a condom.

Table 21: When do you think you would use a condom (among all respondents who have heard of condoms)?

When do you think you would use a condom?	Kathmandu		Pokhara		Total	
	Boys	Girls	Boys	Girls	Boys	Girls
For casual sex	24.5	15.6	18.1	40.0	23.1	21.4
When one has multiple sex partners	29.1	9.4	30.9	30.0	29.5	14.3
To avoid pregnancy	14.4	28.1	5.3	20.0	12.4	26.2
For protection against STDs	14.7	21.9	5.3	10.0	12.6	19.0
In a husband-wife relationship	4.3	15.6	1.1	10.0	3.6	14.3
When having sex with prostitutes	23.6	3.1	28.7	-	24.8	2.4
Never	1.2	6.3	-	-	1.0	4.8
Others	4.0	-	6.4	-	4.5	-
Don't know	22.1	25.0	16.0	30.0	20.7	26.2
N	326	32	94	10	420	42

* Percentage total may exceed one hundred due to multiple responses

6.2 Condom Use and Reasons for Non Use

If you don't have direct contact there is no sexual pleasure, so if you use a condom there is no pleasure. Even if I had a condom in my pocket I wouldn't use it.

FGD Boys

Given low knowledge of correct use of condoms and the attitudes of respondents towards condom use, it is not surprising that condom use is low. The following table summarises the key indicators regarding condom use:

Table 22: Key indicators for condom use

Description	Kathmandu		Pokhara		Total	
	Boys	Girls	Boys	Girls	Boys	Girls
Condom use at first sex (among all sexually active respondents)	25.9% (116)	9.1% (11)	29.0% (31)	N/A	26.5% (147)	9.1% (11)
Condom use at last sexual intercourse (among all sexually active respondents)	35.3% (116)	27.3% (11)	48.4% (31)	N/A	38.1% (147)	27.3% (11)
Condom use at last commercial sex (among all respondents reporting commercial sex)	62.5% (32)	50.0% (2)	33.3% (6)	N/A	57.9% (38)	50.0% (2)
Condom use at last sex with a non-regular partner (among respondents reporting sex with non-regular sex partner)	42.9% (84)	25.0% (4)	57.1% (14)	N/A	44.9% (98)	25.0% (4)
Consistent condom use during sex with a non-regular partner (among respondents reporting condom use during last sex with non-regular sex partner)	41.7% (36)	100% (1)	37.5% (8)	N/A	40.9% (44)	100% (1)
Condom use at last anal sex (among boys reporting sex with male partner)	15.6% (32)	N/A	66.7% (6)	N/A	23.7% (38)	N/A
Intention to use condom during first/next sex (among respondents who have heard of condom)	66.6% (326)	62.5% (32)	70.2% (94)	60.0% (10)	67.4% (420)	61.9% (42)
Perceived ability to use condom for every act of sexual intercourse (among respondents who have heard of condom)	53.1% (326)	53.1% (32)	59.6% (94)	30.0% (10)	54.5% (420)	47.6% (42)
N Value in brackets						

Of particular importance is the fact that of 38 boys reporting anal sex, only 9 boys used condoms during anal sex in the past 12 months. Among these 3 had used condoms every time, 2 boys had used condoms almost every time and the remaining 4 had only used condoms sometimes.

The reported level of condom use varied significantly according to gender group and study area and according to the type of sexual encounter. The following table highlights the types of sexual activity for which reported condom use at last sex is extremely low (50% or below) for each sub-group:

Table 23: Type of sexual encounter with low condom use

Kathmandu Boys	Kathmandu Girls	Pokhara Boys
First sex Sex with non-regular partner Anal sex	First sex Sex with non-regular partner Commercial sex	First sex Commercial sex

Respondents had a low level of confidence that they would be able to use a condom consistently during future sexual encounters: only 54.5% of boys and 47.6% of girls believed they would be able to do so. Of particular importance it should be noted that only 67.4% of boys and 61.9% of girls thought that they would use a condom during their next sexual encounter.

The survey prompted for reasons for non-use of condoms for each respondent reporting sexual activity of different types. The reasons for non-use mentioned are as follows:

1. Not available (in particular when needed)
2. Not like them

3. Trust partner (including non-regular sex partner)
4. Not think of it
5. Not know what condom is
6. Partner too young
7. Size of condom
8. Partner object
9. Lack of money

Condoms are available but when I want to have sex they are not available. At 12 or 1 o'clock at night where can I go find a condom?

FGD, Boys

In discussions children reported non-use of condoms due to not having a condom at the right moment and not having time to obtain one – when they had the opportunity for sex, condom use became a low priority. They know HIV/AIDS is spread through unprotected sex, they know they are having sex with someone who might be infected, but still they do not use condoms.

In instances where condoms are used it is most often due to the behaviour of the sexual partner – in particular, female sex workers who provide condoms and commercial sex with MSMs who provide condoms for anal sex. These tend to be partners who can negotiate condom use. FGDs indicate that street-based girls also encourage condom use but are often not able to negotiate this with sexual partners.

Multivariate Analysis for Condom Use during Last Sexual Intercourse

The multivariate analysis of predictors linked with condom use during last sexual intercourse among sexually active respondents provides important findings. The following estimated odds ratios deserve highlighting:

- The 12-14 year old sexually active respondents are almost three times less likely to use condoms than the 15-17 year age group (statistically significant at 95% confidence interval);
- For sexually active respondents living with family are more than three times more likely to use a condom than those not living with family (statistically significant at 95% confidence interval), although the data also suggests that they are more likely to be engaged in high-risk sexual behaviour in the first place;
- The frequency of contact by organisations regarding HIV/AIDS seems to have little impact on likelihood of condom use.

Table 24: Estimated odds ratios (and 95 percent confidence interval) for condom use during last time sexual intercourse among sexually active respondents by selected predictors

Characteristics	Boys		All respondents	
	OR	95% CI	OR	95% CI
Current age				
12-14 years (ref)	1.00	-	1.00	-
15-17 years	2.89**	1.15-7.31	3.13**	1.24-7.86
Marital status				
Ever married (ref)	1.00	-	1.00	-
Never married	1.16	0.35-3.84	1.03	0.34-3.08
Literacy				
Illiterate (ref)	1.00	-	1.00	-
Literate	1.12	0.53-2.76	1.17	0.52-2.63
Whether or not living with family				
No living with family (ref)	1.00	-	1.00	-
Living with family	3.35**	1.13-9.95	3.64**	1.27-10.39
Types of current work				
Rag-picker (ref)	1.00	-	1.00	-
Other	1.62	0.68-3.86	1.76	0.74-4.17
Adult supervision				
No (ref)	1.00	-	1.00	-
Yes	0.70	0.20-2.43	0.65	0.21-2.04
Currently using any substances				
Yes (ref)	1.00	-	1.00	-
No	1.11	0.34-3.66	1.12	0.38-3.29
Ever visited to any organisation				
Yes (ref)	1.00	-	1.00	-
No	0.99	0.36-2.71	0.95	0.36-2.52
Frequency of contact by any person from an organisation to discuss about how to protect from HIV/AIDS				
Never visited (ref)	1.00	-	1.00	-
Very often/often	0.82	0.25-2.70	0.85	0.27-2.67
Sometimes	1.04	0.42-2.57	1.12	0.46-2.71
Ever had sex while under the influence of drugs or alcohol				
Yes (ref)	1.00	-	1.00	-
No	0.69	0.32-1.52	0.65	0.30-1.41
<i>N</i>	147		158	
<i>LR chi2</i>	15.75		20.01	
<i>Prob>ch2</i>	0.1508		0.0452	
<i>Pseudo R2</i>	0.0806		0.0958	

** denotes statistically significant at 95% confidence interval

Chapter 8 INJECTING RISK BEHAVIOUR

During our visit we met one drug addict. He said he was told he was HIV positive by a doctor at Bir Hospital after he had surgery a few months ago... although according to him he has not had a blood test. He said he shared needles only with his best friend but not others. However at the same time as we talked he shared a syringe with the toilet worker.

Field Researcher Observation

This chapter presents the prevalence of injecting drug use within the sample population and examines needle-sharing behaviour.

7.1 Injecting Drug Use

Table 25: Prevalence of injecting drug users

Ever injected drug	Kathmandu		Pokhara		Total	
	Boys	Girls	Boys	Girls	Boys	Girls
Yes	6.7	7.3	5.8	0.0	6.5	7.3
No	93.3	92.7	94.2	100.0	93.5	92.7
Total percentage	100.0	100.0	100.0	100.0	100.0	100.0
N	359	41	103	10	462	51
Frequency of drug injection in the last month						
Never					46.7	0.0
Daily					20.0	0.0
Several times in a week					13.3	66.7
Once a week					13.3	33.3
Once in two weeks					6.7	0.0
Total percentage					100.0	100.0
N					30	3

In Kathmandu, 6.7% of street-based boys and 7.3% of street-based girls reported having injected drugs. In Pokhara, 5.8% of boys and 0.0% of girls reported injected drugs. Of these, 100% of girls and 53% of boys had injected in the last month. Needle-sharing was reported by 60% of boys & 33% of girls (although the sample was small). Those boys sharing needles appear to do so on a regular basis (at least weekly).

The FGDs indicated that many street-based IDUs are also sexually active with other street-based girls and boys, as well as with commercial sex workers. It can also be assumed that condom use among this group is also low.

Have you ever shared a syringe?

- I have shared
- When I don't have one, I inject a friend's.

Do you know what the consequences of needle-sharing are?

- Yes we know. You catch AIDS.

If you know this, why do you share?

- When you can't get a needle, what else can you do?
- I only share when I can't get a syringe

FGD with street-based boys and girls who inject drugs

Table 26: Prevalence needle-sharing

Ever shared the needle/syringe	Boys		Girls	
	N	%	N	%
Yes	18	60.0	1	33.3
No	12	40.0	2	66.7
Total	30	100.0	3	100.0
Frequency of using same needle/syringe that had been used by someone else in the past month				
Never	6	37.5	1	33.3
Daily	2	12.5	-	-
Several times a week	3	18.7	1	33.3
Once a week	5	31.3	-	-
Once in a month	-	-	1	33.3
Total	16	100.0	3	100.0

Chapter 9 UNDERSTANDING of STIs and HIV/AIDS

This chapter presents the sample population's knowledge and awareness of STIs and HIV/AIDS, before examining attitudes and beliefs surrounding HIV/AIDS which help to understand risk-taking behaviour among the target population.

8.1 Knowledge and Awareness of STIs

Table 27: Knowledge on STIs

Do you know of any infections a person can get through sexual intercourse?	Kathmandu		Pokhara		Total	
	Boys	Girls	Boys	Girls	Boys	Girls
Yes	52.9	48.8	52.4	70.0	52.8	52.9
No	47.1	51.2	47.6	30.0	47.2	47.1
Total	100.0	100.0	100.0	100.0	100.0	100.0
N	359	41	103	10	462	51
How to avoid STIs						
Use of condom	86.3	60.0	66.7	85.7	82.0	66.7
Washing	1.6		3.7		2.0	
Avoiding casual partners	7.9	35.0	9.3	42.9	8.2	37.0
Abstinence	15.8	5.0	3.7	28.6	13.1	11.1
Using herbs or other	3.2		3.7	14.3	3.3	3.7
Avoid needle exchange	1.6	10.0	3.7		2.0	7.4
Avoiding sex w/ STI infected persons	14.7	-	7.4	14.3	13.1	3.7
Others	1.1		3.7	14.3	1.6	3.7
Don't know	8.4	25.0	13.0		9.4	18.5
N	190	20	54	7	244	27

With the exception of Pokhara girls, only approximately half of male and female respondents reported any knowledge of infections that could be spread through sexual intercourse. Of these 66.7% of female respondents and 82.0% of male respondents could identify use of condom as means to avoid STI transmission.

Of those respondents who had heard of STIs only 2.9% of boys reported having had an STI. None of the girls reported having had an STI. These results are surprising given the high rate of unprotected sex, especially with commercial sex workers, suggesting a high level of untreated STIs.

Table 28: Have you ever had an STI?

Have you ever had an STI ?	Kathmandu		Pokhara		Total	
	Boys	Girls	Boys	Girls	Boys	Girls
Yes	3.7	-	-	-	2.9	-
No	92.1	95.0	94.4	100.0	92.6	96.3
Don't know	4.2	5.0	5.6	-	4.5	3.7
Total	100.0	100.0	100.0	100.0	100.0	100.0
N	190	20	54	7	244	27

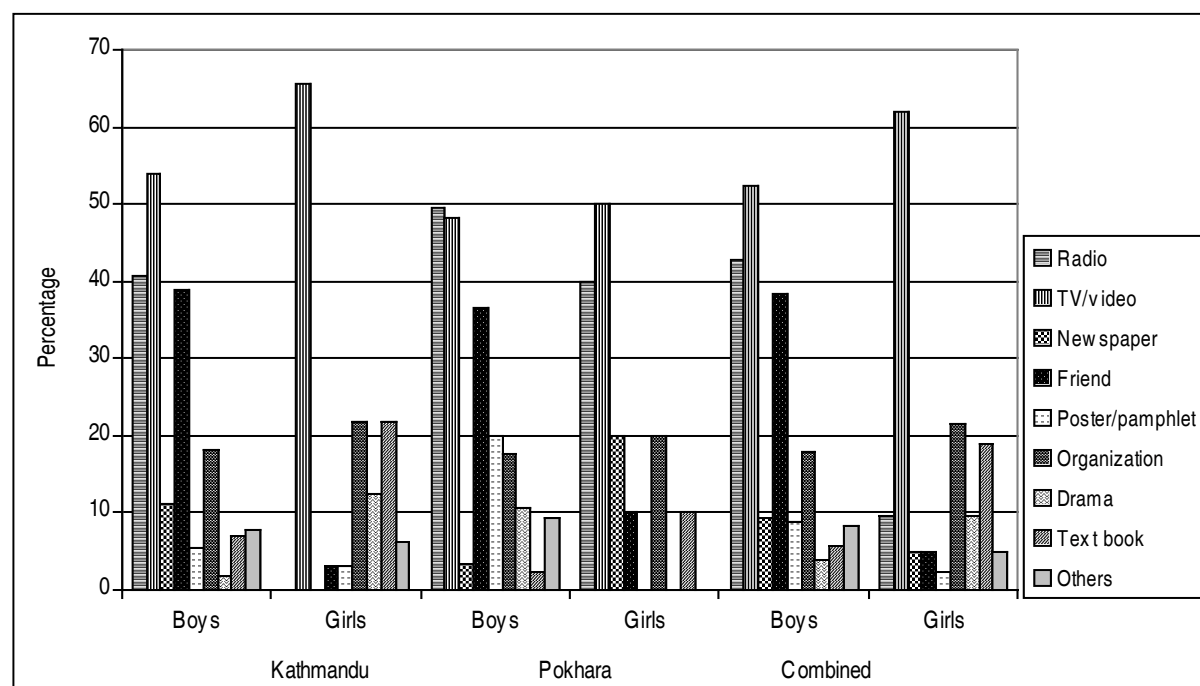
8.2 Awareness about HIV/AIDS

Table 29: Awareness on HIV/AIDS

Heard about HIV/AIDS	Kathmandu		Pokhara		Total	
	Boys	Girls	Boys	Girls	Boys	Girls
Yes	77.2	78.0	82.5	100.0	78.4	82.4
No	22.0	22.0	17.5	-	21.0	17.6
No response	0.8	-	-	-	0.6	-
Total	100.0	100.0	100.0	100.0	100.0	100.0
N	359	41	103	10	462	51
Know anyone who is infected with HIV or has died of AIDS						
Yes	41.9	46.9	38.8	30.0	41.2	42.9
No	51.6	50.0	44.7	60.0	50.0	52.4
Don't know	6.5	3.1	14.1	10.0	8.3	4.8
No response	-	-	2.4	-	0.6	-
Total	100.0	100.0	100.0	100.0	100.0	100.0
N	277	32	85	10	362	42

Most respondents, both girls and boys, had heard of HIV/AIDS. Over 40% of boys and girls also knew someone who was infected with HIV or had died of AIDS. The main sources of information for HIV/AIDS reported by all respondents were television and/or radio. After this boys reported hearing about HIV/AIDS from friends. Approximately 10-20% of respondents had heard about HIV/AIDS from organisations.

Chart 30: Sources of information on HIV/AIDS



Most respondents who had heard of HIV/AIDS believed that it existed, although significantly 25.0% of girls in Kathmandu believed that HIV/AIDS did not exist. Overall 74.0% and 78.6% of boys and girls respectively believed that there were cases of HIV/AIDS among their peers.

Table 31: Beliefs about HIV/AIDS

Whether or not believe that HIV/AIDS exists	Kathmandu		Pokhara		Total	
	Boys	Girls	Boys	Girls	Boys	Girls
Yes	89.2	75.0	97.6	100.0	91.2	81.0
No	10.8	25.0	2.4	0.0	8.8	19.0
Do you think there are cases of HIV/AIDS among street children?						
Yes	78.0	78.1	61.2	80.0	74.0	78.6
No	14.4	21.9	22.4	20.0	16.3	21.4
Don't know	7.6	-	16.5	-	9.7	-
Total	100.0	100.0	100.0	100.0	100.0	100.0
N	277	32	85	10	362	42

8.3 Knowledge about HIV/AIDS

Table 32: Knowledge on modes of transmission

Mode of transmission (unprompted)	Kathmandu		Pokhara		Total	
	Boys	Girls	Boys	Girls	Boys	Girls
Sexual intercourse	71.5	53.1	57.6	80.0	68.2	59.5
Sharing needles/unclean medical equipment	52.3	43.8	28.2	40.0	46.7	42.9
Blood Transfusion	22.4	31.3	12.9	10.0	20.2	26.2
During pregnancy	5.1	9.4	1.2		4.1	7.1
Mother to child during birth	2.5		1.2	10.0	2.2	2.4
Mosquito or other insect bites	6.5		1.2	10.0	5.2	2.4
Casual contact with infected person	14.4	37.5	15.3	10.0	14.6	31.0
Having sex with many	14.1	3.1	20.0	20.0	15.5	7.1
Others	4.0		2.4	20.0	3.6	4.8
Don't know	8.3	12.5	11.8		9.1	9.5
N	277	32	85	10	362	42
Can a person get infected by HIV/AIDS from having unprotected sex?						
Yes	91.7	90.6	95.3	100.0	92.5	92.9
No	1.4	6.3	-	-	1.1	4.8
Don't know	6.9	3.1	4.7	-	6.4	2.4
Can a person get infected by HIV/AIDS by taking injections with a used needle?						
Yes	89.9	90.6	91.8	100.0	90.3	92.9
No	4.0	6.3	2.4	-	3.6	4.8
Don't know	6.1	3.1	5.9	-	6.1	2.4
Total	100.0	100.0	100.0	100.0	100.0	100.0
N	277	32	85	10	362	42

When responding to prompted questions the majority of boys and girls could identify unprotected sex (92.5% and 92.9%) and injecting used needles (90.3% and 92.9%) as potential ways in which a person could become infected with HIV/AIDS. However unprompted only 59.5% of girls and 68.2% of boys identified sexual intercourse as a mode of transmission and only 42.9% of girls and 46.7% of boys identified sharing needles as a mode of transmission. The difference between unprompted knowledge (i.e. attitude) and prompted knowledge (i.e. formal knowledge) may be attributed to the personal attitudes and risk perceptions held by the respondents towards HIV/AIDS.

Knowledge of means of preventing transmission of HIV/AIDS was more limited. 31.5% of boys and 14.3% of girls either believed that there was nothing a person could do to avoid contracting HIV/AIDS or did not know if there was anything that could be done.

Table 33: Knowledge on prevention methods

Is there anything a person can do to avoid getting HIV/AIDS?	Kathmandu		Pokhara		Total	
	Boys	Girls	Boys	Girls	Boys	Girls
Yes	68.2	84.4	69.4	90.0	68.5	85.7
No	19.5	12.5	14.1	0.0	18.2	9.5
Don't know	12.3	3.1	16.5	10.0	13.3	4.8
Total	100.0	100.0	100.0	100.0	100.0	100.0
N	277	32	85	10	362	42
What can a person do? (unprompted)						
Avoid sex completely/abstinence	31.7	25.9	20.3	77.8	29.0	38.9
Stay faithful to partner	4.8	14.8	1.7		4.0	11.1
Encourage partner to stay faithful	3.2			11.1	2.4	2.8
Avoid contaminated blood	13.8	7.4	1.7	22.2	10.9	11.1
Use condoms for every act of sexual intercourse	76.7	48.1	67.8	55.6	74.6	50.0
Avoid sharing needles	36.0	55.6	15.3	33.3	31.0	50.0
Avoid commercial sex workers	15.9	3.7	3.4		12.9	2.8
Avoid casual sex	5.8	25.9		22.2	4.4	25.0
Others	7.4	7.4	27.1	11.1	12.1	8.3
N	189	27	59	9	248	36

74.6% of boys identified use of condoms for every act of sexual intercourse as a means of prevention, while only 50.0% of girls identified this means of prevention. 29.0% of boys and 38.9% of girls identified abstinence as a means of prevention. Regarding infection through needles, only 31.0% of boys and 50.0% of girls identified avoiding sharing needles as means of prevention.

Unprompted only 0.6% of boys identified the three major HIV prevention methods (abstinence, consistent condom use, and monogamy among partners). None of the female respondents identified all three of these prevention methods.

8.4 Attitudes and Beliefs about HIV/AIDS

Concerning the attitudes and beliefs of street-based children about HIV/AIDS there are significant misconceptions:

- 26.5% of boys and 19.0% of girls believe that HIV/AIDS is curable in some cases;
- 43.4% of boys believe that you cannot catch HIV the first time that you have sexual intercourse; and,
- 31.2% of boys and 19.0% of girls do not believe it is possible for a healthy-looking person to have HIV/AIDS.

In responding to prompted question to identify incorrect beliefs about AIDS transmission, only 8.7% of boys and 2.0% of girls could correctly reject the two most common misconceptions about HIV/AIDS and identify that a healthy-looking person could have HIV/AIDS.

Table 34: Beliefs surrounding HIV/AIDS

Beliefs surrounding HIV/AIDS	Kathmandu		Pokhara		Total	
	Boys	Girls	Boys	Girls	Boys	Girls
Can a person get infected by HIV/AIDS by sharing utensils with someone who is infected? *						
Yes	25.3	25.0	43.5	20.0	29.6	23.8
No	68.2	62.5	51.8	70.0	64.4	64.3
Don't know	6.5	12.5	4.7	10.0	6.1	11.9
Can a person get infected by HIV/AIDS from mosquito bite? *						
Yes	49.1	56.3	69.4	40.0	53.9	52.4
No	38.3	25.0	15.3	30.0	32.9	26.2
Don't know	12.6	18.8	15.3	30.0	13.3	21.4
Is it possible for a healthy-looking person to have HIV/AIDS?						
Yes	53.1	75.0	52.9	80.0	53.0	76.2
No	35.7	25.0	16.5	-	31.2	19.0
Don't know	11.2		30.6	20.0	15.7	4.8
Can a person get HIV/AIDS the first time s/he has sex?						
Yes	38.3	75.0	48.2	60.0	40.6	71.4
No	46.2	12.5	34.1	40.0	43.4	19.0
Don't know	15.5	12.5	17.6	-	16.0	9.5
Is HIV/AIDS curable in some cases?						
Yes	26.7	21.9	25.9	10.0	26.5	19.0
No	62.1	75.0	58.8	80.0	61.3	76.2
Don't know	11.2	3.1	15.3	10.0	12.2	4.8
Total	100.0	100.0	100.0	100.0	100.0	100.0
N	277	32	85	10	362	42

* Two most common local misconceptions regarding HIV/AIDS

Given the attitudes and beliefs surrounding HIV/AIDS and the difficult circumstances in which street-based children find themselves it is perhaps not surprising that a relatively low percentage worry about getting infected with HIV even given the clear existence of high-risk behaviour – only 44.2% of boys in Kathmandu and Pokhara identified being worried about infection. The percentage for Kathmandu girls was higher at 68.8%. For Pokhara girls, 20% reported being worried, but it should be noted the low prevalence of risk-behaviour among this group.

In their own risk assessment 33.6%, 59.4% and 47.1% of Kathmandu boys, Kathmandu girls, and Pokhara boys respectively believed they had done something that put them at risk of getting HIV.

Table 35: Risk perception

Do you worry about getting infected with HIV?	Kathmandu		Pokhara		Total	
	Boys	Girls	Boys	Girls	Boys	Girls
Yes	43.3	68.8	47.1	20.0	44.2	57.1
No	56.7	31.3	52.9	80.0	55.8	42.9
Do you think you have done anything that puts you at risk of getting HIV?						
Yes	33.6	59.4	47.1	10.0	36.7	47.6
No	66.4	40.6	52.9	90.0	63.3	52.4
Total	100.0	100.0	100.0	100.0	100.0	100.0
N	277	32	85	10	362	42

Many have heard of HIV/AIDS so why do they engage in sex without using a condom?

- Sometimes you are rushed, or have no money, or the girl is nice.
- If the girl is nice she probably doesn't have AIDS so we do it.
- I don't think HIV can spread in one time.
- When I get the chance to have sex why am I going to start thinking about infections?

FGD Pokhara

Chapter 10 EXPOSURE TO INTERVENTIONS

In most cases I found the children's perceptions about NGOs were negative. They blame the organizations for them remaining on the street. They felt at the beginning they are welcomed by organizations but later on they forget them. They also felt that foreign assistance was not properly spent on them.

Field Researcher Observation

This chapter details the exposure of the sample population to organisational interventions both in general and related to sexual and reproductive health (SRH) and HIV/AIDS. It also details the person from whom respondents would most like to learn more about SRH and HIV/AIDS.

9.1 Exposure to Organisational Interventions

The general exposure of street-based children to organization interventions and programmes was low given the vulnerable and at risk nature of this population. Only 57.4% of boys and 33.3% of girls reported having been visited by NGOs in the past year (outreach/fieldwork). Only 54.1% of boys and 19.6% of girls had visited an organization in the past year. It should be noted that girls' exposure to interventions and therefore access to services was much lower than that of boys. During NGO mapping for the population size estimation not one organization reported working specifically with street-based girls who clearly have distinct needs and challenges.

Table 36: Contact from/with NGOs

Anyone from NGOs/institution visited you in the past year?	Kathmandu		Pokhara		Total	
	Boys	Girls	Boys	Girls	Boys	Girls
Yes	56.0	34.2	62.1	30.0	57.4	33.3
No	44.0	65.8	37.9	70.0	42.6	66.7
Total	100.0	100.0	100.0	100.0	100.0	100.0
N	359	41	103	41	462	51
Ever visited any organisation?						
Yes	54.6	21.9	52.4	10.0	54.1	19.6
No	45.4	78.1	47.6	90.0	45.9	80.4
Total percentage	100.0	100.0	100.0	100.0	100.0	100.0
N	359	41	103	10	462	51

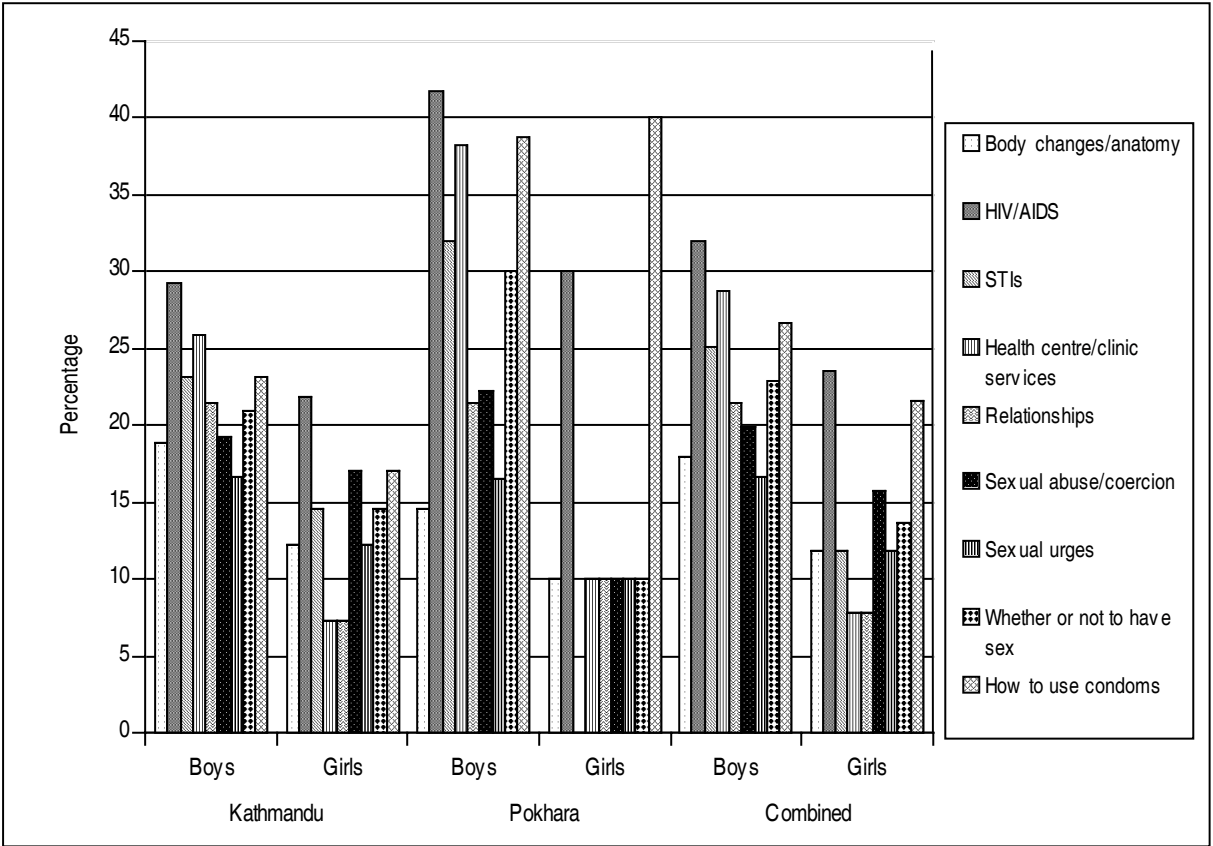
Table 37: Contact with NGOs regarding HIV/AIDS and use of condoms

Topics discussed	Kathmandu		Pokhara		Total	
	Boys	Girls	Boys	Girls	Boys	Girls
HIV/AIDS						
Never	74.1	85.4	67.0	90.0	72.5	86.3
Very often	3.3	9.8	1.9	0.0	3.0	7.8
Often	3.6	0.0	4.8	0.0	3.9	0.0
Sometimes	13.4	4.9	21.4	10.0	15.2	5.9
Don't know	5.6	0.0	4.9	0.0	5.4	0.0
Use of condoms						
Never	73.3	85.4	64.1	90.0	71.2	86.3
Very often	2.2	4.9	0.9	0.0	1.9	3.9
Often	4.5	2.4	6.8	0.0	5.0	2.0
Sometimes	13.1	7.3	24.3	10.0	15.6	7.8
Don't know	6.9	0.0	3.9	0.0	6.3	0.0
Total percentages	100.0	100.0	100.0	100.0	100.0	100.0
N	359	41	103	10	462	51

Of more concern for the scope of this study was that an extremely low proportion of street-based boys and girls have been reached with HIV/AIDS prevention programming. Only 27.5% of boys and 13.7% of girls have discussed HIV/AIDS with someone from an organisation. Only 28.8% of boys and 13.7% of girls have discussed use of condoms with someone from an organisation.

Regarding sexual and reproductive health education, only a small percentage of boys and girls have had access to information from organisations. In particular girls have not been reached. Only 18% of boys and 11.8% of girls have ever discussed puberty or body changes with an educator or organisational staff. Only 16.7% of boys and 11.8% of girls have discussed dealing with sexual urges or feelings. Only 22.9% boys and 13.7% girls have discussed deciding whether or not to have sex. Only 25.1% of boys and 11.8% of girls have discussed access to health centre/clinic services.

Chart 38: Exposure to sexual & reproductive health education



When asked who they would most feel comfortable to learn about sex and sexual health from both boys and girls clearly identified friends.

Table 39: Most comfortable person to learn about sex and sexual health from

Most comfortable person to learn about sex and sexual health	Kathmandu		Pokhara		Total	
	Boys	Girls	Boys	Girls	Boys	Girls
Friends	62.7	43.9	68.9	70.0	64.1	49.0
Boy/girl friends	2.5	17.1	5.8	10.0	3.2	15.7
Counsellor	6.7	2.4	2.9	0.0	5.8	2.0
Peer educator	6.1	0.0	3.9	0.0	5.6	0.0
Street educator	6.4	4.9	12.6	0.0	7.8	3.9
Doctor/nurse	5.6	2.4	-	-	4.3	2.0
Others	2.1	26.8	4.8	20.0	3.0	25.5
None	5.6	2.4	1.0	.0	4.6	2.0
Don't know	1.9	0.0	-	-	1.5	0.0

Total percentage	100.0	100.0	100.0	100.0	100.0	100.0
N	359	41	103	10	462	51

9.2 The *Kawaad* and local community

Children have limited exposure to organisational interventions, both in terms of number of children reached and in the amount of time front line workers spend with children, meaning that it is a much greater challenge for front line workers to be able to have a positive impact on children's attitudes and practices and become positive role models for the children. Given that the children spend a significant part of their time with local communities it is clearly significant to understand more about the normalised attitudes and practices to which children are exposed.

The scrap centers and local communities play an important role in the lives of many street-based children. This role can be both positive and negative. In particular this study revealed that some *kawaads* play a positive role in the children's lives providing condoms to ragpickers, preventing abuse of younger boys, regulating their drug use, encouraging them to save money, and supporting them to find other work. These *kawaads* provide a sense of belonging and connection for many children and can be positive role models in the children's lives.

However, other *kawaads* provide drugs and girls to retain their 'clients' (child ragpickers often bring in the majority of their scrap) and have a motivation to keep children dependent on them. In these areas high risk behaviour is normalized in the daily lives of the ragpickers.

The *kawaads* are also an important place and environment away from the street for organisations to be able to access ragpicking children when they are not working.

In one area the owner of the junkyard didn't allow us to talk with the kids as he said that every hour people from organisations come and don't allow the boys to work. He was annoyed with the people of one organization as he said they come with video games and make kids play for an hour and so he thinks how can these children develop themselves by playing games. How can they earn money to eat. Thinking that we were also like that he didn't allow us to talk with the kids but later knowing the truth he gave time for us to talk with the kids.

Field Researcher Observation

In the same way children involved in all forms of work may have strong relations with the local community or their work colleagues. A diverse range of individuals (drivers, older conductors, hotel owners etc.) may often be the role models for street-based children or be the main sense of connection/stability in their lives. These individuals may have an impact as positive and negative role models in the lives of the children and therefore protective or risk factors in terms of HIV/AIDS vulnerability.

Chapter 11 KEY INDICATORS

This table presents the key indicators from the KAPB survey which are recommended as indicators to monitor change in knowledge, attitudes, beliefs and risk behaviour within the target population over time.

Key Indicators						
Description	Kathmandu		Pokhara		Total	
	Boys	Girls	Boys	Girls	Boys	Girls
Street-based children sexually active	32.3% (359)	26.8% (41)	30.1% (103)	0.0% (10)	31.8% (462)	21.6% (51)
Median age at first sexual intercourse (total number of respondents sexually active)	13.34 (116)	13.0 (11)	12.81 (31)	N/A	13.26 (147)	13.0 (11)
Condom use at first sex (total number of respondents sexually active)	25.9% (116)	9.1% (11)	29.0% (31)	N/A	26.5% (147)	9.1% (11)
Condom use at last sexual intercourse (total number of respondents sexually active)	35.3% (116)	27.3% (11)	48.4% (31)	N/A	38.1% (147)	27.3% (11)
High-risk sex among street-based children (total number of respondents sexually active)	78.5% (116)	36.4% (11)	54.8% (31)	N/A	73.5% (147)	36.4% (11)
Sex with non-regular partner in last 12 months (total number of respondents sexually active)	68.1% (116)	36.4% (11)	45.2% (31)	N/A	66.7% (147)	36.4% (11)
Sex with more than one non-regular partner in last 12 months (total number of respondents reporting non-regular sex partner in last 12 months)	69.6% (79)	50.0% (4)	64.3% (14)	N/A	68.8% (93)	50.0% (4)
Condom use at last sex with a non-regular partner (total number of respondents reporting non-regular sex partner)	42.9% (84)	25.0% (4)	57.1% (14)	N/A	44.9% (98)	25.0% (4)
Consistent condom use during sex with a non-regular partner (total number of respondents reporting condom use during last sex with non-regular sex partner)	41.7% (36)	100% (1)	37.5% (8)	N/A	40.9% (44)	100% (1)
Condom use at last anal sex among those males reporting sex with male partner (total number of respondents reporting experience of anal sex)	15.6% (32)	N/A	66.7% (6)	N/A	23.7% (38)	N/A
Injecting drugs in last 12 months	6.7% (359)	7.3% (41)	5.8% (103)	0.0% (10)	6.5% (463)	7.3% (51)
Injecting users sharing equipment (total number of respondents reporting injecting in last 12 months)					60.0% (30)	33.3% (3)
Contact by organisation to discuss on HIV/AIDS	20.3% (359)	14.7% (41)	28.1% (103)	10.0% (10)	22.1% (463)	7.7% (51)

Knowledge of three major HIV prevention methods (Numerator: Respondents who without prompt identify consistent condom use, mutual monogamy, and abstinence as prevention methods; Denominator: All respondents)	0.8% (359)	0.0% (41)	0.0% (103)	0.0% (10)	0.6% (463)	0.0% (51)
No incorrect beliefs about AIDS transmission (Numerator: Respondents who reject that HIV/AIDS can be spread by mosquito bites or by sharing utensils with infected person, and who know that a healthy-looking person can transmit AIDS; Denominator: All respondents)	10.0% (359)	2.4% (41)	3.9% (103)	0.0% (10)	8.7% (463)	2.0% (51)
N Value in brackets						
Unless otherwise stated denominator is total number of respondents surveyed						

Chapter 12

SUMMARY, DISCUSSION and CONCLUSIONS

12.1 Summary of Key Findings

This study confirms that street-based children are at high risk of HIV/AIDS infection due to high-risk sexual and injecting behaviours. In particular the following risk behaviours are important to highlight:

- Among street-based children a **significant percentage are sexually active**
- **Early age of sexual initiation** among both boys and girls
- **Sexual intercourse is usually high-risk** with children involved in anal sex, sex with multiple/non-regular partners, and commercial sex
- Of those sexually active, **children below fourteen are more likely to be involved in high risk sex and less likely to use a condom**
- **Condom use is low** for all types of sexual encounters
- Despite the low number of cases reported by respondents, it is likely that there are a large number of cases of untreated STIs given the level of unprotected sex
- **High percentage of needle-sharing** among those children reporting injecting drugs

The majority of street-based children have a basic knowledge of HIV/AIDS:

- Most boys and girls have **heard of HIV/AIDS**
- Many **can identify that a person can get infected with HIV/AIDS from having unprotected sex** (73% and 76% of boys and girls respectively).
- The majority of boys and girls **can identify that a person can get infected with HIV/AIDS by taking injections with a used needle** (71% and 76% of boys and girls respectively).
- **Knowledge on prevention methods is more limited** but does exist among a significant percentage of boys and girls, particularly with regard to condom use for sexual intercourse.

However, there exist dangerous misconceptions and false beliefs about HIV/AIDS:

- Many boys hold the **belief that you cannot get infected with HIV/AIDS the first time you have sex**
- A significant percentage of boys and girls hold the **belief that it is not possible for a healthy-looking person to have HIV/AIDS.**

Street-based children have had limited exposure to HIV/AIDS prevention and SRH interventions:

- Although many children are frequently visited by or visit many NGOs, a **significant percentage have not had any contact with an organisation in the last year**
- In particular **street-based girls have very limited contact with organisations**
- Among all respondents, **few have discussed HIV/AIDS with someone from an organisation** (27.5% of boys and 13.7% of girls)
- There has been **limited access of street-based children to sexual and reproductive health education.**

12.2 Discussion and Conclusions

“If you have a condom it’s fine. If you don’t it’s also fine. It’s enough to have money for sex.”

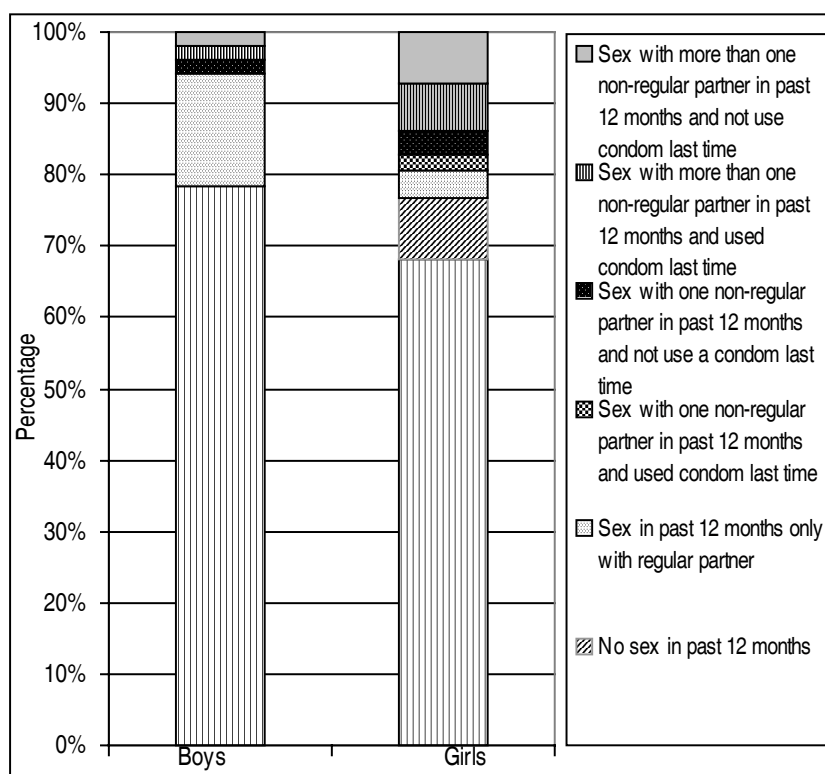
“I only share a needle, when I can’t get a new syringe.”

The study reveals inconsistencies within the knowledge, attitudes, practices, and beliefs of street-based children in the context of HIV/AIDS. Although respondents had basic knowledge regarding HIV/AIDS, practical knowledge on the basic facts of transmission and prevention is more limited and unclear. In particular, the study highlights inconsistencies between knowledge and attitudes and beliefs, and between knowledge and behaviour.

The existence of knowledge has not resulted in the elimination of false beliefs or negative attitudes: children still believe they can judge whether a person is HIV infected by looking at them; children still believe that if they only share needles sometimes they are unlikely to be infected; children believe that you cannot become infected with HIV the first time you have sex.

The existence of knowledge has not resulted in any changes in behaviour. IDUs share needles even when they know they should not; children do not use condoms even though they know they are at risk of HIV infection.

Chart 40: Sexual Risk Behaviours among street-based children



Early sexual initiation, sex with multiple non-regular partners, inconsistent condom use (if condoms are used at all), and needle-sharing among IDUs are the major behavioural challenges in preventing the spread of HIV/AIDS. A particular focus should be given to sexual risk behaviours. A total of 6.5% and 7.4% of boys and girls respectively reported ever injecting drugs, whereas 31.8% and 21.6% of boys and girls respectively are sexually active.

Many types of sexual activity appear to be normalised from an early age. There exists pressure to engage in sexual risk behaviours, as well as a widespread perception of the existence of risk-taking behaviours among peers (i.e. “everyone is doing it”). Both these factors encourage risk-taking. Programmes need to target peer norms and influences to succeed in addressing sexual risk behaviours, including early sexual initiation and coercive sex, and supporting positive peer role models.

The first step must be to address the culture of silence which surrounds sex and sexuality. In particular the young must be targeted. Sexually active children below 14 years of age are more likely to be

involved in high-risk sexual behaviour and are less likely to use a condom. At the same time children are less likely to have had any exposure to sexual and reproductive health interventions. Their maturation and sexual development occurs without access to support and information. They do not have the opportunity to learn about puberty, adolescence, sexuality and becoming an adult. There is no opportunity to discuss the consequences of present behaviour on their futures.¹⁸

This study shows that although increased awareness and education are important to prevent the spread of HIV/AIDS among street-based children, the key is translating this knowledge into safer behaviour and practices. Children need the skills to make decisions, to deal with stress, and, to have positive relationships. The importance of all life skills must be recognised: self-awareness, managing emotions, coping with stress, empathy, effective communication, interpersonal relationships, critical thinking, creative thinking, decision-making, and, problem solving. Also practical skills, such as self-efficacy in condom use and negotiating condom use, should be developed among children.

The impact of social isolation, stress, and the street environment often result in negative coping mechanisms among street-based children manifesting in increased risk-taking behaviours. A child with no self-esteem does not think about tomorrow. A child with a devalued sense of his/her body won't use a condom. Street-based children need a positive self-image of themselves to hope and plan for their future. The importance of promoting children's self-esteem through a holistic approach to HIV prevention should be recognised.

Not all street-based children are engaged in high risk-behaviour. They may share the same situations and face the same risks, but they can respond differently. The resilience demonstrated by many is a reflection of their individual agency.¹⁹ More needs to be understood about why some children are able to practice protective behaviours and others not: "There is mounting evidence that the most effective interventions enhance protective factors of young people and do not simply attempt to reduce risk."²⁰ In particular the importance of meaningful relationships with families, community members, peer educators, or mentors is worth highlighting.

Interventions therefore need to work at not only the individual level but also at the community level. Many stakeholders have an impact on the protective and risk behaviours of street-based children: peers, older youth, employers, colleagues, peer educators, front line workers, hotel owners, police, *kawaad* owners etc. Interventions should be based on the contexts and realities of the children taking into account their needs and wants, and also their stage of development (effective interventions for pre-adolescents and adolescents should be different).

The estimated population range of street-based children in Kathmandu valley is from 1616 to 2123, and in Pokhara from 103 to 215. Of these less than an estimated 30% of boys and 15% of girls have ever discussed HIV/AIDS with someone from an organisation. It may have been assumed that the majority of those street-based children at risk of HIV/AIDS fell into interventions targeted at IDUs and CSWs. This study clearly shows that this is not the case. Youth HIV/AIDS prevention interventions must mainstream these vulnerable urban children into their programming. Interventions for street-based children must mainstream HIV/AIDS prevention into their programming.

¹⁸ See P.A.U. Education/UNESCO. 2004. *Street Children and HIV/AIDS* www.paueducation.com/sida

¹⁹ See Panter-Brick C. 2002. *Street Children, Human Rights, and Public Health: A Critique and Future Directions*. *Anthropology* 32 147-71

²⁰ WHO (2004) *Risk and protective factors affecting adolescent reproductive health in developing countries: an analysis of adolescent sexual and reproductive health literature from around the world: summary*.

Chapter 13 RECOMMENDATIONS

This chapter details the key recommendations for action based on the findings of the study:

1. The vulnerable situation of street-based children combined with a high level of risk-taking behaviours make street-based children extremely vulnerable to HIV/AIDS. Incidents of HIV/AIDS infection have been recorded in the population and the risk behaviours exist for the virus to rapidly expand within this vulnerable population. Prevention programmes are urgently needed to protect these children. Street-based children should be recognised and prioritised by GOs, INGOs, and NGOs as a sub-population highly vulnerable to HIV infection.
2. From this study there is no evidence to suggest that street-based children can be seen as a core transmitter group spreading HIV/AIDS to the general population. GOs, INGOs and NGOs should be careful that information dissemination or advocacy initiatives do not result in increased discrimination against street-based children, an already marginalised group in society.
3. Separate HIV/AIDS interventions for street-based children should not be initiated as these may result in duplication and also in increased discrimination against street-based children. Street-based children and HIV/AIDS prevention should be integrated into existing programming for this population. In particular:
 - a. HIV/AIDS prevention programming should be mainstreamed into existing programmes for street-based children;
 - b. Street-based children as a target group should be mainstreamed into existing HIV/AIDS prevention programming for youth.
4. Organisations working with street-based children should develop a coordinated and integrated strategy for HIV prevention to reach all street-based children, both girls and boys, giving special consideration to their context. The responsibility for coordination and the development of a joint integrated strategy should be taken up by the National Alliance of Organisations for Street Children.
5. GOs, INGOs and funding agencies should financially and technically support front line organisations to develop a coordinated and integrated strategy for HIV/AIDS prevention among street-based children, supporting organisations to work together to address the issue.
6. HIV/AIDS should not be treated as separate programme within interventions for street-based children. A holistic approach should be adopted integrating HIV/AIDS prevention into programmes for health, sexual and reproductive health, life skills, non-formal education etc.
7. Children's participation should be promoted in the design and implementation of any intervention. This will result in more effective and relevant programming as well as providing an opportunity for the children to develop skills. Street-based children living with HIV/AIDS should be involved as much as possible in prevention interventions.

8. Interventions should take into account the realities and contexts of the children. Programmes which compromise children's ability to survive will not be successful unless alternative forms of income generation can be identified and supported.
9. As well as reinforcing knowledge on HIV/AIDS prevention methods, programming should aim for behavioural change reducing risk-taking behaviour with the following specific objectives:
 - a. Delaying first sexual intercourse
 - b. Reducing high risk sexual practices
 - c. Increasing condom use for all types of sex, with a particular focus on anal sex
 - d. Reducing needle sharing among IDU street-based children
10. To achieve a reduction in risk-taking behaviour, programming will have to integrate a strong life skills component focusing in particular on increasing the self-esteem of children, their skills to deal with peer pressure, their practical skills in condom use, and ability to manage and deal with emotions.
11. Street-based children have identified friends, i.e. peers, as the people with whom they are most comfortable learning about sex and sexual and reproductive health. This study has shown that existing programmes and front line workers have had limited impact on reaching children on these issues. Immediate focus should be given on promoting awareness-raising on SRH (including HIV/AIDS) and life skills among street-based children through trained peer educators, supported and supervised by trained adults.
12. High risk behaviour exists among street-based children from an early age. Interventions need to target children at a young age and immediately as they come to the street, before the onset of risk-taking behaviour. Sexual and reproductive health education must begin with children as young as ten years old. Interventions should take into account the stage of development of the target group and be adapted accordingly.
13. Based on the documented methodology, the KAPB study should be repeated after two to three years to assess the impact of interventions implemented following this study and monitor any changes in knowledge, attitude, practice and belief among the target population.
14. Based on the documented methodology, the KAPB study should be replicated in different urban areas to provide quality information for effective prevention interventions and to monitor the situation of street-based children in relation to HIV/AIDS.

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ANNEX THREE
HIV_AIDS KAPB Survey
Screening Questionnaire to Identify Potential Respondents

1. Is the child between 12 and 17 years of age inclusive?

YES → Go to Question 2

NO → Do not include

2. Does the child sleep on the street?

YES → Potential Respondent

NO → Go to Question 3

3. Does the child live with family, relatives, or responsible adults?

NO → Potential Respondent

YES → Go to Question 5

4. Does the child live in a night-shelter or temporary residential programme?

(Field researchers to list those organisations included according to NGO/social mapping phase)

YES → Potential Respondent

NO → Go to Question 5

5. Is the child involved in a worst form of child labour?

Ragpicker → Potential Respondent

Short-distance Porter → Potential Respondent

Conductor → Potential Respondent

Begging → Potential Respondent

Street-based commercial sex worker → Potential Respondent

Street-based criminal activities → Potential Respondent

(inc. pick pocketing, street drug selling, street gang etc.)

Other work → Go to Question 6

No work → Go to Question 6

6. Does the child have “adequate responsible adult supervision”?

NO → Potential Respondent

Any child spending a regular amount of time on the street over an extended period of time outside of responsible adult supervision (i.e. no family, adult or community supervision) for work or hanging around should be seen as not having “adequate adult supervision”.

“Street” is to be understood as a space, environment and culture. As a space it should be understood in the widest sense of the word to include abandoned buildings, parks, empty land etc.

YES → Do not include

If Potential Respondent continue to request *informed consent*

**ANNEX FOUR
POPULATION SIZE ESTIMATION DATA**

Social Mapping: Kathmandu and Patan Data by Site

S.N.	Site	Size					
		Male		Female		Total	
		Min	Max	Min	Max	Min	Max
1	Anamnagar	1	3	1	1	2	4
2	Bagalamukhi	22	22			22	22
3	Balaju	41	54	6	8	47	62
4	Balkhu	40	57	8	10	48	67
5	Basantapur	48	60	15	20	63	80
6	Basundhara	3	5			3	5
7	Bhadrakali	4	6	1	2	5	8
8	Bhaisepati	35	35			35	35
9	Bhanimandal	10	12			10	12
10	Bhatkekopul	6	11			6	11
11	Bir Hospital	14	23	3	8	17	31
12	Boudha	33	43	15	17	48	60
13	Chabahil	22	36			22	36
14	Chamati	18	28			18	28
15	Dhalko	51	51			51	51
16	Dhobighat	5	8			5	8
17	Dillibazar	80	80			80	80
18	Durbarmarg	18	28			18	28
19	Exhibition Road	7	10	1	2	8	12
20	Gaushala	5	9	2	3	7	12
21	Gokarna, Hanumanthan	1	2			1	2
22	Gongabu	25	33			25	33
23	Gwarko	4	8			4	8
24	Hadigaun			13	13	13	13
25	Indra chowk	4	6			4	6
26	Jamal	14	18	7	8	21	26
27	Jawalakhel	16	23			16	23
28	Jayabageshwori	5	6			5	6
29	Jorpati	4	4			4	4
30	Kalanki	84	107	4	6	88	113
31	Kalimati	57	70	23	28	80	98
32	Kalopul	9	15			9	15
33	Kamalpokhari	10	15			10	15
34	Kirtipur	4	6			4	6
35	Koteshwor	8	15	2	4	10	19
36	Kuleshwor	40	45	25	26	65	71
37	Kumbheshwor	15	20			15	20
38	Kusunti	21	26			21	26
39	Lagankhel	77	108			77	108
40	Lainchour	10	13			10	13
41	Lokanthali	8	10			8	10
42	Mahankal	4	8	1	2	5	10
43	Maharajgunj	31	36	9	9	40	45

44	Maitidevi	10	15			10	15
45	Mandikhatar	19	19			19	19
46	Mulpani	11	14			11	14
47	Nagdhunga	30	35	10	15	40	50
48	Nayabazar	4	6			4	6
49	New Baneshwor	21	30	2	4	23	34
50	New road	5	10	3	5	8	15
51	Old Baneshwor	19	37	1	2	20	39
52	Pashupati	50	63	10	15	60	78
53	Patan Durbar Square	8	10	20	30	28	40
54	Pulchowk	6	8			6	8
55	Putali sadak	19	28	1	3	20	31
56	Ratna Park	73	86	1	2	74	88
57	Ravi Bhavan	30	30			30	30
58	RNAC	22	34			22	34
59	Sangam Chowk	20	20			20	20
60	Satdobato	2	4			2	4
61	Shahid gate	10	15			10	15
62	Shantinagar	10	15	1	4	11	19
63	Subidhanagar	6	8	1	3	7	11
64	Sundhara	24	44	1	2	25	46
65	Swoyambhu	31	43			31	43
66	Teaching hospital	1	2			1	2
67	Teku	20	30	10	15	30	45
68	Thamel	15	20	2	2	17	22
69	Thapathali	5	13	1	5	6	18
70	Tilganga	17	19	14	16	31	35
Total		1402	1833	214	290	1616	2123

Social Mapping: Pokhara Data by Site

SN	Site	Location	Key Info	Size					
				Male		Female		Total	
				Min	Max	Min	Max	Min	Max
1	Mahendrapool	Medical Line	1	7	8	0	0	7	8
			2	6	7	0	0	6	7
			3	6	8	0	0	6	8
Total				6	8	0	0	6	8
2	Mahendrapool	Chipledhunga	1	10	12	0	0	10	12
			2	10	11	0	0	10	11
			3	9	10	1	2	10	12
Total				9	12	1	2	10	14
3	Mahendrapool	Mahendrapool Chowk	1	6	7	0	0	6	7
			2	5	6	0	0	5	6
			3	4	5	0	0	4	5
Total				4	7	0	0	4	7
4	Mahendrapool	Chipledhunga Line	1	4	5	0	0	4	5
			2	5	6	0	0	5	6
			3	3	4	1	2	4	6
Total				3	6	1	2	4	8
1	Prithwi Chowk	Slum Area	1	7	9	0	0	7	9
			2	6	8	4	6	10	14
			3	8	10	2	3	10	13
Total				6	10	2	6	8	16
2	Prithwi Chowk	Slum Area	1	4	5	6	7	10	12
			2	10	12	6	9	16	21
			3	7	9	3	5	10	14
Total				4	12	3	9	7	21
3	Prithwi Chowk	Market Area	1	9	12	0	0	9	12
			2	10	15	0	0	10	15
			3	6	8	0	0	6	8
Total				6	15	0	0	6	15
4	Prithwi Chowk	Bus Park's Bus Stand	1	9	12	0	0	9	12
			2	6	9	1	2	7	11
			3	10	15	0	0	10	15
Total				6	15	1	2	7	17
5	Prithwi Chowk	Way to Nagdhunga	1	7	12	0	0	7	12
			2	6	9	0	0	6	9
			3	10	12	0	0	10	12
Total				6	12	0	0	6	12
1	Ram Krishna Tole	Tole Line	1	7	8	0	0	7	8
			2	8	10	0	0	8	10
			3	7	8	0	0	7	8
Total				7	10	0	0	7	10
2	Gaira patan	Nabin Ma.Vi School line	1	5	6	0	0	5	6
		Kalicharan Gaddhi	2	5	6	0	0	5	6
		Sambu Gaddhi	3	7	8	0	0	7	8
Total				5	8	0	0	5	8

1	Ram Bazar	Indra Marg	1	3	4	0	0	3	4
		Indra Marg	2	3	4	0	0	3	4
		Ghale Gaun	3	3	4	0	0	3	4
Total				3	4	0	0	3	4
2	Ram Bazar	Indian Pension Camp	1	2	3	0	0	2	3
			2	4	5	0	0	4	5
			3	6	7	0	0	6	7
Total				2	7	0	0	2	7
1	Naya Bazar	Slum Area	1	4	6	0	0	4	6
			2	2	4	3	4	5	8
			3	4	7	0	0	4	7
Total				2	7	3	4	5	11
1	Prithwi Chowk	Subji Mandi	1	9	12	7	10	16	22
			2	15	20	10	15	25	35
			3	10	15	5	8	15	23
Total				9	20	5	15	14	35
1	Bachhibuduwa	Landfield Side	1	3	4	0	0	3	4
			2	3	4	0	0	3	4
			3	4	5	0	0	4	5
Total				3	5	0	0	3	5
2	Baglung Buspark	Buspark	1	5	6	0	0	5	6
			2	8	9	0	0	8	9
			3	3	4	0	0	3	4
Total				3	9	0	0	3	9
3	Birauta	Chowk Area	1	2	4	0	0	2	4
			2	2	3	0	0	2	3
			3	3	4	0	0	3	4
Total				2	4	0	0	2	4
4	Ratnachowk	Janapriya Campus Line	1	2	3	0	0	2	3
			2	1	2	0	0	1	2
			3	3	4	0	0	3	4
Total				1	4	0	0	1	4
Grand Total				87	175	16	40	103	215

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