UNIVERSITY OF SOUTHAMPTON

Context, process and determinants of trafficking and health seeking behaviour of trafficked women and girls in Nepal: Implications for social and public health policy.

Padam Prasad Simkhada

A thesis submitted in fulfilment of the requirements for the degree of Doctor of Philosophy (PhD)

Department of Social Work Studies
Faculty of Social Sciences

January 2003

UNIVERSITY OF SOUTHAMPTON

ABSTRACT

FACULTY OF SOCIAL SCIENCE
DEPARTMENT OF SOCIAL WORK STUDIES

Doctor of Philosophy

Context, process and determinants of trafficking and health seeking behaviour of trafficked women and girls in Nepal: Implications for social and public health policy.

By Padam Prasad Simkhada

There are no solid data on the magnitude, the determinants and processes of trafficking in Nepal, and the needs of trafficked persons who return. Similarly, interventions strategies are seldom systematically assessed and, thus, their rate of success is not known. Women and girls who are trafficked face abuse, exploitation, and a high risk of infection by HIV/AIDS. Health need, health services utilization practices and other health risk behaviour of these trafficked women and girls are not known.

Given above background, this thesis focuses on context, process and determinants of trafficking of women and girls from Nepal to India and health seeking behaviour and health need of trafficked women and girls in Nepal.

Information was collected from returned trafficked women and girls by using ethnographic study (42 in-depth interviews and observation) and field surveys (n=206). It also examined national laws as well as documents produced by anti-trafficking projects, interviewed key policymakers, program managers, and activists.

Women and girls from more than 25 ethnic groups from 37 districts were found to be trafficked in Indian brothels. The root cause of trafficking is multiple and complex. Poverty, lack of employment opportunities, gender discrimination, lack of female education, a lack of awareness among the general population, and abuse in migration were seen as important causes for

trafficking in Nepal. Study also discovered that trafficking operates primarily through personal connections and social network.

This study found that awareness on sexual health issues, particularly about STIs, and HIV/AIDS was poor among the returned trafficked women and girls. The Nepali trafficked sex workers in Indian brothels are powerless to negotiate any terms of sex in order to protect themselves from HIV infection. These women and girls held a holistic view of health in which dietary balance, avoidance of 'addictions' (such as drinking and smoking) and emotional stability were seen as essential to well being.

The study found that there is no consistent definition of trafficking in law and policy documents in Nepal, which leads to confusion about what activities constitute trafficking. This study also revealed that many trafficking policies and programmes may inadvertently infringe on the human rights of women who wish to migrate.

There is no easy or uni-dimensional solution to human trafficking, since it is influenced by a complex set of factors, often working in combination with one another. It concludes that control measures alone cannot stop the flow of trafficking in women and that a legal approach which relies solely on one type of legislation would be too narrow.

Anti-trafficking strategies must shift from paternalistic approaches to more holistic and participatory empowerment approaches. An effective strategy must combine and balance punitive measures with protection of human rights, women empowerment and the removal of the root causes. Measures must be agreed and coordinated between origin, transit and receiving countries as well. Anti-trafficking interventions need to be re-focused so that they do not infringe upon the human rights of women who wish to migrate but who are at risk of trafficking. Interventions should provide support systems to permit safe migration and to help women once they reach their destinations.

Acknowledgements

I am very much delighted to express my sincere gratitude to my supervisor Professor Chris Bagley for his invaluable direction, constructive comments and valuable guidance in the completion of this thesis. I would like to express my sincere gratitude to my advisor Dr. Monique Hennink for her advice, support and encouragement in both academic and personal matters throughout the course of my studies. Their positive remarks and trust in my work always helped me to be optimistic and enthusiastic

I wish to extend my gratitude and sincere appreciation to Professor Joan Orme, Jackie Powell, Frances Sheldon, Dr. Roger Ingham and Anita Sargeant for their support and help. I would like to express my sincere thanks to all staff and all lecturers in Southampton University who directly or indirectly helped me to complete this thesis.

I'm very grateful to Mrs Laxmi Pokhrel (ABC Nepal), Shandha Shresthal (CWIN), sister Deepa (Karuna Bhawan), Shanta Sapkota (Peace Home Nepal) and Evana (Naba Joti Kendra Nepal) for their support, co-operation in accessing the research participants during my field study.

I must salute and extend my gratitude to the innocent women and girls who were interviewed and were very co-operative during fieldwork. I wish to thank my research assistants, who helped me for the data collection.

I wish to thank all my family for their inspiration and unstinting support during my study and field work. I'd like to thank my wife, Bibha Simkhada, for her continuous support and encouragement, which helped a lot not only in this study but also in every area of my life.

Finally, I acknowledge with gratitude to the Department of Social Work Studies, University of Southampton, Opportunities and Choices University of Southampton, Parkes Foundation and Simon Population Trust for their financial support.

Table of Contents

Title		I
Abstract		II
Acknowledgements		IV
Table of contents		V
List of tables		VIII
List of figures		VIII
Abbreviations used		IX

CHAPTER ONE

1	**The Problem of Trafficking: The Research Background**	**1**
1.1	Introduction	1
1.2	The magnitude of the problems	2
1.3	Rational of the study	4
1.4	Aims and objectives of the present study	8
1.5	Structure of the thesis	9
1.6	Limitation of the study	10

CHAPTER TWO

2	**Socio-Political Overview of Nepal**	**11**
2.1	Introduction	11
2.2	Nepal-initial overview	11
2.3	Health service utilisation and human resources	13
2.3.1	Doctors	15
2.3.2	Nurses	15
2.3.3	Auxiliary Nurse Midwives (ANM)	15
2.3.4	Maternal and Child Health Workers	16
2.3.5	Village Health Workers	16
2.3.6	Female Community Health Volunteers	17
2.3.7	Traditional Birth Attendants	17
2.3.8	Traditional Healers	18
2.4	Financing of Health	18
2.4.1	Public expenditure	19
2.4.2	External sources	19
2.4.3	Private enterprises	19
2.4.5	Non-governmental organisations	20
2.5	Organisation of Health System	20
2.6	Gender Issues in Nepal	26
2.6.1	Socialisation Patterns of the Male and Female Child	27
2.6.2	Women in Work	27
2.6.3	Women in the Family Environment	29
2.6.4	Women in the National Environment	34
2.7	Law and Policy related to Trafficking	35
2.8	Policy on rescue and rehabilitation	37

2.9 Conclusions 38

CHAPTER THREE

3 Literature Review and Conceptual Framework 40
3.1 Introduction 40
3.2 Definition of trafficking 40
3.3 Approaches to Trafficking 42
3.3.1 A Moral problem 42
3.3.2 A Criminal problem 42
3.3.3 A Migration problem 43
3.3.4 A Human rights problem 43
3.3.5 A Public order problem 43
3.3.6 A Labour issue problem 43
3.4 Prostitution from different perspective 44
3.4.1 The structuralist perspective 45
3.4.2 The sex worker's perspective 45
3.4.3 The feminist perspective 46
3.5 Trafficking and prostitution 48
3.6 Trafficking and migration 51
3.7 Women contrasted with children: Issues of consent and choice 53
3.8 Trafficking in women and girls: Global overview 55
3.9 Trafficking and prostitution in Asia 58
3.10 Trafficking in Nepal 61
3.11 Trafficking for prostitution and HIV/AIDS 66
3.12 Trafficking and other health problems 69
3.13 Health services for trafficked women and sex workers 70
3.14 Research framework 79
3.15 Problems and weakness of available literature 84
3.16 Conclusions 89

CHAPTER FOUR

4 Research Methodology 90
4.1 Introduction 90
4.2 Approach of my research 91
4.3 Ethnography within case study framework 95
4.4 Case Study 100
4.5 Research process and methods 103
4.5.1 Access to study site 103
4.5.2 Preliminary visit, recruitment of research assistants and pilot study 107
4.5.3 Tools of the data collection and sample size 108
4.5.4 Recording interview data 114
4.5.5 Analysing data 116
4.6 Validity and Reliability 119
4.7 Ethical Considerations 124
4.8 Conclusions 126

CHAPTER FIVE

5	**The Context, Determinant and Process of Trafficking**	**129**
5.1	Introduction	129
5.2	Background Information of trafficked women and girls	129
5.3	Recruitment, Movement and Initiation	132
	5.3.1 Methods and means of trafficking	132
	5.3.2 Family involvement in trafficking	138
	5.3.3 Causes of trafficking	139
5.4	Ways of trafficking, Traffickers and Destination	143
5.5	Life in Brothels	146
	5.5.1 Debt Bondage and earning in the brothels	150
	5.5.2 Illegal confinement	153
	5.5.3 Working conditions	155
5.6	Back home from brothels (The return)	156
5.7	Discussion and Conclusions	160

CHAPTER SIX

6	**Awareness about Sexual Health and Health Seeking Behaviour**	**170**
6.1	Introduction	170
6.2	Socio-demographic information	172
6.3	Access to information about sexual health and condom use	177
6.4	Understandings of health and health problems	177
6.5	Choice of healthcare providers and utilisation	180
6.6	Therapy management	194
6.7	Discussion and conclusions	199

CHAPTER SEVEN

7	**Conclusions and Implementations on Policy and Further Research**	**206**
7.1	Introduction	206
7.2	Conceptual clarification and approach	206
7.3	Causes and context of trafficking	209
7.4	Care support for trafficked persons and preventive strategies	210
7.5	Health seeking behaviour and appropriate health services for returned trafficked women and girls	216
7.6	Further research on health seeking behaviour	222
	References	**224**
	Appendixes	245

List of Tables

Table no	Title	Page number
3.1	Conceptual frameworks to understand the health seeking behaviour	80
5.1	Selected socio-demographic characteristics	130
5.2	Distribution of trafficking by district, zone and region	131
5.3	Major motivating methods and means of trafficking	138
5.4	Ways of trafficking, traffickers and destination	145
5.5	Life in brothels	149
5.6	Total duration stay in brothels in month * mode of return	159
6.1	Selected socio-demographic characteristics	171
6.2	Glossary of terms for sexually transmitted diseases and other related problems	178

List of figures

Figure no	Title	Page number
1.1	Map of Nepal	12
4.1	Conceptual Framework	83

Acronyms and Abbreviations Used

AATWIN	Alliance Against Trafficking in Women and Children in Nepal
ABC Nepal	Agro-forestry Basic Health and Co-operatives Nepal
ADB	Asian Development Bank
AIDS	Acquired Immune Deficiency Syndrome
ARI	Acute Respiratory Infection
ATSEC	Alliance Against Trafficking and Sexual Exploitation of Children
CAR	Children At Risk (Network)
CATW	Coalition Against Trafficking in Women
CBO	Community-Based Organization
CBS	Central Bureau of Statistics
CEDAW	Convention for the Elimination of All Forms of Discrimination Against Women
CeLRRd	Centre for Legal Research and Resource Development
CSW	Commercial Sex Worker
CWIN	Child Workers in Nepal Concerned Centre
DDC	District Development Committee
ESCAP	Economic and Social Council for Asia and Pacific
FCHV	Female Community Health Volunteer
F/P	Family Planning
GAATW	Global Alliance Against Trafficking in Women
GO	Governmental Organization
HDI	Human development Index
HIV	Human Immune-deficiency Virus
HMG	His Majesty's Government
HMG/N	His Majesty's Government of Nepal
HP	Health Post
HPI	Human Poverty Index
ICCPR	International Convention on Civil and Political Rights
IEC	Information, Education and Communication
ILO	International Labour Organization

INGO	International Non Governmental Organisation
IOM	International Organization for Migration
IPEC	International Program on the Elimination of Child Labour
LDC	Less Developed Country
MCH	Mother and Child Health
MOH	Ministry of Health
MOWCSW	Ministry of Women, Children and Social Welfare
Mt.	Mountain
NESAC	Nepal South Asia Centre
NGO	Non Governmental Organisation
NNAGT	National Network Against Girl Trafficking
NPC	National Planning Commission
OHCHR	Office of the High Commissioner for Human Rights
PHC	Primary Health Care
Rs.	Rupees (Nepalese Currency)
SAARC	South Asian Association for Regional Cooperation
Sq.ft.	Square feet
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TBA	Traditional Birth attendance
TU	Tribhuvan University, Nepal
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	The United Nations Population Fund
UNICEF	United Nations International Children's Emergency Fund
USAID	United States Agency for International Development
VDC	Village Development Committee
WB	World Bank
WHO	World Health Organisation
WOREC	Women's Rehabilitation Centre

CHAPTER ONE

THE PROBLEM OF TRAFFICKING: THE RESEARCH BACKGROUND

1. Introduction

Trafficking in persons is a global problem. The UN Protocol on Trafficking in Persons, signed by 80 countries in December 2000 in Palermo, Italy, officially recognizes trafficking as a modern form of slavery and forced labour that relies on coercion, fraud or abduction in order to flourish. Worldwide, it is estimated that somewhere between 700,000 (U.S. Department of State, 2001) and four million (UNFPA, 2000) women, children and men are trafficked each year, and no region is unaffected. The large differential in estimated levels of trafficking reflects the difficulty in obtaining accurate data. However, that this is a significant and deplorable global phenomenon is not in doubt. The global trafficking industry generates an estimated five to seven billion U.S. dollars each year, more than the profits generated by the arms and narcotics trades (Widgren, 1994).

International attention is beginning to focus on the issues of human trafficking and the obvious risks to the health and well-being of the person involved in trafficking (Gushulak and MacPherson, 2000). Ill health and disease in these individuals have direct effects on trafficked women and girls. They also have broader implications for the health of individuals and populations at the place of origin, as well as for those who interact with the migrant during the trafficking process and for the community into which the person is trafficked.

Trafficking for prostitution is no new phenomenon and it has a long history in Nepal. Religious and traditional forms of prostitution have to some extent paved the way for the present situation. Those forms, however, were less obvious and hidden behind their respective cultural context.

The scale and significance of involvement by Nepalese girls and women in the sex industry in India received particular attention after the publication of an article by *Times of India* in January 1986 (Seddon, 1998), which quoted figures (produced by the Indian health Organisation) indicating that 100,000 Nepalese

young women were working in Indian brothels. Measures introduced by Indian Health authorities after 1986 to test commercial sex workers for HIV led to deportation of many Nepalese women who had worked in Indian sex industry and were found to be infected (or were even thought to be infected). Similarly, another watershed event occurred in February 1996 when the Indian government tried to forcibly repatriate two hundred Nepali women from brothels in Mumbai (ABC Nepal, 1996; Pradhan, 1996).

These events drew considerable media attention, especially when a number of girls were forcibly tested for HIV and found positive. Challenged by the immense need of these victims, many NGOs developed anti-trafficking programs, attracting considerable support from international donor agencies. Awareness of the HIV pandemic added a sense of urgency, since the social and economic processes underlying trafficking are in many ways similar to those fuelling the spread of HIV (AIDS Action, 1998; UNDP, 2000).

Although the problem of trafficking is serious and chronic in Nepal, the effort to abolish trafficking is being intensified only after a multi-party democracy established in 1990. Since early 1990s, trafficking of women and girls was identified as a priority issue. Within twelve years, non-governmental organisations (NGOs) and community-based organisations (CBOs) began to address and combat the problem through expanded social, cultural, and economic programs. The international donor community, including the United Nations, bilateral and multilateral donors, increased funding for many social issues that had been relegated to the background, including issues related to women, children, bonded labour and human rights. His Majesty's Government of Nepal (HMG/N) established the Ministry of Women, Children and Social Welfare (MOWCSW), and began to formulate national policies and plans to integrate women and children into the national development process

2. The magnitude of the problems

The magnitude and structure of trafficking in Nepal are largely unknown at this time, and most figures are at best educated guesses (Human Rights Watch, 1995; O'Dea, 1993; Rozario and Rita, 1988). There are some notorious accounts of *Maya Tamang* repeated in almost all trafficking related literature.

Wife sold by husband, girls sold by the traffickers, assassination after rape, lost woman found in Mumbai, girl children in prostitution, intention of marrying own adopted daughter and trafficking, and flesh trade in *Birgunj* are some of the eye catching headlines of newspapers. There is disagreement among the investigators, police and NGOs working in this field on actual numbers, causes of trafficking and the extent of abuses. However, the most widely quoted statistics are that five to seven thousand Nepali girls are trafficked for prostitution each year, and that 200,000 Nepali girls and women are currently working in the sex industry in India. The use of these figures to estimate the magnitude of trafficking in Nepal is based on several problematic assumptions. This frequently quoted estimate is speculative, and is based on observations and few case studies. It does not take into account trafficking to other Indian cities or other parts of the sub-continent. There are many lacks in these studies. Firstly, none of the quoted statistics on Nepali girls and women in sex work outside Nepal are based on systematic studies. Secondly, estimating the number of Nepali girls and women in sex work is not the same as estimating the number of trafficked Nepali girls and women since a substantial but unknown proportion of Nepali sex workers are not victims of trafficking. Thirdly, such figures do not take into account those who were trafficked for purposes other than prostitution or trafficked in-country or to foreign destinations other than India. Due to the clandestine nature of trafficking and the lack of consensus on its definition, there are essentially no reliable data on the magnitude of the trafficking problem in Nepal. But it is widely believed, however, that 1) trafficking in both Nepal and South Asia is on the increase; 2) most women and girls are trafficked into the sex industry; and 3) increasingly younger girls are being trafficked to brothels.

Human trafficking is not only social problem; it is an important health problem as well. Despite the paucity of formal studies, the trafficking in women and children is associated with a considerable morbidity, and significant mortality. Much of the reported mortality takes place during the direct period of movement. Effects on morbidity are even less completely understood or reported. Many of the diseases and much of the ill health that pose risks for trafficked migrants can significantly affect the long-term health and well-being

of the trafficked person and their families. Given the size and importance of these problems, recognizing, better defining, and addressing these issues need to be undertaken with expediency by national and international agencies.

Current estimates of people living with HIV/AIDS in Nepal stand at 35,000 (UNAIDS, 2000a) with the major transmission route being through heterosexual relations. One third of these cases are believed to be among young people under the age of 25 years with 13 percent among the 14-19 year old age group. Although the number of actual reported cases of HIV is relatively low there is the potential for rapid growth due to the large scale trafficking of girls and women into the sex trade, migrant labour patterns and drug use. Rates of HIV infection among sex workers in urban areas range from 17% in Nepal (UNAIDS, 2000a) to as high as 72% in sex workers under 18 years of age in Mumbai, India (Salunke *et al*, 1998). A study of sex workers in the *Terai* in Nepal found that 4% of sex workers overall were HIV positive while 17% of those who had worked in India were HIV positive. Of the 218 Nepalese girls rescued in February 1996 from a Mumbai police raid, 60 to70% of them were HIV positive (McGirk, 1997). But there are no available data on the rate of HIV among trafficked women and girls. Some epidemiologists conclude that those trafficked for prostitution would assume the same or even higher prevalence of HIV as the sex workers in the area in which they are held (Asia Foundation/Population Council, 2001).

Studies conducted among commercial sex workers have revealed that over two-thirds (72%) are currently infected with an STI and only 20 percent report consistent condom use with clients (Bhatt *et al.* 1993; Furber *et al.* 2002). Younger and less experienced women and girls appear to be much less likely to use a condom. Moreover, more than 50 percent of all the female STI patients in Nepal have been found to be involved in the commercial sex trade, and casual or professional commercial sex workers have been identified as the source of STIs in more than 86 percent of patients (Dahal, 1999; UNFPA, 1996). Even those women and girls who are trafficked for purposes other than prostitution are often subject to sexual abuse and are therefore at increased risk of contracting HIV. Trafficked women and children are not able to control even the most basic aspects of their lives, least of all to negotiate safe sexual

relations. As seen in other migrant groups, language barriers and displacement from family and community support systems increase vulnerability and subsequent risk of HIV infection (Guest, 2000; AIDS Action, 1998). In addition, those who are trafficked internationally are usually classified as illegal immigrants in their country of destination and further marginalized with less access to education, services, and protection. If they seek help, they may be subject to prosecution for the crime of illegal immigration, rather than assisted as victims of trafficking (Wijers and Lap-Chew, 1997). There is assumption that girls may not leave the brothels until they have repaid the investment made in them, at which time they are often sick with HIV and/or tuberculosis, and may even have children of their own (Wadhwa, 1998). There are no available studies indicating whether the women themselves have accumulated savings from their earnings in sex work, or have been able to remit earnings to their families.

4. Rationale of the study

From the above background it is clear that there is a serious lack of systematic research on the pattern and context of trafficking in Nepal. Existing knowledge of the causes and processes of trafficking is based mainly on the field experience of the NGOs in Nepal who are active in the anti-trafficking field. There is no clear evidence to prove the suppose relationship between trafficking and social exclusion. The extent of familial involvement in trafficking is cause for much controversy. Determining the extent to which trafficking is organised through formal networks, and the exact methods used require further research. The failure to distinguish between trafficking and both illegal migration and prostitution has seriously impeded this task. Much more systematic, comprehensive, and reliable research in this area is required to inform the development of effective anti-trafficking interventions.

The current statistics reflect either numbers of women and girls who have migrated in general or are engaged in sex work. Even the estimated number of Nepali women and girls engaged in prostitution in Indian brothels has not been accurately verified. There is also a need for more research that informs intervention strategies and their subsequent monitoring and evaluation.

Current information is largely anecdotal. Research should include the analysis of the socio-economic context and process of trafficking. An understanding of this is fundamental to the development of appropriate intervention strategies. Documentation of known trafficking cases to develop a clearer picture of current trafficking methods, sites and processes, and also to develop a clearer picture of who is at risk and why and how to define vulnerability is needed. This would assist the appropriate targeting of interventions. Documentation and follow-up of "rescued" and "intercepted" trafficked women and girls, including those who do and who do not return home to their families, and those who are HIV positive should be undertaken. Again, this would help develop a better understanding of vulnerability and is important to inform and refine care and support strategies. Therefore, research to determine appropriate and effective strategies for both the prevention of trafficking and the care and support of trafficked persons is necessary.

The root cause of trafficking could be multiple and complex. However, some of the more frequently cited factors leading to trafficking are poverty, lack of employment opportunities, low social status of the girl child, a general lack of education and awareness, corruption of officials, an open border with India, lax law and weak law enforcement machinery. All these reasons, no doubt, contribute towards the problem. However, it still does not explain why only certain communities are affected, although all share similar socio economic conditions. In general, information regarding the trafficking remains limited to a small number of studies due to social and cultural taboos and inhibitions; for sexual and health behaviour of trafficked girls and women this is particularly pertinent. Therefore, there is a need to conduct research with adequate representative samples and appropriate methodology.

Although trafficked persons are at great risk of HIV associated with disenfranchised mobile populations and/or sex workers, emphasis on this risk in prevention and education programmes may not be in their best interest. Messages that highlight the risk of HIV associated with migration and trafficking increase stigma, both for returned victims and other migrants. The current panic associated with the AIDS epidemic in Nepal is such that women returning from India are stigmatised as carriers of HIV, regardless of whether

they have been engaged in sex work. In many districts, the common perception is that "a returnee from Mumbai is a carrier of AIDS." Years of sexual and physical abuse, social ostracism and health problems might have untold effects on the minds and bodies of young women, which is not researched yet and require more qualitative research.

Inadequate access to modern health services and their under-utilisation have been the major reasons for poor health conditions in Nepal. On average, 77.4% of urban individuals and 66% of rural individuals receive treatment from a health care practitioner when they become ill (Hotchkiss *et al*, 1998). Among those health services users, 41% of urban individuals and 56% of rural individuals use public health institutions. At present there are no accurate estimates either of the annual number of physician consultations by the persons reporting STIs related symptoms or of the number of persons who do not obtain any medical treatment for their symptoms potentially attributable to a STI. Few studies in other Asian countries (UNAIDS, 2000b) reveal that socially marginalized groups such as sex workers, trafficked women and girls could not fully utilised that available health facilities. The number of returned trafficked women or sex workers in a community who have or are at risk for STIs is far greater than the number who are seen in the clinic and cured. Health services utilisation practices and other health risk behaviour among Nepali sex workers and trafficked women and girls is not known yet (Poudel and Carryer, 2000). Reasons for non-utilisation of existing health services by returned trafficked women or sex worker are unknown. More research is needed on the determinants care-seeking behaviour, a number of barriers exist to seeking care in the formal sector.

Studies examining the utilisation of health facilities provide important information or data for the process of health sector planning. Delays in symptom recognition and seeking care can increase the incidence of disease. Reducing the time between onset of infection and cure, through improved utilisation of services and education about symptom recognition, could play an important role STI control.

There has been very little documentation, monitoring, or evaluation of the effectiveness, feasibility or sustainability of current intervention approaches. Existing interventions have been reviewed many times as part of broad-brush anti-trafficking strategy development activities, but their individual components have rarely been examined in-depth. Given the likelihood of increased funding for anti-trafficking work, a thorough understanding of how different approaches may (or may not) be working, what lessons have been learned, and which areas require further in-depth study is crucial. The cumulative experience of the NGOs working in care and support has also not been documented. Although each NGO has kept records (to some degree) of the girls and women in their care, these have not been collated to build a comprehensive picture of the determinants and processes of trafficking in Nepal or of the issues and lessons learned for reintegration.

In conclusion, there are no solid data on the magnitude of trafficking in Nepal, the determinants and processes of trafficking, and the needs of trafficked persons who return. Practices related to maintenance of health and prevention of diseases including health-seeking behaviour of trafficked women and girls are not known. Similarly, interventions such as interception strategies are seldom systematically assessed and, thus, their rate of success is not known. Therefore, this study was carried to answer the above questions and it has following aims and objectives.

4. Aims and objectives of the present study

The main objectives of this research are:

- To understand more fully the pattern, context and whole process of trafficking (process and determinants of trafficking) of women from Nepal to India for the propose of prostitution
- To find out the practices related to maintenance of health and prevention of diseases including health-seeking behaviour of trafficked women and girls
- To identify the necessary health care and social support for the trafficked women.

5. Structure of the thesis

This thesis mainly focuses on two areas (process of trafficking and health seeking behaviour of trafficked women and girls). To cover these two issues this thesis has 7 main chapters.

Chapter 1 describes the background, Rationale and aims of the study. Furthermore, it gives the summary of each chapter and ends with limitations of the study.

Chapter 2 presents a short summary of the relevant socio-economic features of Nepal. This chapter is relatively long. While this thesis is ultimately about the sexual trafficking of girls and women in and from Nepal, it has a broader purpose which justifies this lengthy introduction to Nepal's socio-political system, its health care systems, and issues surrounding the economic and social status of women. First of all, the issues of trafficking cannot be understood in isolation from Nepal's complex history, geography and social structure. Secondly, this thesis hopes to make a contribution to the development of Nepal's system of health and social services, and for this purpose the broader issues and history of the country must be examined. Finally, since the writer has a key interest in health care delivery systems as they effect women who have been sex workers, the conditions of health of women and their families must be looked at in detail. How former sex workers use health services in relation to their health needs is an important theme in the research undertaken.

Chapter 3 is mainly for Literature review. Firstly it clarifies the confusion on different terminology like "trafficking", "migration" and "prostitution". Second section reviews the literature on global, regional and national trends of trafficking and prostitution. Third section reviews literature on knowledge and health seeking behaviour of trafficked women and the last section presents the care and support need for trafficked women.

Chapter 4 deals with methodological issues. This chapter firstly describes the approach of this research, and discusses the ethnographic approach, which was employed in this study. Secondly, it discusses the research design, mainly

access to the study site, data collection tools followed by recording and analysis of qualitative data. Thirdly it discusses the validity and reliability of this research. Finally, it describes ethical issues and chapter ends with concluding remarks.

Chapter 5 is the first chapter of analysis and discussion. It mainly describes the finding from field study, which includes current patterns of trafficking, methods of procurement, pushing and pulling factors. It also examines constraints that keep many trafficked girls and women from returning to Nepal, and it describes problems faced on a return.

Chapter 6 mainly describes sexual and health-seeking behaviour of returned trafficked women. It also describes the health consequences of trafficking and special emphasis is placed on the threat of HIV/AIDS. Finally it assesses strategies of national and non-governmental intervention. It focuses on care and support needed for trafficked women and girls.

Chapter 7 presents conclusions, policy implications and recommendations.

6. Limitations of the study

This study has tried to be as comprehensive as possible to uncover trafficking and health issues prevalent in Nepal. However, due to limited time, resources and location, it will not cover every aspect of trafficking. Further some limitations have been encountered whilst working at the institutional level where regular interactions, and constant observations with the every staff were not possible.

CHAPTER TWO

SOCIO-POLITICAL OVERVIEW OF NEPAL

1. Introduction

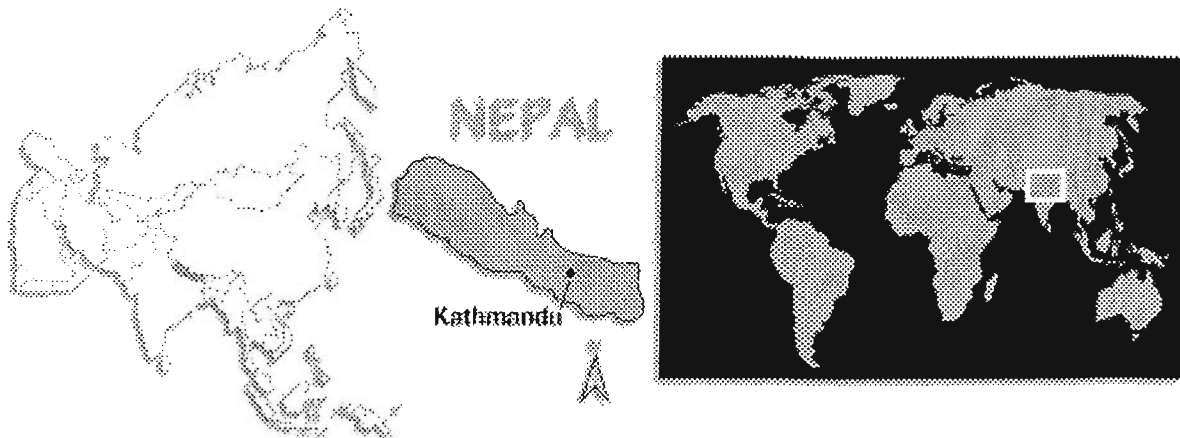
While this thesis is ultimately about the sexual trafficking of girls and women in and from Nepal, it has a broader purpose which justifies this lengthy introduction to Nepal's socio-political system, its health care systems, and issues surrounding the economic and social status of women. First of all, the issues of trafficking cannot be understood in isolation from Nepal's complex history, geography and social structure. Secondly, this thesis hopes to make a contribution to the development of Nepal's system of health and social services, and for this purpose the broader issues and history of the country must be examined. Finally, since the writer has a key interest in health care delivery systems as they effect women who have been sex workers, the conditions of health of women and their families must be looked at in detail. How former sex workers use health services in relation to their health needs is an important theme in the research undertaken.

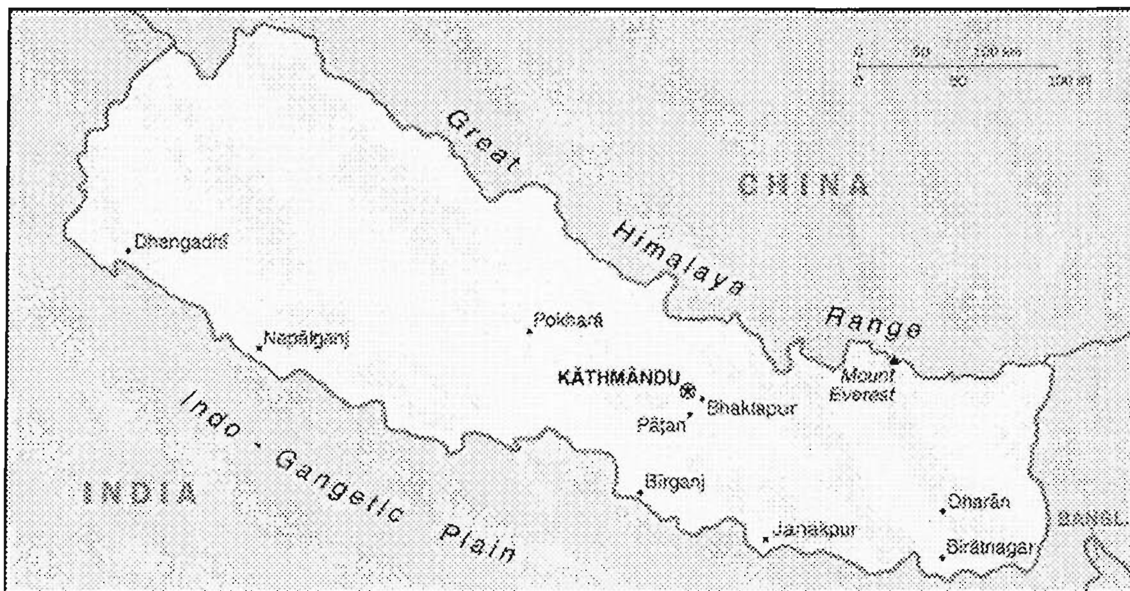
2. Nepal – initial overview

Nepal, a landlocked country squeezed between India and China, covers an area of 147,181 sq. km. The landscape tiers down from the Himalayas, through middle hills, to plains in the south. The population of Nepal consists of 23.4 million inhabitants with more than 60 ethnic groups (CBS, 2001), and an annual population growth rate of 2.6% (UNDP, 1998a). Tourism and carpet exports are the main sources of income in addition to development aid. Despite Nepal's large number of development grants and loans since the restoration of democracy in 1990, it is still one of the poorest nations in the world.

The population is poor, and there are limited communications and infrastructure. The gross national product per head is about $220 (£145, €223) (World Bank, 2002), life expectancy is 58 years, about 60% of adults are illiterate (World Bank, 2002) and more than 70% of the people live below the poverty line.

Map of Nepal





The life expectancy of women is lower than that of men. Nepal, one of the three countries in the world where men live longer than women, has a maternal mortality rate that is one of the highest (850/100,000 live births) in the world. The infant mortality rate is 98 per thousand (UNDP, 1998a) and about half the children under the age of five suffer from moderate to severe malnutrition. Less than half of pregnant women attend for any antenatal care and over 90% of births occur at home (MOH, 2001). Only about 37% of the population have

access to safe drinking water and only 6% of the total population have access to proper sanitation facilities. Women and children are most vulnerable to the various forms of exploitation created by poverty, caste traditions and gender discrimination (details of Nepal are described in appendix 1 because of the world limit. Only health service utilisation, gender issues and policy issues related to trafficking are describing here).

3. Health service utilisation and human resources

The high level of morbidity and mortality in developing countries has been attributed partly to non-availability of services and partly to poor utilisation of services even when they are available. Both maternal and child survival are closely related to the availability and use of basic maternal health services. The MMR of women who have not received antenatal or delivery care services during pregnancy and childbirth, and the IMR of their children, is much higher than those who have received care (MOH, 1993).

Low utilisation of health services is a result of reliance on traditional forms of maternal health care; on lack of awareness of the availability and importance of maternal health care; on difficult access to health services, especially in the hill and mountain areas; and in women's low confidence in health services due to lack of supplies, inadequate staff and a low proportion of female health workers at Health Posts, Sub-Health Posts and hospitals (Simkhada, 1999).

Women in need of emergency obstetric care, including obstructed labour, haemorrhage, sepsis and unsafe abortion - all potential causes of maternal death - must have immediate access to obstetric services at district hospitals. In some cases, obstetric problems can be predicted by health workers and the persons referred to a hospital. In many cases, transportation difficulties and unpredictable problems preclude hospital care. At present, few zonal and central-level hospitals have emergency obstetric capacity, and lack of communications and emergency transportation facilities make it extremely difficult to attend to the majority of serious complications of pregnancy.

The under-utilisation of health services reflects the under use of health services generally in the country. As examples, the antenatal visit rate is only 15.5 percent, the EPI coverage is low, with measles the lowest at 32 percent for children nine to 11 months, and only 12 percent of children are covered by growth monitoring (NPC/UNICEF, 1996). While under-utilisation is a product of potential health-users' lack of awareness and easy access, it is also a product of their low confidence in health services, due in large part to the inadequate management of these services and the poor availability of essential drugs. Incomplete mobilisation and the lack of training and motivation of village level health workers, including TBAs and FCHVs, also contribute to the problem.

The use of health services is being addressed by HMG/N's Community Drugs Programme (CDP). By involving community members in the management of community health services and by strengthening the collaboration of government institutions to support the programme at both district and community levels, the programme intends to ensure the local availability of essential drugs, improve the performance of health facilities, and increase their impact at the household level. In support of these activities, efforts are being made to bring health care into the home, by providing increased training of and support to front-line health workers and by helping communities identify their own health needs. In this way, it is intended that public confidence in health services will grow and health-seeking behaviour will increase.

A review of recent annual budgets shows that the actual percentage of the national budget spent on health is an average of 3.52 percent per year. However, of the total health budget, 70.7 percent has been allocated to primary health care activity (HMG/MOH/WHO, 1990). Human resources in the health sector are a top priority for future development of the primary health care system in Nepal. Over the years, His Majesty's Government has developed and implemented several types of community-based health personnel approaches in attempts to bring basic health services to rural women and children. Such persons now include Auxiliary Nurse Midwives (ANMs), Village Health Workers, Community Health Leaders, Maternal and

Child Health Workers (MCHWs), Female Community Health Volunteers and Traditional Birth Attendants.

3.1 Doctors

The total number of practising doctors as reported in the Economic Survey of 1993/94 stands at 1,497, a national average of one doctor for 12,611 people. However, it is estimated that 60 percent are working in the Kathmandu Valley. Thus, outside the Kathmandu Valley, the average is one doctor for 52,456 people (UNDP, 1998a).

As the population of Nepal will reach 30 million even by a conservative estimate by the year 2010, the ratio of medical and more importantly paramedical staff ratios in the total population needs serious re-examination. Most notable is the present national capacity for health personnel training, which needs considerable strengthening in order to have all the necessary health staff at all levels by the year 2005.

3.2 Nurses

Nurses are trained in different campuses throughout the Kingdom. Their training includes a substantial community and midwifery component, which equips them to undertake a variety of roles. At present, there is a shortage of nurses in hospital posts and very few of the established public health nurse posts are filled. The Economic Survey of 1993/94 reports that there are 2,999 practising nurses. This figure puts the ratio of nurses to the population at 1: 6,295.

3.3 Auxiliary Nurse Midwives (ANM)

The ANM is the key worker for women at the Health Post level. ANMs are the most important and appropriately qualified personnel for implementing MCH activities at the Health Post and are often the only women present. There are 2,126 ANMs working under the Ministry of Health (MOH, 1995). However, many Health Posts still lack ANMs. One attempt to fill this gap has been to train and appoint MCHWs to Health Posts where there are few or no ANMs.

In baseline surveys conducted by the Division of Nursing, it has been found that although 43 percent of Health Posts had vacant ANM posts, over 75 percent were providing some type of MCH service. Most Health Posts cannot handle complicated deliveries (breech birth, septic infection, prolonged labour or neonatal tetanus) and have to refer clients to the district or zonal hospitals. It should be noted that ANMs who are to provide fundamental maternal health care are not permitted to do so. Their effectiveness is consequently reduced in the absence of reliable referral networks. Hospitals usually have ANMs, at an average of five per hospital (UNICEF, 1996a).

3.4. Maternal and Child Health Workers

MCHWs are recruited from the area where they are to work, and undergo 90 days of training in all aspects of basic maternal and child health care. There is provision for one MCHW per Sub-Health Post. As of this time (end of 2001), over 2,500 MCHWs have been trained and assigned to SHPs.

3.5. Village Health Workers

The Village Health Worker is selected from the community served by the Health Post or Sub-Health Post. VHWs are usually males, and are trained over 90 days in primary health care. The VHW is accountable to the HP or SHP In charge and preferably works within his or her own community or Village Development Committee. The number of VHWs was 4,015 as of 1994/95.

VHWs have to conduct household visits, provide basic treatment and medicines, make referrals when necessary and provide health education. Since 1988, VHWs have been trained in immunisation and now conduct immunisation outreach clinics. Each month, VHWs visit wards in their own service area to provide children with immunisations, including tetanus toxoid for women, motivate communities for family planning, identify and keep a record of pregnant women and all children under five, and teach the importance of birth spacing, ORT and immunisation.

An important part of the VHW's work is co-ordinating health education and training, and supervising Female Community Health Volunteers. In many

instances, many of the VHWs' tasks are performed by the FCHV, particularly maternal health care, and as most of the VHWs are male and for cultural reasons, they are less able to communicate with women about their health problems and needs.

3.6. Female Community Health Volunteers

Although they receive scant recognition and minimal support from the government, Female Community Health Volunteers are perhaps the most important health persons in the overall MOH service delivery strategy. With TBAs, they are the only health workers who provide routine direct contact at the family level. FCHVs are local women who are trained for a brief period of time and supervised by Health Post staff. Working with HP and SHP staff, the FCHV is expected to promote the utilisation of available health services and communicate basic knowledge of immunisation, family planning, ORT, nutrition, first aid and antenatal care at the family level, both in the home and through women's groups. FCHVs provide monthly reports to VHWs. Although FCHVs are considered the key to bringing primary health care services and information to the home, the programme has had mixed success. FCHVs are not paid for their services, only receiving remuneration for their yearly refresher training. Recently this training, and the remuneration, have been reduced. This, in combination with lack of support from the HP and SHP level, including provision of essential drugs for their drug kits, has significantly reduced the motivation of many FCHVs.

3.7. Traditional Birth Attendants

Traditional Birth Attendants are the frontline health workers directed at women in the perinatal period. They promote the utilisation of maternal health services, provide information on maternal health and nutrition, breastfeeding and complementary feeding, and assist in the delivery of infants. They are trained to recognise signs of future obstetric difficulties in pregnant women and refer them to trained health workers and hospitals. They promote safe, clean childbirth and the use of Safe Home Delivery Kits to ensure hygienic birthing.

As of 1991, the Division of Nursing had trained over 4,500 TBAs in 28 districts. In 1994/95, there were 11,179 trained TBAs. TBAs are trained and mobilised in 36 of Nepal's 75 districts. Periodic assessments of TBA activities indicate a positive impact. The new health policy states that the number of TBAs is to be increased to the ratio of one TBA per 1,000 population. A total of 22,000 trained TBAs are required nation-wide. The objective of the TBA programme is to provide basic training to 10,000 and refresher training to 12,000 TBAs to ensure the availability of at least one trained TBA within a two-hour walk of all women of reproductive age. The target is set at one TBA per 220 deliveries in the mountains, one TBA per 40 deliveries in the hills, and one TBA per 60 deliveries in the Terai (MOH, 2000).

3.8. Traditional Healers

A 1980 study estimated the number of traditional healers in the country at between 400,000 and 800,000 (Shrestha and Lediard, 1990). A more recent survey, conducted for UNICEF in the three districts of Nuwakot, Doti and Kanchanpur, showed that the majority of the clients who visited Health Posts had first consulted a traditional healer. In Doti district, the figure was 73.3 percent, in Kanchanpur 71.9 percent and in Nuwakot 54.8 percent. Numerous other studies have borne out the importance of the traditional healer as the first point of contact for most rural Nepalis for both minor and major illnesses (Uprety and Simkhada, 1992). Their advice is listened to, and their treatments are used. As yet, little use has been made of the healers by the formal health sector.

4. Financing of Health

Several internal and external funding agencies provide financing for health (ADB, 1994). The internal funding agencies consist of the government, private companies and private households. The external agencies consist of external development partners and donors inclusive of multilateral and bilateral agencies, as well as international non-governmental organisations and religious/philanthropic missions. In 1994/95, the total expenditure made by these agencies in the health sector amounted to Rs. 10.94 billion, equivalent to 5.3 percent of GDP ($ 1= Rs 75). This level of health expenditure/GDP ratio

is substantially higher than in Bangladesh and Pakistan. Among the South Asian countries, only India, which spends approximately 6 percent of its GDP on health, exceeds the ratio for Nepal (UNDP, 1998c).

Households provide, by far, the largest share of the health expenditure funds, while the government, development partners and donors, and the profit-making private sector accounted for much smaller levels. For example, the total health expenditure of Rs 10.94 billion for 1994, households accounted for over *76* percent. Development partners and inter-national donors accounted for 14 percent, and the government for 10 percent. Within the government, the MOH accounted for over 90 percent of the public sector health expenditure. The remaining portion was allocated by the Ministry of Defence via the Army Hospital, by the Ministry of Home via the Police Hospital, and by the Ministry of Education via the Tribhuvan University's Institute of Medicine.

4.1. Public expenditure

As noted, the MOH administers over 90 percent of the health expenditure in the public sector. Between 1991/92 and 1998/99, it increased approximately four-fold at current prices and two-fold at real prices. MOH expenditure as a percent of the total national budget grew from 3.47 percent in 1991/92 to approximately 6 in 1998/99. However, as a percent of GDP, this amount still accounts for slightly more than one percent only.

4.2. External sources

A large part of the country's development expenditure is met through international assistance. The health sector is no exception. International assistance to the health sector, as a proportion of total governmental expenditure on health, ranged from 36 percent in 1991/92 to 49 in 1998/99. However, of the total flow of international assistance in 1998/99, only 4 percent was allocated to the health sector.

4.3. Private enterprises

The financial investment made by the private sector organisations, in recent years, has been substantial. The share of health services delivered by

the private sector through nursing homes and hospitals, particularly in the urban areas, has been growing. Illustratively, the private sector, which started with 2 nursing homes in 1985, comprised 45 functioning nursing homes in 1996. The number of beds in the nursing homes also grew from 10 to 1126 during this period. Many nursing homes are well equipped. It is estimated that 4-5 thousand sick persons receive medical services a day in the outpatient departments of private nursing homes (MOH, 1996b). No attempt has yet been made to estimate the expenditures made by the private manufacturing establishments in the health sector. A preliminary survey carried out by the ADB in three districts, however, shows that these establishments make significant investments in drug and equipment manufacture.

Except for the manufacturing sub-sector, health benefits arising out of the private sector investments are very largely limited to the middle and upper income group residents in the urban areas. Further, they are exclusively concentrated in the provision of curative and specialised services. Some such enterprises, some nursing homes in particular, are motivated by short-term financial benefits accruing out of governmental incentives - which provide for preferential import customs duties - to such enterprises.

4.4. Non-governmental organisations

The financial contribution made by the International Non-governmental Organisations (INGOs) and NGOs in the health sector is often under-reported. A recent survey shows that 18 INGOs spent a total of Rs. 386.02 million in 1994/95 on health-related activities. Of the 18 INGOs, 10 are working in primary health care activities in different parts of the country (UNDP, 1998a). Such activities range from primary health care to child survival, family planning, reproductive health services, AIDS and STD control and eye care. In addition, according to a case study, 32 NGOs spent a total of Rs. 284.67 million on health-related activities in 1994/95. Among the NGOs, the Nepal Red Cross Society contributed the largest amount, followed by the Family Planning Association of Nepal.

5. Organisation of Health System

Multiple health and medical systems coexist simultaneously and sometimes uneasily in the country. Such systems, for the present purpose, can be divided into four broad categories: the home-based system, the traditional faith healing-based system, the *ayurvedic, homeopathic* and *unani* systems, and the modern *allopathic* system (see details in following heading). The allopathic system has been ascendant for the last several decades, not the least because much of the state as well as market support is concentrated in its favour. The other three receive minuscule state support. The home-based and traditional faith healing systems receive little direct support from the state, but efforts at linking them with the public health system have been made in the last 15 years. Such efforts, nonetheless, have been peripheral and lukewarm.

5.1. Home-based system

The primacy of the household extends to the domain of health and medication. Almost all households, at least at the initial stage of sickness, utilise the fairly wide stock of intergenerationally transmitted as well as newly acquired knowledge and practices of healing to nurse the sick back to good health. The localised nature of the society, limited access to, and relatively low quality of, public health institutions and the prohibitive costs of allopathic medicine and modern health services also force most households to rely on home remedies which span from divination to faith healing and the use of local herbs. Increasingly, they also involve the use of off-the-counter allopathic drugs, which remain almost completely unregulated.

5.2. Faith healing

In general, the failure of home remedy to cure the sick invites intervention from community-level healers. Such healers base their treatment on an intimate knowledge of the sick person and the latter's physical and social niche assurance, divination/ancestor invocation and herbal remedies. Healers often specialise in particular techniques and which specialist is consulted is a function of illness itself (Stone, 1976). The number of such healers is very large, which can itself be taken as an indication of the legitimacy of the system. One study estimated the number of various

categories of local faith healers at 400,000 to 800,000 (Shrestha and Lediard 1990, cited in UNICEF 1992b), which roughly translates to one faith healer for every six households. The significant role of local healers has been widely noted (Pandey, 1980; Blustain, 1976; Wake, 1976; Uprety and Simkhada, 1992). The majority of the sick persons in the rural areas who eventually visit the allopathy-dominant health posts had first consulted a traditional healer (UNICEF, 1992a). The majority of the women in the central region utilise the services of local traditional birth attendants (Reissland and Burghart, 1989), partly because women there prefer to deliver a baby at home.

5.3. Ayurvedic, Homeopathic and Unani systems

The *ayurvedic* system of healing has been practised in South Asia since ancient times. It bases itself on a well-developed system of the physiological characteristics of the sick person, symptoms of sickness and detailed pharmacological knowledge of herbs and their processing techniques. The herbal treatments that households and local healers perform are often borrowed from the *ayurvedic* system. This system, therefore, has a wide reach. Most ayurvedic healers work within the private domain. In addition, the system is also supported publicly. *Ayurvedic* healing in the public sector is performed through one central ayurvedic hospital with 50 beds, one 15-bed zonal hospital, 172 dispensaries in 55 districts, and a central drug manufacturing unit (MOH, 1997).

Homeopathy was introduced Nepal as early as 1920 as a natural healing system. Homeopathic healing is largely a private sector initiative which encompasses approximately 500 practitioners and 100 clinics (MOH, 1997). Within the public sector, there is only one homeopathic facility with hospitalisation facilities for six patients. The unani healing system, which provides preventive, promotive and curative services, has an extremely limited reach. In addition, the Tibetan healing system and naturopathy are also practised in selected areas of the country.

5.4. Allopathic system

Nepal embarked upon implementing a modern, allopathic public health system at the end of the 19th century when the Bir Hospital was established in Kathmandu. Vaccination against smallpox was available after the First World War (Kansakar 1981, cited in Shah 1987). By 1955, there were 34 small-scale allopathic hospitals with a total of 623 beds and 24 dispensaries. In addition, 63 *ayurvedic* dispensaries had been established (Pandey, 1980). Nearly one-half of all services delivered through these institutions were concentrated in the Kathmandu Valley (Shah, 1987).

Organised, national-level, public efforts at the development of modern health services started in the mid-1950s (Pant and Acharya 1988; Shah 1987; Pandey, 1980). A large-scale malaria control programme was launched in 1955; the leprosy and tuberculosis control projects were initiated in 1966; the smallpox eradication programme was launched in 1968; and a family planning and maternal and child health board was established in 1968 (CBS, 1989). In 1971, the division of basic health services was formed within the Department of Health to provide basic health services to the maximum number of people (Justice, 1986). Small-scale public hospitals were established at various regional and district centres. In 1977, the successful smallpox project was converted to the expanded programme for immunisation. Other vertical programmes such as the nutrition support and diarrhoeal disease control programmes were integrated with EPI in 1980 (World Bank, 1989). Private and INGO initiatives also led to the establishment of rural health posts, clinics, hospitals and drug retail outlets. One teaching hospital was also established within the public sector. Public health offices were established in all of the districts.

Significant steps were taken by successive governments to expand the public health network at various levels. Of particular salience were two policy decisions taken in the mid '80s and the early '90s. The first policy led to the formation of a cadre of community-based women volunteer health workers. At present they number more than 42,000. The level of their paramedical training is very low. But their achievements in terms of local sensitisation and referral are significant. The other policy decision, currently in the final year of implementation, is related to extending the reach of public health institutions

right to the VDC level and the creation of an integrated institutional structure of public health. Implementation of this policy is leading to the establishment of community level sub-health posts in all VDCs in the country. Better equipped health posts, covering 6-8 VDCs, would cater to cases referred by the sub-health posts. Finally, a primary health centre, with a qualified doctor, would serve each of the 205 electoral constituencies, each of which comprises, on the average, 18-20 VDCs.

The large-scale expansion of the public health infrastructure, however, has not paid off in terms of the commensurably improved coverage and quality of health services. Most public health institutions are still ill equipped. The annual drug rations allocated to health posts are adequate for only 3-6 months. A rational drug dispensing policy at the patient level is not in sight either. Medical personnel often remain absent from the rural-based sub-health posts and health posts, and even from regional and district hospitals. Thus, in a 1995 survey of 10 districts, out of the 94 positions of doctors sanctioned, those on duty were only 28. Similarly, out of the 117 positions of nurses sanctioned, only 42 were on duty. Also, of the 18 positions for laboratory technicians sanctioned, only 12 were on duty (MOH, 1996b). The scale of training and re-training programmes for the medical and paramedical personnel is inadequate at the same time that the training programmes are much too costly. Equally significantly, there is little interaction and linkage between the public health institutions and local representative and other community-level bodies. Such linkages are generally not mandated in public health policies.

Qualitatively, the hospital situation has not improved either. District hospitals, which are supposed to have three physicians each, are often short of doctors as well as other categories of health personnel. Doctors assigned to these hospitals are often quite young and inexperienced. In 11 of the 75 districts, there are no hospital services at all. There are very few obstetricians or surgeons in district hospitals. Overall, district hospitals are understaffed, especially for dealing with emergency maternal and neonatal health care.

Hospitals have inadequate service facilities to meet the needs of the rural population. In a survey of five hospitals in the districts where TBA training had been conducted, only the zonal hospital (located in one of the five districts) could perform caesarean sections or provide blood transfusions. Emergency obstetric services were lacking. Most of the hospitals surveyed could handle anaemia and toxaemia, but not neonatal tetanus or septic infections. None of the five hospitals had an incubator and not one could handle severely low birth weight or premature new-borns. District hospitals had an average of only two to three beds for labour and postpartum recovery.

Currently, there are 775 Health Posts in Nepal, mostly located at the sub-district levels with a total number of 4,028 Village Health Workers, of which only ten to 20 percent are women. A fully staffed Health Post should have the following personnel to carry out' primary' health care, including MCH, services: one Health Post In-charge; two Auxiliary Health Workers; two Auxiliary Nurse Midwives; one to two MCH Workers; and seven to 12 Village Health Workers. Usually, one Village Health Worker is assigned to one Village Development Committee.

In accordance with the National Health Policy of HMG/N, one Sub-Health Posts in each VDC has to establish by 1997. A total of 2,597 have been established to date (End of 2000). These Sub-Health Post provides Basic primary health care services. These services include immunisation, family planning, maternal and child health care, and education on health, environment, nutrition and sanitation. Each Sub-Health Post is staffed by a Village Health Worker (VHW), an Auxiliary Health Worker (AHW), and a Maternity and Child Health Worker (MCHW). Sub-Health Posts provide support for village-level FCHVs and TBAs.

It is the intention of the National Health Policy to upgrade 205 Health Posts throughout the country to Primary Health Centres (PHCs), to serve as an intermediate health delivery station between the hospital and the Health Post, primarily to manage maternity and emergency cases. PHCs are staffed by one medical doctor, one Health Assistant and three Village' Health Workers. At present, there are 83 PHCs operating in the country (MOH, 1999).

6. Gender Issues in Nepal

Issues on trafficking cannot be understood without understanding gender issues in Nepal. With the exception of certain ethnic communities of the Tibeto-Burman group, Nepali society is predominantly patriarchal, governed by Hinduism as a strong ideological force. All aspects of the growth and development of the child, both male and female, are shaped by a social structure value system informed by patriarchal traditions. Even among the Tibeto-Burman communities, an increasing trend towards the adoption of Hindu values and norms is noticeable among upwardly mobile groups.

Nepal is a country with a very high incidence of son preference (RIDA, 1991). Sons are economic insurance against the insecurities of old age, they virtually open the gateway to heaven by performing the death rites for their parents, and they carry on the family name and legacy. Daughters, however, are to given away in marriage, to care for their husband's parents and protect their husbands' property. In the consideration of many parents, daughter's' economic value is restricted to their childhood years, and investments in their future, as education and often health care, are poor investments. A popular saying in rural areas: *"To have girl is like watering a neighbour's tree. You have the trouble and expense of nurturing the plant, but the profit goes to somebody else."* Thus, if a girl baby survives until early childhood, the peril of neglect faces her. Although receiving the same care and nutrition as boys when infants, older girls often receive less health care and less food, resulting in higher mortality, and morbidity rates than boys. In middle and late childhood, they assume a large share of domestic responsibilities, including sibling care, often to the detriment of their education and social participation.

As adolescents, Nepali girl children face early marriage and pregnancy (as described in earlier section). Combined with poor health and inadequate perinatal practices, they face a high risk of health complications following birth, and subsequent mortality. Their nutritional deficiencies may have effects on their children, resulting in the female infants' low weight birth, disabilities or death. As they grow older, repeated pregnancies, anaemia, continued malnutrition and excessive workload can result in early death, and Nepal is

one of the few countries in which women's average lifespan is shorter than men's (MOH, 1991).

6.1. Socialisation Patterns of the Male and Female Child

The socialization patterns in Nepali society are such that young boys are prepared for the world of productive work and decision-making, while girls are trained to be housewives, mothers and service-providers. From a very young age, it is instilled into girls' minds that their duty lies in providing services to their family, first their own, then their husbands'. Boys' and girls' tasks are quite distinct in Nepali society, and boys, while helping with their fathers' work, seldom participate in household tasks (UNICEF, 1996a).

Confidence and self-esteem are not cultivated during the socialisation of girl children. The portrayal and practice of self-denial, self-effacement, gentleness, sacrifice, unassertiveness and other "feminine" qualities are encouraged in their upbringing. Decision-making, strength of expression, opinion-formation and assertion of their needs and interests are implicitly discouraged in the socialisation process. In terms of social interaction, girls are for the most part confined to the "inside world" of the home. They have little contact with males outside their family or females outside their community, and lack access to the "outside world" of information, knowledge and resources. Although not the case among all of Nepal's ethnic communities, open and frank discussions between young daughters, mothers and senior women regarding menstruation, sex and pregnancy are not the normal rule in traditional Nepali households. Girls often learn the facts of life from their peers and may be embarrassed to talk about their concerns with older women. Adolescent girls have little access to health education or medical services to deal with their problems, and virtually no access to sex education. While adolescent boys also lack access to sex education, their relative social freedom relieves them of many of the adolescent anxieties that girls undergo.

6.2. Women in work

A recent assessment of the major changes in women's lives in Nepal over the past decade has shown that despite higher attainments of literacy,

social mobility and awareness, women still remain confined to the roles prescribed by Nepal's traditionally patriarchal social, economic, political and legal frameworks (Shtri Shakti, 1995). Since the early 1980s, it has been urged in several quarters that women in Nepal are vital contributors to the domestic, and thus the national, economy (Acharya and Bennett, 1981). Their access to knowledge, skills, resources, opportunities and power, however, remains low. The adult female literacy rate (23 percent) is much lower than the adult male literacy rate (57 percent) (HMG/NPC/UNICEF, 1995). Net enrolment of girls in primary school (61.37 percent) is lower than that of boys (80.38 percent), and their drop-out rates are much higher. Only one-fourth of females over six years of age are literate as compared to 55 percent literacy among mates over six years (HMG/NPC/UNICEF, 1995). These data indicate not only restriction of the basic rights of women, but diminishment of their capacity to fully perform their role as caregivers. Women's average work burden has increased slightly over the past twelve years, from 10.8 hours per day in 1981 (Acharya and Bennett, 1981) to a 1995 average of 10.9 hours (Shtri Shakti, 1995). Men's average work burden presently is 7.8 hours per day, 3.1 hours lower than that of women.

While women's day-to-day work burden is increasing, changes in its composition are also noted. Women today participate more in agriculture and, to a small extent, more in outside employment. The percentage of the female labour force in agriculture has increased considerably, from 30.4 percent in 1971 to 45 percent in 1991 (Shtri Shakti,1995). Over the past 15 years, women's participation in economic activities has moved beyond agriculture into the local market economy. Their participation in the informal sector has increased significantly in both urban and rural areas. Vending, petty trade, liquor making and vegetable selling are some of the more common employment ventures.

There are an increasing number of women entering the labour market in the formal manufacturing sector due to economic necessity. They are primarily concentrated in low-skilled, menial and repetitive jobs, which may be looked upon as extensions of their household activities. Even in the textile and

carpet industries, women are paid relatively lower wages than men and kept at unskilled levels.

Approximately 82 percent of women working outside the domestic sphere are self-employed and 12 percent are wage-employed, as compared to 69 percent and 27 percent in the case of men (CBS, 1991). More than 4 percent of them are unpaid family workers, the only status where women have outnumbered men. Less than I percent of working women hold the status of "employer".

The 1981 Status of Women in Nepal study showed a strong relationship between women's level of input in the outside economy and decision-making processes within the household (Acharya and Bennett, 1981). However, the 1995 study mentioned above revealed a downward trend in decision-making for women, despite an improvement in household income as a result of development interventions such as credit facilities, subsidy programmes and water systems (Shtri Shakti, 1995).

While outside employment adds to household incomes, it does not necessarily mean an improvement in women's lives or in their capacity to care for children. Women may not have control over household monies, which may be used by men for other than family support. Home alternative employment, such as a raising cash crops or milk from buffaloes, may increase the workload of women, depriving them of time needed for tasks directly related to child care, such as kitchen gardening or administering to illnesses, resulting in the lowered nutrition and health of their children.

6.3. Women in the Family Environment

Broadly, two types of family system prevail in Nepal: the joint family and the nuclear family. Large, extended families appear to be the norm among larger landholders and high-caste orthodox Hindus, the Newar of the Kathmandu Valley, and several ethnic groups of the Terai. In the hills and mountains, families are usually smaller, often only parents with their married sons and their families.

In the past, the agro-economy of the country has played a major role in maintaining the joint family system. There is an increasing trend, however, for families to split into nuclear units as landholdings are increasingly fragmented and incapable of supporting large numbers of family members. The nuclear family is also becoming more popular in urban areas, bringing with it problems concerning childcare and protection. With some exceptions in urban communities, the distinction between extended and nuclear families is very relative, as the term refers only to household residence. In most cases, extended family members live in close proximity, sharing many household and agricultural tasks.

In the traditional Hindu family structure, age and sex are the main ordering principles in family hierarchy. The male is accorded superiority over the female and the elder over the younger. According to custom, the eldest male has authority and control over all other members of the family, and since only males can ensure the continuity of their lineage, they enjoy primary rights over paternal inheritance. Females serve as links among patrilineal groups and assist in perpetuating the family lines.

Expressed Hindu tradition, however, belies some important elements in the Nepali family system. Hindu marriage tradition in Nepal is primarily patrilocal, and sons generally care for their parents in their home in old age. While authority and control is ostensibly vested in the eldest male, in reality it often lies with the mother of the sons, who frequently exercises firm control over household tasks, household resources and the activities of the sons' wives. The "mother-in-law", as well, is often the perpetuator of traditions and practices, which discriminate against younger women and girls. She can be a major decision-maker regarding her sons' marriage partners, the dispensing of her husband's property and the education of family members. To date, this family figure has received insufficient attention in research and in the implementation of activities at the family level.

Among Tibeto-Burman communities such as the *Sherpa* and the *Gurung,* the kinship patterns more flexible. In these societies, women

accorded more decision-making power, have more access to resources and property, and more likely to conduct business on their behalf.

It is generally considered that in most families, women have considerably less access and control over family resources than men. While it has been reasonably ascertained women have less control over money, the extent to which women have control over family resources, such as food, seeds, household goods, firewood and water, is not clearly known. It be supposed that, considering women's labour obligations regarding these resources, they some, and in some cases total, control.

At present, there is insufficient data to clearly understand the extent of women's decision-making power within the home. While it is generally agreed that women have less decision-making power *per se,* it is unknown to what extent women have total, zero or shared decision-making power with their husbands and parents-in-law regarding their boy or girl children being taken to health services, provided education, set to household tasks, reprimanded, married, provided money or given recreation. It is also unknown to what extent women have decision-making power over their own fertility, their own access to health services or education, their participation or their own workloads. It is not known to what extent women have decision-making power over their husbands' activities, including recreation, planting of crops and travel, or what roles parents-in-law, brothers, children and other family and community members play in family decision-making processes. Similarly, very little is presently known about child care-giving patterns in the home. The collection of data and the formation of general conclusions are confounded by the likelihood of radically different care-giving patterns among Nepal's many different ethnic groups. While it is clear that women and girl children perform the majority of basic child care tasks, such as feeding, carrying, watching and cleaning young children, little is known about the teaching and stimulating aspects of child care in the Nepali home. Songs, stories and learning games for children, both from the parents and from other children, in different ethnic communities need to be studied. This information will provide the foundation for increasing caregivers' awareness and skills in childcare within the Nepali cultural context.

It is generally presumed that men participate very little, if at all, in the care of their children. However, these presumptions are based primarily on observations of family life during daytime working hours, and no known research has been conducted on men's interaction with their children in the confines of their homes. Various studies over the years have clearly indicated that children share a major portion of the household burden, especially in rural Nepal. The study revealed that domestic work, including child care, constitutes 70 percent of the total work burden of both sexes in the six-to-nine age group and over 50 percent in the ten-to-14 age group at all poverty levels and in all regions of the country. A 1990 study revealed that the workload of out-of-school girls aged six to nine years averages seven hours per day, and the workload of out-of-school girls aged ten to 14 averages 9.5 hours per day (RIDA, 1991).

It has been found that the work of boys is directly related to the work of older males in the household. Under 14, boys perform functions such as taking the livestock to the forests, collecting fodder and animal bedding, and helping to carry in logs and firewood. Over 14, they take on the full agricultural work of males, such as ploughing, digging and chopping logs. They are little or not at all involved in fetching water, cleaning, washing clothes and caring for children, which are delegated to girl children. The extra work burden of girls compared with that of boys lies in household chores such as helping with cooking, washing dishes, looking after younger siblings and fetching water. The 1990 study found that for girls of the six-to-nine age group, child care accounts for about half of the domestic work burden. It is only after the age of about 12 that girls take on the full agricultural tasks of their mothers and other women in the household.

The volume of work varies considerably between children who do or do not go to school. Although recent data are unavailable, the 1990 study mentioned above noted that out-of-school children, both boys and girls, work two to three times as long as those who go to school. Given the disparity between the number of boy and girl children attending school, far more girl children nationwide perform domestic labour than boy children do. Home work obligations and traditional attitudes are not the only factors that keep children

from attending school. Changes in family livelihood strategies, including agricultural peak seasons, out-migration of household members, environment-related hardships and parents' work changes, also appear to affect children's schooling, particularly that of girls.

Due to resource constraints, or simply the desire for additional income, children are increasingly sent to urban areas to work. The prevalence and the proportion of boy and girl children are unknown. A study (UNICEF, 1996a) noted that among the "wealthy" *Tamang* community in Sindhuli District, daughters are often sent to work in urban carpet factories rather than to school. In indebted families, children often work in the homes and fields of the creditors, or in the urban homes of the creditors' extended families. Again, the prevalence and the proportion of boy and girt children in this situation are unknown at this time.

Over the past decade, there have been considerable attitudinal changes in many communities' towards sending girls to school, and the value of education for girls has been amply stressed. However, family wealth, women's workload and the need for girl's labour remain important factors in determining the number of girls who can go to school, and often prevail despite attitudinal changes. Similar factors influence boys' attendance at school.

The general trend today is that a girl child is sent to school as long as there are sufficient resources in the family, but the moment resource constraints set in, the first casualty is the girl child's education. Undoubtedly, therefore, girl children in families in the lower economic strata have fewer opportunities to complete primary education, and even if they do, their chances of going beyond secondary level are minimal. Early marriage and consequent movement to the husbands' household is a factor that obstructs girls' education at the secondary level.

There is a marked difference between urban and rural areas as to the relative amount of education considered desirable for girls as described earlier. In urban areas, girls' education is generally considered important, especially among the wealthier classes. In rural areas, however, the reason

most often given by parents for girls receiving less education than boys is that it is difficult to find husbands for highly-educated girls (Shtri Shakti, 1995). It is notable that in 1981, the predominant reason given for not educating girls or educating them less was because they were needed for household or field work.

6.4. Women in the National Environment

Despite the momentum gained in women's political access after the adoption of a new Constitution in 1990, the participation of women in various spheres of public life, both within the government and outside, has been relatively minimal. The Constitution has made provisions for 5 percent of all candidates running for Parliament to be women, and there is a special provision for nominating three women to the Upper House.

The traditional norm that politics are inappropriate for women remains deeply rooted. In the 1991 general elections, 82 women contested (6.1 percent) out of a total of 1,345 candidates. Of the 205 members elected, only seven (3.4 percent) were women and three were nominated to the Upper House. In the Mid-term elections in 1994, only eight women won seats to the Lower House. In the local-level elections in 1991, only 0.33 percent of the candidates for District Development Committee membership were women. For Village and Town Development Committee elections, the number of female candidates was 956 out of 102,502, out of whom only 241 women (0.55 percent) were elected.

During the Interim Government, set up before the promulgation of the new Constitution, there was one female minister. In the following Nepali Congress government, there was also one woman minister, holding the portfolio of Agriculture and Forestry. Women's representation in the judiciary is comparatively low in Nepal, with very few women currently in the legal profession. In the diplomatic corps, so far only one woman has been appointed as a Nepal ambassador abroad. With regard to women's access to decision-making processes in the higher levels of the bureaucracy, until very recently there were no women at the highest level, officers of the "Special Class". Two notable exceptions are the recent appointees as Special Class

Secretaries in the Ministry of Women and Social Welfare and the judicial Service. At the lower levels, there are indications of increasing participation of women as officers in public administration: from 4.2 percent in 1971 to 6.6 percent in 1981, to 9.3 percent in 1991. In selected government agencies and semi-government corporations, the overall percentage of female personnel has increased from 8.9 per cent in 1978 to 11.7 percent in 1993, although the heaviest concentration of women is at the level of non-gazetted officer (UNICEF, 1996a).

The Ninth Plan does reflect such concerns for gender equality. The problem, however, from past experience seems to be in the implementation. In this contest, Participatory District Development Programme (PDDP) provides an excellent opportunity to operationalize Sustainable Human Development (SHD) policies in Nepal in practical terms. The objective of the PDDP is to assist HMG/N through NPC, and the local authorities (DDC/VDC) to implement policies and practices to empower the rural people of, to enlarge their choice and opportunities to participate in decisions that effect their lives and their capacities to mobilise resources for poverty alleviation.

7. Law and Policy related to trafficking

Although government policy does not necessarily determine the field realities of NGO programs, it does determine the environment within which the donors and NGOs operate. In order to define the policy environment, national policy and domestic laws on trafficking in Nepal need to be analysed. The first domestic law specifically targeting trafficking in Nepal is the Traffic in Human (Control) Act in 1986. The New *Muluki Ain* (Code of Law of the Land) dating from 1964 already outlawed taking persons across the Nepal border for the purpose of selling them, although it did not use the term "trafficking." In addition, the 1964 code outlawed slavery, bonded labour, and separating minors from their guardians without consent.

The 1986 Traffic in Human (Control) Act replaced the New *Muluki Ain* for issues relating to the control of trafficking. It is widely considered to be ineffective due to a combination of factors, including the complex and lengthy legal procedures required for prosecution under the law and lack of political

and judiciary will to enforce it. It is considered one of the most poorly enforced acts in Nepal (CeLRRd, 2000).

Governments of the South Asian region have acknowledged the problem of trafficking of women and girls under combined pressure from international organisations and civil society groups, and have demonstrated varying degrees of commitment at national and regional levels to combat the problem. Countries of origin, such as Nepal and Bangladesh, have exhibited greater proactive initiative to address the issue as compared to their neighbours in the region.

Mounting concerns over the trafficking of women and girls in Nepal have spurred considerable activity to address the problem. Several anti-trafficking interventions are underway in the country. In 1998, the HMG/N Ministry of Women, Children and Social Welfare (MOWCSW) with support from the International Programme on the Elimination of Child Labour and the International Labour Organisation (ILO-IPEC), developed a comprehensive thirteen-point strategy for the prevention of trafficking. HMG/N has also initiated steps to address the problems of gender discrimination, violation of child rights, and increased out migration. MOWCSW has hosted several consultative workshops on trafficking and actively provided a forum for national and international NGOs, government organisations, community-based organisations, policy-makers, women's groups, and members of the civil society. The United Nations Children's Fund (UNICEF) and the United States Agency for International Development (USAID) have provided support to several organisations, including the Department of Police, to intensify their anti-trafficking initiatives. HMG/N has ratified several United Nations Conventions that deal, directly or indirectly, with the issue of trafficking.

Recently, rising concern about the trafficking of Nepali women and children has inspired criticism of national and local level political apathy on the issue, and the chronic lack of law enforcement and political will to address this problem. While the government has expressed a commitment to gender and child rights issues, most of these programs are conducted in isolation (UNDP 1999). Although the government of Nepal has begun several concrete activities that address trafficking, most of the initiatives are still either in the planning stages or awaiting financial commitments from various donors.

The 1986 Traffic in Human (Control) Act, which is currently in effect, defines trafficking in Article 4 of the act as: "*selling a person for any purpose; taking a person abroad with an intention of selling her/him; having a woman engage in prostitution by persuasion, enticement, deception, fraud or pressure, or to encourage anyone to be engaged in such acts; or making an attempt to commit or rendering assistance to commit such acts.*" This covers some of the components defined by the United Nations Special Rapporteur, including the concepts of transfer (sale), movement, and coercion, but does not require all of them to be present for an act to be considered trafficking. Selling persons for "any purpose" is included, whether or not it is associated with movement or travel. On the other hand, "taking a person abroad" with the intention of selling him/her is included, suggesting that when travel is involved in trafficking, it is international cross-border movement.

In addition, the 1986 Act only addresses the outcomes of trafficking that relate to prostitution. "Encouraging" or "persuading" a woman to engage in prostitution is considered trafficking, even if it occurs with her full knowledge and consent, in her community of origin, and she is not held in forced labour or slavery-like conditions. Conversely, recruitment by deception for the purpose of bonded labour in carpet factories, circuses, or other types of employment is not covered under this act unless there is an explicit "sale."

At the regional level, the current draft of the "SAARC Convention for Preventing and Combating Trafficking in Women and Children" defines trafficking as *"moving, selling, buying, kidnapping or fraudulent marriage of women and children within or outside a country for monetary or other considerations with or without the consent of such person."* This definition does not include exploitative labour conditions as a component of trafficking. In addition, it includes simple movement of persons for any consideration," even with their consent. Individual components of this definition are further discussed in the relevant sections and appendix 2.

8. Policy on rescue and rehabilitation

The MOWCSW consistently emphasises rescue and rehabilitation operations and income generation schemes in both the National Plan of Action

and in their proposed reform bill, although both approaches have been criticised for their ineffectiveness and paternalistic approach to trafficked persons and those vulnerable to trafficking (Bruce and Dwyer, 1989; Kabeer, 1995; Tinker, 1990).

Both the National Plan of Action and the proposed anti-trafficking reform bill include provisions for the establishment of rehabilitation centres for victims of trafficking. The National Plan directs these services at *"helpless women who have been subjected to prostitution"* or have been *"rescued from a brothel."* Neither the National Plan of Action nor the proposed anti-trafficking bill specifies the desired outcome or content of such programs or the duration of stay at such centres. Moreover, no provision is made for persons who may be rescued from trafficking for other purposes.

9. Conclusions

His Majesty's Government of Nepal has made considerable effort to develop policies and laws that specifically address the problem of trafficking. In addition, it has designated the Ministry of Women, Children, and Social Welfare as a clear focal point within the government for anti-trafficking initiatives and developed a National Policy and Plan of Action to control trafficking.

However, current law and policy documents in Nepal and in the region are not based on a clear and consistent definition of trafficking that encompasses the entire process of recruitment, deception, transport, and exploitative labour conditions. The current law and policy in Nepal focuses on trafficking for the purpose of prostitution. By emphasising the endpoint, the violence and abuse of human rights that occurs during the process of trafficking for all purposes are not addressed. The MOWCSW proposed reform bill would take this one step further, effectively criminalizing prostitution, and thereby denying redress for women trafficked into prostitution.

Anti-trafficking policy and laws that are proposed or are currently in effect impact negatively on women by denying access to services, housing, and redress under the law for women in sex work, and denying the right to

voluntary migration (with or without assistance). In addition, they do not specifically protect a trafficked person's rights during rescue, rehabilitation, and reintegration interventions.

CHAPTER THREE

LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK

1. Introduction

The subject of trafficking in human beings has captured a lot of attention during the last few years from many interest groups. Trafficking is problematic in its nature and consequences, and trafficking has also assumed a major profile as a social problem, despite the inexactitude of the evidence. No studies on trafficking would be complete without mentioning general concepts and patterns of migration and prostitution. Therefore, this chapter seeks to clarify some of the debates concerning the definition, causes and effects of trafficking and consider strategies for addressing some of the causes and seeking to combat trafficking of women and children in Nepal. A number of, available and considered as important, study reports, seminar papers, books and articles are reviewed in this section. Information is scattered and scare and comprehensive reports are not available. Therefore, only certain aspects of the complex phenomena can be highlighted and limitations are identified at points where reliable material does not exist.

The chapter will start by reviewing the definition of trafficking, its approaches and its relation with prostitution and migration. This will be followed by an analysis of the causes of trafficking and prostitution in global level, regional level (Asia) and local level (Nepal). Third section reviews literature on knowledge and health seeking behaviour of trafficked women and presents the care and support need for trafficked women. Finally, this chapter discuss on conceptual frameworks used in this study and points the weakness of the literature on trafficking and prostitution issues.

2. Definition of trafficking

Even after many years of discussion and creation of numerous laws, policies, and programmes designed to prevent trafficking, there is no international consensus on the definition of sex trafficking. The term has been used to describe a vast array of activities, including voluntary facilitated migration, voluntary prostitution, and forced labour in which sex work is only an

incidental feature. As trafficking in women is a very complex issue, bound up with various and often conflicting interests on behalf of states and NGOs, the definition becomes even more important. When outlining measures and policies to prevent trafficking, wording of the definition can make the difference between a law, policy or measure that assists the women involved and one that further victimises them. However, there is increasing recognition of trafficking as a dynamic concept, which encapsulates a process of recruitment (involving coercion and/or deception), transport, and exploitative labour conditions.

For the purpose of this Thesis, I have adopted the definition proposed by the United Nations Special Rapporteur in a recent report to the United Nations Commission on Human Rights (Coomaraswamy, 2000):

> *"Trafficking in persons means the recruitment, transportation, purchase, sale, transfer, harbouring or receipt of persons by threat or use of violence, abduction, force, fraud, deception or coercion (including the abuse of authority), or debt bondage, for the purpose of placing or holding such person, whether for pay or not, in forced labour or slavery-like practices, in a community other than the one in which such person lived at the time of the original act described."*

In 1994, the UN defined trafficking as the:

> *Illicit and clandestine movement of persons across national and international borders, largely from developing countries and some countries with economies in transition, with the end goal of forcing women and girl children into sexually or economically oppressive and economically oppressive and exploitative situations for the profit of recruiters, traffickers, such as forced domestic labour, false marriages, clandestine employment and false adoption.*

The United States government definition of trafficking is similar to the United Nation's definition as follows:

> *"The recruitment, transport, or sale of persons across international borders or within a country through fraud, coercion, or force for purposes of forced labour or services, including forced prostitution, domestic servitude, debt bondage, or other slavery-like practices."(USAID, 1999)*

What is common in all the definitions is the fact that trafficking is inducing another into prostitution by violence, or by threatening violence, or by using her or her authority (including parental) circumstance or misrepresentation, into

slavery-like situations. All these definitions recognise that trafficking takes place within countries, as well as across national borders. In addition, these definitions refer to "trafficked persons" without reference to age or gender. However, the United Nations definition more explicitly establishes a trafficking chain that includes both those persons at the beginning of the chain who recruit and/or sell the trafficked person, and those at the end of the chain who receive and/or purchase the person and hold him/her in forced labour or abusive conditions. It is the combination of both ends of the chain that makes trafficking a distinct violation.

In case of minors there is a general agreement among the international community that the trafficking term applies whether a child was taken forcibly or voluntarily. Trafficking is distinguished from alien smuggling which involves the provision of a service, albeit illegal, to people who knowingly buy the service in order to get into a foreign country.

3. Approaches to trafficking

Though Trafficking has become an issue of international concern it is a multi-tiered issue as is seen by the fact that even in international discourse there are very divergent positions on the subject. Even now there is no internationally or even regionally accepted approach on trafficking. However, Wijers and Lap-Chew (1997) sheds some light on the issue by distinguishing between different approaches to trafficking and the strategies these imply:

3.1. A Moral problem

According to Ms Wijers this approach is the most used and sees trafficking in women and prostitution as an evil (inevitable or not) that should be controlled. Actions against trafficking within this approach aim at controlling and punishing the parties involved. Problematic with this approach is that women in prostitution risk punishment, which in turn leads to stigmatisation of the victims.

3.2. A Criminal problem

The criminal approach aims at introducing heavier punishments, improving international police co-operation and other measures which enable a more effective prosecution of the offenders. This approach is not without risks as the interest of the women are subordinate to the interests of the prosecution. The criminal approach often hits back at the women themselves, being guilty of prostitution or illegal migration.

3.3. A Migration problem

In the migrant approach, trafficking is a problem of illegal migration and actions aimed at "keeping your women at home" such as stricter border control, supervision of mixed marriages. This approach reflects the interest of the state to be protected from undesirable aliens.

3.4. A Human rights problem

Treating trafficking in women as a human rights problem offers two ways of analysis: prostitution is per se a human rights violation and should be abolished. The other is that prostitution as such does not violate women's human rights, but the conditions women in prostitution live under, such as deceit, abuse, violence, debt-bondage, blackmail, deprivation of freedom of movement etc are the violation of human rights.

3.4. A Public order problem

This approach views trafficking in women and prostitution as a public order issue or a public health issue. Solutions are to increase control by introducing e.g. medical examination.

3.5. A Labour issue problem

With this approach, trafficking in women can be understood as the result of the poor legal and social position of women: as women, as workers and as migrants. This approach calls for labour opportunities and working rights: pensions, state benefits etc to women in prostitution.

The approach determines what kind of strategies the state or NGO will employ to fight trafficking. These vary between on the one hand repressive

strategies, which aim at suppressing organised crime, illegal migration or prostitution and on the other strategies, which aim at supporting the women concerned and strengthening their rights (CATW, 1997). Both repressive and empowering strategies can be of value. However, Wijers (1997) warns of the dangers of mixing approaches and the interests of NGOs and the state respectively. The interests of the state and those of NGOs are often conflicting. The concern of the latter is to assist and protect the women involved whereas the former has great interest in restricting illegal migration and organised crime. Mixing approaches might lead to undesirable side effects for women e.g. restriction of women's freedom of movement or using women as witnesses for combating organised crime without allowing them the corresponding protection.

Most of the organisations in the west such The Foundation Against Trafficking in Women in the Netherlands, CHANGE in UK and some others have a human rights approach where trafficking is treated as an issue of violence against women. These organisations stress the importance of NGOs being on the side of the women involved, always evaluating programmes and policies by how they affect the women. Most NGOs agree on this approach and on the fact that women who are victims of trafficking have a set of interest in common. For example the need to be freed from imprisonment, authority of trafficker, violent contexts, the need to be protected from reprisals of traffickers, protection from deportation and prosecution, opportunities for counselling and social empowerment, possibilities of economic sustainability, possibilities of assistance to return home.

4. Prostitution from different perspective

The Oxford Dictionary defines a prostitute as a woman*: who hires out her body for sexual intercourse*; while prostitution *is an organised system in which women hire themselves out for sexual intercourse*; and to prostitute is to: *put to dishonourable use for the sake of money*. Thus the prostitution is defined in a negative way. It refers to women and it involves a commercial transaction. Social disapproval is defined by many media articles which refer to prostitution as 'vice'. But society has double standards where sexual activity is concerned.

There may be other rewards such as privilege, power, food shelter, clothing or anything of exchangeable value. It has also been argued that this exchange of rewards for sex may occur within marriage.

While prostitution in itself is considered to be undesirable, there are sections of society who challenge this view. There are clearly different perspectives and social workers, health workers and legal professional will also represent a variety of moralistic, liberal and professional viewpoints. The following section summarises three clear yet contradictory prospective on prostitution.

4.1. The Structuralist Perspective

The traditional perspective was described by a male sociologist, Davis in 1930s (Davis, 1937). Davis argues that society regulates sexual activity and reproduction through the institution of the family. He shifts the emphasis away from economic factors, i.e. women doing sex for money, towards the issue of demand, and claims that demand is the result of a simple male biological appetite. When all the other legitimate sources of sexual gratification fall through, the prostitute provides relief to the man with a craving for variety, for perverse gratification, for a mysterious and provocative surrounding, and sex free emotional commitment. The limitation on satisfaction is not morality or convention but the ability to pay the price.

Davis offers a traditional, structuralist male perspective on the social containment of female sexuality within marriage for one man (monogamy), which simultaneously allows male sexuality to be satisfied by prostitution.

4.2. The sex worker's perspective

Prostitutes have tries to shift the discourse surrounding prostitution away from legal and moral debates about deviance, towards a discourse about legally recognised work, choice and civil rights. The aim is to decriminalise prostitution, which has been freely entered into by adults. Jeness (1990) emphases the conceptual shift required in thinking from seeing sex as sin, or crime, to seeing sex as work. This view is based on the nation that women who

'work' (prostitute) has made a choice to do so, just as 'A women has the right to sell her brains to a law firm' (Jeness, 1990).

Some women refer to the freedom and autonomy the work offers as well as the potential to earn a lot of money in a short time. It is important to understand that women who hold this view are already sexually experienced when they take up sex work, they are sure of their own sexuality, and they understand the distinction between physical sex and love.

A further argument is that prostitution as work offers a service to society by reducing the extent of rape and the sexual abuse of other women. As the provider of such a service the women has the right not to be subject to public harassment from the law, but to be protected from the violence, rape and exploitation of punters and pimps, from the stigma of society in general, and from some police officers.

4.3. The feminist perspective

Many feminists consider prostitution to be a phenomenon created by a patriarchal society to control female sexuality. Central to feminist concerns are the goals of liberating women from social inequality, and from sexual double standards. Since prostitution is an institution which reflects the oppression of women in society, or the sexual exploitation to women by men, it is felt to be an undesirable occupation, which adds to women's exploitation (Smart, 1984).

Feminists rejects the structuralist perspective and its implication of the double standards of sexual morality, embodied in the ideology of the male sexual needs which must be satisfied and maintained by the institution of the monogamous wife. Instead they focus concern on efforts to change the laws on soliciting and prostitution, but at the same time 'feminism and prostitution are not easily reconcilable'. Taylor (1991) suggests that prostitution is just one aspect of female sexuality rather than a contradiction of the female sex role in society. She takes sex out of the 'relationship' context and examines the wider social context, thereby showing how sex serves many functions, which may have nothing to do with love at all.

The social dilemma arises here. There is a lot of resistance in society to the idea that women can have sex without love (yet it happens in many marriages) and that women might use their own body as a sexual object for sale. It is only relatively recently that some women have asserted their right to pursue sexual pleasure.

However, prostitutes have challenged feminist arguments by showing that the laws which operate against prostitutes, together with the stigma associated with sex work, keep all women from determining their own sexuality.

Thus two strands of feminist thinking have emerged. On the one hand it is felt that prostitutes are wrong to 'work', and that they are therefore, being exploited by men. On the other hand it is acknowledged that prostitution may have been freely chosen as a form of work by women in a society that has little to offer many women (Fogarty, 1982). Moreover, for some women who may have been sexually abused at an early age, this may be the first time they are actively in control of their own bodies, as they make men pay for that which was previously taken.

In trying to understand prostitution it is useful to consider the key factor of these three perspectives. The underlying emphasis of prostitutes themselves is that commercial sex or prostitution is work, a means to earn money in a society where female wages are comparatively low. It is chosen. For many feminists commercial sex is purely exploitation by men, and women should not allow themselves to be exploited. Others believe that sex should be contained within marriage, or at the very least within a monogamous relationship, and that where this is not possible prostitution will provide relief. The question of choice or the coercive power of men over women is not considered by the Structuralist perspective.

Apart from female economic need and male sexual demand, feminist interest in the underlying reasons for women becoming involved in prostitution has drawn attention to the importance of the 'self concept of sexuality' in societies where women are valued on the basis of their sexuality.

5.Trafficking and prostitution

Many laws, policies, and interventions limit the definition of trafficking to only those acts involving prostitution. These interventions may overlook protection and assistance to the large numbers of persons trafficked for other purposes, such as other forms of forced labour and forced marriages even though these other forms involve either sexual exploitation or its risk. This focus dates back to the United Nations 1949 Convention for the Suppression of the Traffic in Persons and the Exploitation of the Prostitution of Others, which still stands as the sole international treaty on trafficking (Coomaraswamy, 2000). By focusing solely on the outcome of trafficking, such definitions fail to take into account and protect against the abuse and human rights violations committed during the entire process of recruitment, transport, and confinement to exploitative labour conditions.

This focus on the end point of forced prostitution has prompted some organisations to advocate the abolition of prostitution as a means to control trafficking. Discussion of the control of trafficking is often side-tracked into the debate over whether or not prostitution should be criminalized.

The movement to abolish prostitution is led internationally by the Coalition Against Trafficking in Women (CATW) and within Nepal by the National Network Against Girl Trafficking (NNAGT). It is based on a belief that both trafficking and prostitution are an abrogation of women's rights and a violation of their dignity. However, recent declarations by CATW are framed within a human rights paradigm and recognise the difficulties of eliminating prostitution altogether. Hence, while this remains a long-term goal, CATW also strongly stresses the need to "provide rights and protection for women in conditions of sex trafficking and prostitution" (CATW, 1999).

Organisations that argue against abolition and criminalization of prostitution include the Global Alliance Against Traffic in Women (GAATW) and allied groups, including the Alliance Against Trafficking in Women and Children in Nepal (AATWIN). In their view, it is the right of adult women to choose to engage in sex work.

> *"It is not prostitution that the anti-trafficking framework opposes but the violation of rights that may occur while involved in that work. Although a woman may enter into prostitution by choice, she does not choose the exploitative conditions she is forced to endure. It is therefore the exploitative conditions and not the sex work itself that need to be targeted."* (WOREC/CEDPA, 1999)

Advocates on both sides of the criminalization issue agree on the urgent need to address the exploitative conditions inherent in the sex trade and to protect the rights of women involved in sex work. Moreover, although GAATW advocates a woman's right to "choose" sex work, they recognise that this "choice" may be little more than a response to the limited options available to disadvantaged women, echoing the position taken by CATW. The distinction between entry into sex work via trafficking and coercion versus voluntary entry is often not clear. The same set of social, familial, and economic circumstances that lead women to a decision to enter sex work increase their likelihood of being trafficked. Even when women enter sex work by "choice," they may not know beforehand exactly what this work entails and may be unprepared for its exploitative nature. Depending on the context, they may become embroiled in the same processes of slavery-like conditions or debt-bondage as trafficked women - and be as unable to escape. Conversely, women who enter sex work through trafficking may conclude that this represents a profitable livelihood strategy and may not necessarily wish to be "rescued" (Frederick, 1998; Doezema, 1999).

Another effect of the focus on prostitution in trafficking is that women in prostitution are divided into two types: innocent victims of trafficking and immoral voluntary prostitutes (Kempadoo and Doezema, 1998). It appears that most women in sex work suffer rights abuses and abusive working conditions and deserve protection.

While various international conventions now acknowledge the need to protect the rights of trafficked prostitutes, not a single convention promotes the rights of all women involved in sex work. Indeed, many states place the distinction between guilty and innocent women at the heart of their legislation on prostitution and trafficking. In Germany for example, the penalty for trafficking is a reduced in case where the person knew she was going to be a

prostitute. Likewise, in countries such as Colombia, Uganda, Brazil, and Japan, the use of violence to force a person into prostitution is only prohibited in cases where the woman concerned is of "undisputed virtue" (Doezema, 1998).

A narrow definition of prostitution limits our understanding of commercial sex. If we assume that prostitution is the exchange of sex for some form of material reward then sex work involves a substantial proportion of the general population. Sexual intimacy may be exchanged for a variety of resources – food, shelter, clothing, transport and social capital. Some people do this on a regular basis. Others do so occasionally - sometimes for fun and sometimes because of need. Many of these individuals would never perceive themselves to be sex workers and sex work is not their primary occupation (even if it is their primary source of income).

The sex industry in Asia is moving out of traditional sites and concentrations in red light areas and becoming dispersed throughout cities, in suburbs and along highways. It is straddling international borders and growing wherever there is a high density and movement of people. There is a clear move away from direct sex work and towards indirect prostitution in all Asian countries. Bars, clubs, massage parlours, karaoke bars, restaurants and hotels are typical venues. Sex workers increasingly operate in private houses in suburbs and they may use mobile phones or the internet to contact and negotiate with clients. This makes mapping of sex work sites, the control of exploitation within the industry and dissemination of advice on sexual health extremely problematic because the industry has no geographically defined borders and only a minority of sex workers can be labelled as having a sex worker identity.

Customers may believe that there is more to their relationship with an indirect sex worker than an exchange of sex and money and, indeed, this may be true. The worker maintains the fiction that they are not selling sex and the client is not alarmed that he is courting health risks by having sex with a prostitute. The perceived nature of a commercial sexual encounter may be changing and this has implications for the mapping of sex work sites, gauging the numbers of sex workers, and in particular, the promotion of condom use in

high risk situations (World Bank, 2000). Amongst many sex workers and their clients there may no longer be a perception of high risk precisely because they are not self-identified as 'workers' and 'clients'.

6. Trafficking and Migration

The conflation of trafficking and migration and the muddling of definitions have obscured the fact that many sex workers are increasingly mobile and will migrate in search of work. There are increasingly complex regional linkages throughout Asia that are expressed in terms of economics, trade, population movements and sexual networks. This phenomenon is apparent, for example, in the Mekong Delta, the 'Golden Triangle' island, Southeast Asia, and the Indo-Nepal border (WHO, 2001).

The financial rewards of elite and middle-income prostitution have also encouraged sex workers from outside the region to migrate to Asia. It is possible, for example to find highly visible sex workers from the former Soviet Union and Eastern Europe working in clubs, bars and hotels throughout both poor and affluent Asia.

In most Asian countries prostitution is illegal. The sex industry is regulated by legal codes, social custom and organised crime. These factors determine the type and form of sex work. They also penalise the sex worker in different forms: either by punishing workers with imprisonment or fines, stigmatising and shaming them, or economically exploiting them. Organised crime reaps enormous profits from the sex industry. In more developed Asia the forces of poverty bring many girls and young women into trafficking networks and agents. Within cities, organized crime is heavily involved in the sex trade. And throughout Asia police forces are often involved in the sex market.

In areas where efforts have been made to tackle abuses the result has been to clean up recognised sex work sites but also to push the most exploitative aspects of the industry further underground. In particular, young vulnerable trafficked women and girls many find themselves locked into socially invisible systems of sexual exploitation.

While all trafficking involves migration, not all migration is trafficking. Many women voluntarily choose to migrate. If such migration is not accompanied by coercion or deception and does not result in forced labour or slavery-like conditions, it is not trafficking. Women migrate for many reasons, both economic and social. Their right to move must be protected and maintained within anti-trafficking efforts. Many laws, policies, and interventions fail to distinguish between migration and trafficking. This has resulted in laws, predominantly directed against women, which limit the freedom to migrate and interventions that view all migrating women and girls as victims of trafficking.

For example, some intervention programs in Nepal measure success by the degree of reduction in migration of women at the village level. There have also been reported instances of women and girls who were prevented from crossing the border of Nepal despite their vehement protestations that they were travelling of their own free will. The boundary between migration and trafficking is not always clear. Even when there is an element of deception present in migration, it is not recognisable as trafficking until the destination is reached and the deception is revealed. Until then, the journey is usually indistinguishable from legal and voluntary migration, making it often impossible to intercept traffickers at the border while respecting the rights of migrating women.

In addition, women are sometimes trafficked *after* migration in a two-step process. For example, women are trafficked from carpet factories in Kathmandu after voluntarily migrating to the city from their villages for economic reasons. Therefore, attempts to control trafficking by curbing migration at the village level are misplaced and may serve to restrict women's rights to seek better livelihood opportunities outside the village.

Blocking migration not only impinges on the rights of citizens; it is not an effective anti-trafficking intervention. Many believe that restriction of migration will simply drive trafficking further underground, rendering it still more invisible and difficult to identify. This lesson has been learned repeatedly from other states that have enforced increasingly stringent immigration control as a response to heightened trafficking in persons and narcotics (Altink, 1995;

Azize-Vargus, 1996; Johnston and Khan, 1998). Even in the course of legal migration, women are frequently subject to violence and abuse when travelling, in proportion to their degree of social, economic, and gender disadvantage. When forced to migrate illegally, their vulnerability to violence, abuse, and presumably trafficking increases in an environment lacking state protection.

> *"Closing borders and limiting movement of women does not end trafficking. First, it fails to address the largest number of victims - those trafficked within their own country. Secondly, in today's era of growing economic inequality, people often need to migrate to urban areas or richer countries in order to earn a livelihood. When borders are closed desperation and desire will drive victims into the arms of traffickers. In fact, a victim's status as an illegal migrant is often a very effective tool in the hands of traffickers, leaving the migrant vulnerable to further coercion and abuse"* (USAID, 1999).

The major international anti-trafficking networks, Global Alliance Against Trafficking in Women (GAATW) and Coalition Against Trafficking in Women (CATW), advocate interventions that focus on addressing the abuse of human rights occurring during migration or at the workplace, rather than hindering migration per se. This focus is echoed by an NGO in Nepal:

> *"With the traditional subsistence culture no longer a viable means of livelihood, women often migrate for their own survival. It is therefore imperative that a woman's right to mobility not be impinged upon but rather that the human rights of those who choose to migrate be secured"* (WOREC/CEDPA, 1999).

It is important to focus on safe migration, rather than attempting to block all migration. The forces driving people, including women, to migrate continue to operate despite efforts to stop migration. If migration laws limit legal options for international movement, women will find ways to migrate illegally, no longer under protection of the law.

7. Women contrasted with children: Issues of consent and choice

Most of the people who sell sex in Asia do so because they are compelled by economic and social inequality and by terribly restricted life chances. Especially in the poorer countries of the region, they often have no other realistic option. Some moreover are physically coerced and a large proportion of women staffing the brothel sector have been trafficked into the

business. Those women who are held in debt bondage may receive only a fraction of the money paid by clients. On the other hand, in patriarchal societies in which women have inferior access to economic resources, sex work gives many uneducated and unskilled women an income that far exceeds that which they could obtain in any other occupation.

Many people are selling sex because of relative deprivation rather than absolute poverty. An undocumented number of young women from Asia's middle classes are now selling sex – often on a part time basis - to supplement salaries or to provide extra money while they are in education. Anecdotal evidence suggests that these part time sex workers are attracting business away from traditional sex work venues and full time workers (WHO, 2001).

Contentious debates over sex work in the Asia region have done a great injustice to many sex workers and those who are held in sexual slavery because the discussion creates an artificial dualism of passive victim versus the sex worker who exercises agency. Most sex workers in the lower ranks of the industry are victims of many kinds of social and economic injustice and it is inaccurate and patronising to exaggerate their degree of agency and their power to negotiate with clients and the management of the industry (Brown, 2000). Some sex workers profit well from their work but the sex trade, as a whole is exploitative of the women and men who work within it.

Youth is an essential prerequisite of sex workers throughout the world but in Asia there appears to be an even greater client demand for the very young. The premium age for sex workers in many Asian societies is between the ages of 12 and 16 (WHO, 2001).

A complicating factor is that the transition from childhood to adulthood, commonly defined in the West as occurring at eighteen years of age, does not have cultural resonance in many Asian countries – especially less developed South Asian countries (Blanchet, 1996) Here the acknowledgement of a female's adult status may occur at puberty or marriage - whichever is the sooner. Definitions of child prostitution as the prostitution of those under eighteen years of age may seem meaningless in a context in which cultural

norms encourage females to marry when they are fourteen, fifteen or sixteen-years-old.

Like females in their early teens, adult women may also be vulnerable to economic, social and psychological pressures. There is nothing magical about a girl's eighteenth birthday that guarantees that she can make free and unpressured choices. What is important in the context of prostitution and the controversy over 'choice' is an individual's ability to manage power hierarchies and to retain an element of control within them. For the youngest women and for those from ethnic minorities, fragile communities, despised social groups and castes (in other words, those who commonly fill the lowest rungs of the sex work ladder) this power and ability to control their lives is negligible.

The youngest girls are too young to make an informed choice to join the sex industry. They are extremely vulnerable. Their youth contributes to their powerlessness and makes them less able to negotiate with clients on anything approaching an equal basis.

Policy and interventions need to clearly distinguish between the control of trafficking for adults versus that for children. When there is no clear distinction, women are infantilised, and considered in need of paternalistic protection. There must be recognition of an adult woman's right to make her own decisions, even if this includes, for example, migrating to work in the sex trade. Women may also choose to remain in sex work after being "rescued" from trafficking. In contrast, the issue of consent is not relevant to a discussion on trafficking in children. There is international agreement that child trafficking and child prostitution of any kind is a criminal violation of a child's rights. Children should always be removed from exploitative situations.

8.Trafficking in women and girls: Global overview

For many women and young girls in Central Europe and the former Soviet Union the promise of a job as a waitress, dancer, model, au pair, or maid in a foreign country is difficult to resist in the face of diminished economic opportunities at home. The problem is especially severe in economically stagnant countries where women have the strongest incentives to go abroad in

search of work. One study in 1998 estimated that in Ukraine alone as many as 400,000 women had either left the country or had been trafficked since the collapse of communism (IOM, 1998). The number of victims in Latin American and Caribbean is growing. An estimated 100,000 women and children are trafficked for sexual exploitation annually (Maki and Park, 2000). Interpol has estimated that more then 35,000 women and girls are trafficked each year from Colombia alone (Pratt, 2001).

In Africa, trafficking not only involves women and girls for the sex trade, but also the abduction of children to work in the agricultural sector and to serve as soldiers in internal conflicts. In West Africa particularly, traffickers take advantage of long-standing customs that permit sharing of children among extended families and communities. Thus, parents may believe that their children are receiving well-paid employment and educational opportunities, either in other villages or abroad. It has been reported that between 10,000 and 15,000 Malian boys-likely trafficked outside their county-were working on plantations in the Ivory Coast during 1998 (Anti-Slavery Organisation, 2001a). Another study conducted in Benin and Gabon noted a dramatic increase in the number of children trafficked outside Benin from 117 in 1995 to 802 in 1997 (Anti-Slavery Organisation, 2001b).

In Asia, available literature shows that traffickers target the most powerless and vulnerable groups in society. Trafficking victims are most often women and children who are poor, uneducated, unaware of their legal rights, and are engaged in marginal and low-status work. Ethnic minorities, "scheduled castes," unemployed or floating populations and indigenous people are particularly vulnerable to trafficking (USAID, 2001). A large percentage of victims are trafficked into prostitution, while others are subjected to domestic servitude, forced marriage, begging, illegal adoption, and other forms of exploitation. Some literature shows that traffickers may deceive parents or lure women and girls with false promises of well-paid work or marriage to wealthy husbands. Traffickers also obtain victims by purchasing them outright from family members or through debt bondage and kidnapping. Poverty, the corruption of law enforcement authorities, and pervasive discrimination against

women and girls contribute to a regional environment in which trafficking flourishes (Asia Foundation/Population Council, 2000; USAID, 2001).

Trafficking of persons is common phenomenon in South Asia and there is evidence that new form, routes, and sources of trafficking have arisen in recent years. According to some U.S. reports, Southeast Asia is the greatest source of trafficked women and girls into the United States (IOM, 2000). A significant amount of trafficking in Asia takes place within country borders (ILO/IPEC, 1998). Nepal and Bangladesh have been designated as "sending" countries or countries of origin in the regional web of trafficking. India and Pakistan are usually referred to as countries of "transit" or "destination." Girls and women are trafficked within country boundaries, to other countries within the region and across regions and continents beyond South Asia.

Among the SAARC countries, Bhutan is less well researched with regards to trafficking in women and girls in prostitution. There are no authentic studies, but according to the newspapers in Nepal, some of the Bhutanese refugee women residing in eastern-Nepal have been found practising prostitution. It might be the compulsion of refugee-life or they are simply doing the job they have done in their home country. Some of the Indian reports have also indicated Bhutan as one of the sources countries of sex workers in the sex market.

India is generally the destination of trafficking in South-Asia. However, there are some instances of India being a transit place for trafficking in women to Pakistan. Sanjay-Amar Colony in the outskirts Delhi is known as a large slum area where girls aged from eight to eighteen are procured and sent to Pakistan with fake marriage certificates that eases the exit and entry in the Indo-Pak border (Debabrata, 1997).

Pakistan has also problems related to trafficking. The Lawyers for Human Rights and Legal Aid (LHRA) is a Karachi based association working for the trafficked men and women in Pakistan. It is also aware of the trafficking prevalence in SAARC countries. Pakistan's trafficking problem within the country exists from the roots in distant villages to the big cities like Karachi, Islamabad and Peshawar. But Pakistani and Bangladeshi literature seem

reluctant to mention the accounts of prostitution and sex work. Bangladeshi and Burmese women are sold in Pakistan and Pakistani women are sold in Arabian countries. There are some transit points in India to traffic children to Pakistan. Some Burmese are also found with a few from Sri Lanka and Nigeria imprisoned in Pakistan (LHRA, 1997). A report mentions that there are several jockey boys used for the camel racing in the United Arab Emirates (UAE). These boys aged 10-15, are trafficked from Bangladesh, Pakistan and Sri Lanka (LHRA, 1997).

9. Trafficking and prostitution in Asia

The sex industry in Asia is changing rapidly. The Asian sex market is highly segmented. It is becoming increasingly complicated, with highly differentiated sub sectors. The majority of studies, together with anecdotal evidence, suggest that commercial sex is becoming more common and that it is involving a greater number of people in a greater variety of sites.

Assessing the size of the market is difficult because the trade is largely illegal and often underground. The most authoritative studies available suggest that the market is vast. The sex industry in four Southeast Asian countries (Malaysia, Thailand, Indonesia and the Philippines) has been estimated to account for between 2% -14% of Gross Domestic Product (Lim, 1998). Estimates of the Japanese sex sector's annual earnings suggest figures of between 4-10 trillion yen and that the industry accounts for approximately 1% - 3% of Gross National Product (Human Rights Watch, 2000). Between 1993 and 1995 profits from the Thai sex industry were thought to be three times higher than profits from the drugs trade (Phongpaichit *et al*, 1998).

There is an international market catering to foreigners (Bishop and Robinson, 1998). This market is relatively small in terms of the number of sex acts performed but it is comparatively lucrative for workers because of the ability and willingness of relatively affluent foreigners in less developed Asian countries to pay higher prices per act than most domestic sex consumers.

The domestic market catering to local men is much larger but far less visible (Sinha and Sleightholme, 1996; Skrobanek, 1997). Neither of these

markets is sealed – local men may patronise sex workers who entertain tourists, and tourists may visit sex work sites that are patronised by local men but, in general, there is a division based not only on price but also on the preferred form of sexual advertisement (Brown, 2000).

The sophistication and level of differentiation between sub-sectors of the industry varies according to a country's level of economic development. As economies develop, more men have greater spending power. They can spend this on commercial sexual encounters and upon doing so in increasingly luxurious sites. Less developed economies have a large mass market for sex work, a far smaller middle-income sector and a tiny group of elite sex workers. Highly developed economies have a far greater number of sex workers operating in the middle-income range and in a variety of sites, often catering to niche markets. This breakdown of sex work into sub sectors defined by income-levels mirrors class and income distribution within society as a whole.

The bulk of research and literature on sex work in Asia focuses on the supply side of the trade: on the women who provide sexual services as opposed to the men who buy them. The nature of client demand and its cultural foundations are rarely analysed. This is a major failing of research and policy analysis because the success of the sex industry is dependent not only on there being a supply of women to the trade but, perhaps more importantly, on there being consumer demand.

A strict sexual double standard operates throughout the region. Sex outside the confines of marriage is not considered acceptable in the official codes of most Asian societies – at least for women. In practice, men's purchase of commercial sex is tolerated and, in some instances, may be actively encouraged by local definitions of masculinity. Cultural models in the region foster the sex industry by dividing women into two principal categories: good women who are wives and who are not supposed to enjoy sex very much; and bad women -the prostitutes - who do like sex (or who have no choice in the matter). It is a common expectation that men will turn to sex workers when they do not find sexual satisfaction in marriage or when single men do not have sexual access to women because of strict norms prescribing

virginity and chastity as essential characteristics of respectable unmarried women. A flourishing sex industry and a supply of prostituted women therefore contribute to the construction of sexuality and the maintenance of gender roles in some Asian societies. It has been argued that they are the logical outcomes of sexually repressive cultures and highly unequal gender relations (Brown, 2000).

There is a reluctance to acknowledge the size of the sex industry within the region. In some countries, most men will pay for sex at some point in their lives and many will do so on a regular basis. In South Asia the practice of commercial sex appears to be less prevalent but it is still grossly underestimated by governments, health departments and by public opinion. This unwillingness to confront uncomfortable issues extends to all aspects of sexuality including basic sex education, and the prevention and treatment of STDs.

Throughout the region mobile populations of men form a large proportion of sex consumers. Transport workers, seafarers, businessmen and men who are separated from their families and communities either by migration or by joining the armed forces are regular clients.

Urbanisation, the associated loosening of traditional social controls and the emergence of new avenues for sexual expression are encouraging the growth of a market for commercial sex (Herdt, 1997). The spread of consumer cultures has also had a dramatic impact on the Asian sex industry. It has created a growth market by commercialising sex acts. Sex can be seen as a product through which men define themselves. Men wish to buy the commodities they associate with an exciting, modern, urban lifestyle: women are one of these commodities. Materialism has also created a supply of women for the trade. It encourages women's involvement in sex work by offering them the opportunity to buy coveted symbols of modern consumer culture and it has simultaneously turned women into a tradable commodity. In this context, materialism and the financial benefits to be gained from selling sex outweigh customary social disapproval. This process is occurring at different speeds throughout both developed and less developed parts of the region and is

encouraged by the fact that women's traditionally low social status in Asian societies, and their unequal access to economic resources, permits their easy exploitation within the sex industry. In some areas of Thailand, Nepal, India and China prostitution is socially accepted.

10. Trafficking in Nepal

There is a consensus among groups internationally and within Nepal that female trafficking is a complex multi-caused phenomenon (O'Dea, 1993; Acharya, 1998; ILO/IPEC, 1998; ABC Nepal, 1996; Rajbhandari and Rajbhandari, 1997; Asia Foundation/ Population Council, 2000). At the local level, trafficking involves deep-rooted processes of gender discrimination, lack of female education, ignorance and naivete of rural populations, poverty and lack of economic opportunities in rural areas with consequent marginalization of particular social groups. These local level processes are in turn shaped by macro-level economic and social changes that are changing the way markets operate and the kind of labour that is required. Many of the factors contributing to trafficking are aggravated by national and local level political apathy and lack of law enforcement mechanisms.

Although there are no studies to support the correlation of these factors with trafficking, there is general agreement among those working in trafficking prevention that these factors are in part at least responsible for increasing rates of both trafficking and voluntary migration (legal and illegal). To a woman living in an environment of restricted rights and freedoms with few employment opportunities open to her, a trafficker offering a chance for economic independence may be seen as the only opportunity to improve her situation (UNDP, 1999a).

A number of studies have mentioned socio-economic factors as major determinants of trafficking in Nepal, relating traditional social and economic conditions of the society with the conditions that make trafficking possible, or even desirable for some segments who stand to gain from exploiting the trafficked women. Nepali trafficking and involvement of girls in prostitution is described as existing with the help of its relation to capitalist patriarchy, and modernisation in which some countries demand an inflow of fresh girls for

purposes of sexual exploitation. Prevailing caste system and various manipulations of religion as well as denial of the property rights to the women have all created a lower status for women leading them to be vulnerable to fall prey to the flesh traders. A study conducted on violence against women and girls in Kathmandu, Jhapa, Kanchanpur, Banke and Nuwakot shows that the level of mental cruelty, beating, rape, sexual abuse, forced prostitution, forced abortion, polygamy and accusations of witchcraft are in highest proportion in Nuwakot district (Rana-Deuba *et al*, 1997). The social circumstances that both oppress women and encourage women and girls to leave home may also make them prey to the pimps and traffickers.

Almost all stories of trafficking are in one or another way related to poverty. The story of Maya Tamang, a daughter of a drunkard has been frequently taken as an example by several writers (Pradhan, 1990; Rajbhandari and Rajbhandari, 1997). The family problem in the household has intergenerational consequences related to trafficking and prostitution. Problems with parents and of parents in trafficking of their own daughters (Thapa, 1990) and involvement of wives in prostitution as a result of husbands' behaviour are also found in various case reports.

Migration is playing an increasingly important part in Nepal's economy and social structure. Based on the 1996 National Living Standards Survey, 24% of rural households receive remittances, mostly from other places in Nepal and from India, accounting for 25% of their total household income (Seddon et al, 1999). As these factors lead to an increase in migration, more people may be trafficked in the process (O'Dea, 1993; Acharya, 1998; ILO/IPEC, 1998; ABC, Nepal 1996; Rajbhandari and Rajbhandari, 1997; Asia Foundation/Population Council, 2000).

It is not clear to what extent these figures on migration in Nepal involve women. The report by Seddon *et al* (1999) found that 23% of registered migrants were women, but suggest these that the great majority of female migrants are likely to be unrecorded because female labour is mainly concentrated in the informal, unregulated economic sectors. Girls and women are often relegated to the unprotected and often-illegal labour sectors, where

poor labour standards create the conditions for abusive recruitment practices and exploitative working conditions.

The nature of the vulnerability to being trafficked (as opposed to migrating safely) has not been explored in any depth in Nepal. Dominant representations of trafficked "victims" in Nepal usually depict a happy, innocent, and naïve village girl who is suddenly tricked or kidnapped by a stranger and sold into sexual slavery. Some authors (Frederick, 1998; Frederick and Kelly, 2000) have challenged this picture as a myth and question the assumptions of village and family life underlying many representations of trafficking. Their work and the little research that exists seem to indicate that many (though not all) women are trafficked by people known to them. Like other women in prostitution, many come from disturbed and difficult family circumstances, including divorce, alcoholism, sexual, physical or emotional abuse, or death of a breadwinner (Asia Foundation/Population Council, 2000; ABC Nepal, 1998; Pradhan, 1996). Lacking crucial social supports, such women may be particularly desperate to change their situations.

Reports from NGOs in the anti-trafficking field (Rajbhandari, 1997; Pradhan, 1996; ABC Nepal, 1996; Acharya, 1998) suggest that both trafficking and migration operate primarily through personal connections and social networks (such as an aunt who returns to the village and takes her niece back to the city), and through unregistered brokers who may or may not be strangers to the locality. They report that women and girls are attracted by reports of the wealth and fun to be had in the city and are easily duped into trusting the mediator. Likewise, some women are deceived into false marriages with the broker and are subsequently sold into the sex industry.

In certain communities (such as the *Badi* and the *Deuki*), sex work is a customary practice and continues to this day. In other communities in a few districts (notably Nuwakot and Sindupalchowk), there has likewise been a tradition of sending girls to "service" the ruling classes in Kathmandu, which, in time, has changed into involvement in commercial sex. In these communities, female involvement in sex work is common knowledge and an important source of income. In most cases, however, it is suggested that although

parents may sanction a daughter's migration and may even accept money in advance for her labour, they do not fully understand her risk of entering the sex trade (or of otherwise being exploited). Likewise, parents may accompany daughters to the carpet factories in Kathmandu but may not be aware of, or involved in, any subsequent trafficking. There are families with their female members practising prostitution in India. Some of the women used to come to home with an Indian man for couple of weeks and go back to brothels. Household expenditure is made possible by financial assistance from these *lahure* (jobholder in India) women (Bhatta, 1990).

The Nepali literature on trafficking and prostitution often argues that the Indian sex market has a great demand for Nepali women. Even among the Nepalis, the fair Mongoloid faces are in great demand (Rajbhandari and Rajbhandari, 1997; Pradhan, 1990). An official police record revealed that there were 716 cases of sex workers filed from 1989 to 1996 and an overwhelming majority of 92.0 per cent was Mongoloids; there were 4.5 per cent scheduled castes; 3.2 per cent Brahman and Chhetry; and 0.3 Others as victims. The studies highlighting the psychological demand for Mongoloid women from Nepal are supported by the police source statistics. However, the Indian literature on trafficking does not seem accepting of this hypothesis. If the Mongoloid faces were in great demand, the trafficking from the similar areas of India (areas in India where more Mongoloid group reside) itself would also have flourished. The Indian states with similar culture and ethnic groups like Nepal have apparently a low prevalence of trafficking. There might be two main reasons behind these finding. First, the Indian studies have generally ignored the Mongoloid origin women in their studies; and second, involvement of Nepali women in the Indian sex market could have been exaggerated and amplified. In both cases there is a need to conduct research in India with adequate representative samples and appropriate methodology.

In Nepal, high level decision makers, lawmakers and politicians at the local level are often accused of being the protector of the traffickers. Many authors have blamed the lack of enforcement aspects of the legal provisions. Policies are sound in Nepal but not the implementation. Political commitment is required to implement public policies. Stating 'quite often' Pradhan (Undated)

has written that the local administration or the police in certain districts have released accused traffickers because of the direct command of ministers and politicians. However, it is easy to speculate about the official involvement in a cover-up, but really hard to prove with tangible evidence. Malpractice in political and administrative levels in both places of origin (Nepal) and destination (India) of trafficking almost certainly does occur, and may be widespread. Studies have observed less political commitment to prevent trafficking, than to tackle other key issues. Political leaders and higher authorities in bureaucracy are accused of releasing the arrested traffickers from custody and taking political and monetary benefits from them (Rajbhandari and Rajbhandari, 1997; Ghimire, 1998; Thapa, 1990). This implies that trafficking is big business, and in the hands of organised criminal networks capable of bribing officials. Some political leaders are alleged to have association with pimps and brothel keepers (Friedman, 1996).

There are few opportunities for income in the hills and mountains of Nepal, so that families are easily persuaded to make the ground favourable for the pimps and traffickers. In addition, the Indian demand for skilled workers in making carpets has traditionally sought a number of naive young people from rural areas. The owners of these industries are said to have linkage with high level political and administrative authorities. Women in search of a job may legitimately enter into these industries that are the places en route to the red light area in Mumbai and other cities in India.

The evidence on association between the educational level of girls and women and trafficking is mixed. One study by WOREC (Rajbhandari and Rajbhandari, 1997) states that a hundred per cent of trafficked (or involved in prostitution) women and girls were completely illiterate. She argues that lack of educational opportunities and the poor access to education are the main reasons for widespread ignorance, which ultimately leads to trafficking. This is in contract to the information presented by Adhikary (1996) of the same organisation. Adhikari (1996) found that some literate women including women with ten years of schooling were found in brothels.

Most of the international developmental organisations argue that the lower literacy and lower socio-economic development of the South Asian countries have further made trafficking and prostitution severe (UNICEF, 1998; ADB, 2002). Traditional values and norms are hindrances to rehabilitation efforts. Society does not easily accept the return of women once trafficked and involved in prostitution. Social reintegration becomes much more painful for the person once involved in prostitution and rehabilitated later, which may force women to stay in the sex trade even they came back to Nepal. It is to be noted that a significant proportion of women have reported their unwillingness to go back home after they are made prostitutes. It is not clear whether they are in prostitution with their own consent or not. Therefore, working in Indian brothels over a long period and the proportion of Nepali women in Indian sex markets have been a concern of research (ASMITA, 1998).

Increasing demand for commercial sex in urban areas exercises a 'pull' factor, leading the recruitment by all means possible, of young women from rural areas. The highway syndrome and the growth of long-distance transport and trucking helps increase sexual promiscuity, and also to carry the women them from their distant residences to metropolitan areas. A study by Hameed *et al* (1997) asserts that some 40 per cent of the commercial sex workers in Indian cities constitute minors that are brought every year from distant places in India and Nepal.

Destitution and desire for fun are quite opposite to each other, but they both make women vulnerable for trafficking and her involvement in prostitution. Bedi (1990) collected these motives among the major themes of the studies conducted on prostitution in India. Most of the studies reported that women falling prey into selling of sex was the consequence of destitution, inclination, seduction, abandonment, alcoholism in family member, ill treatment by family members, bad company, persuasion, conscription and violation. Sexual promiscuity, illicit sexual relations, sexual urge and unfaithfulness of the partner or husband are other alleged causes of women's involvement in prostitution.

11. Trafficking for Prostitution and HIV/AIDS

The most frequently highlighted association between trafficking and HIV is the increased likelihood of HIV infection in women and children trafficked for purposes of prostitution. The understandable preoccupation with HIV/AIDS has sidelined many other problems relating to sex work. HIV/AIDS intervention programmes correctly identify workers' powerlessness as an important factor in transmission of the disease because it makes them less able to negotiate the terms of the sex act and client condom usage. Reports throughout the world consistently state that sex workers' ability to negotiate condom usage is limited. Many programmes seek to empower women and hence, by extension, to tackle a whole range of problems. Yet for many women involved in the trade, avoiding the threat of AIDS does not appear high on their list of priorities when they are faced with more immediate concerns such as debt, violence, ill-health and social exclusion for themselves and their children.

It appears that condom usage has been increasing in key sex work sites but that safe sex practices are not necessarily followed by those who are most vulnerable: particularly by young women. Nor is condom use thought to be high or consistent amongst indirect sex workers.

Condom promotion programmes have been extremely successful amongst direct sex workers in countries like Thailand and in select sex work sites in other countries. The link between the condom and commercial sex is reflected in consistent reports throughout the Asian region that indicate that although many sex workers use condoms with their clients they do not do so with their regular partners or lovers. This behaviour expresses the non-commercial nature of their relationship.

Although there are no available data on the rate of HIV among trafficked women and girls, it is reasonable to conclude that those trafficked for prostitution would assume the same prevalence of HIV as the sex workers in the area in which they are held. A study in Thailand found the highest incidence for HIV seroconversion to be in the first six months of sex work (Kilmarx *et al*, 1998). The authors postulated that this was due to customers who perceived new sex workers to be at low risk of infection and therefore did not use condoms and/or the relative lack of experience and skill among new

sex workers to negotiate for condom use. Both would apply to young, trafficked Nepali girls. In addition, trafficked girls and women are presumably less likely to be beneficiaries of sex worker interventions and empowerment movements due to their forced working conditions, debt bondage, and language barriers.

Trafficked women and children are not able to control even the most basic aspects of their lives, least of all to negotiate safe sexual relations. As seen in other migrant groups, language barriers and displacement from family and community support systems increase vulnerability and subsequent risk of HIV infection (Guest, 2000; AIDS Action, 1998). In addition, those who are trafficked internationally are usually classified as illegal immigrants in their country of destination and further marginalized with less access to education, services, and protection. If they seek help, they may be subject to prosecution for the crime of illegal immigration, rather than assisted as victims of trafficking (Wijers and Lap-Chew, 1997).

Although trafficked persons assume the risk of HIV associated with disenfranchised mobile populations and/or sex workers, emphasis on this risk in prevention and education programs may not be in their best interest. Messages that highlight the risk of HIV associated with migration and trafficking increase stigma, both for returned victims and other migrants. In the past, women who left sex work could reintegrate into their communities with relatively few problems, especially if they returned with some wealth. The current panic associated with the AIDS epidemic in Nepal is such that women returning from India are stigmatised as carriers of HIV, regardless of whether they have been engaged in sex work. In many districts, the common perception is that "a returnee from Mumbai is a carrier of AIDS." While the increased risk of HIV infection as a result of trafficking should not be over-emphasised at the community intervention level, there is much to be gained from examining the HIV/AIDS control experience to inform the anti-trafficking movement at the policy and planning level.

Nepal has entered into the HIV/AIDS era; and prostitution of Nepali girls in India, with a background of trafficking is blamed for pandemic of this disease in the country. Most of the HIV infection in Nepal is through sexual

transmission. Mostly young prostitutes are found with infection, and those who have returned home after working as sex workers in foreign brothels have high probability of getting infected with HIV/AIDS (Guruvarcharya, Undated).

Dixit estimated almost 30 to 40 per cent of sex workers in red light districts in Mumbai were infected with HIV in 1990; that was also applied for the estimated 30,000 Nepali prostitutes constituting as estimated number of 9,000. However, there is no reliable data, but if we consider a minimum estimate that about only 5 per cent of 9,000 or 450 prostitutes had made their way back to Nepal, Nepal has already many more HIV positives than estimated by other sources even in 1990 (Dixit, 1991). Lacking diagnostic facilities, people in remote villages may die with syndrome and no one would know or even suspect the reason would have been HIV/AIDS.

12.Trafficking and other health problems

Apart from HIV/AIDS there are many other health problems associated with trafficking and prostitution. Several studies (WHO, 2001; UNAIDS, 2000a) revealed that acute and chronic pelvic pain, pathological vaginal discharge, genital ulcers, skin disease, generalised weakness and pain during urinating are common problems for sex workers. In addition, neonatal death after delivery, amenorrhea (cessation of menstruation) and infertility are also common in these groups.

The other area of problem is injuries from violence that sex workers (more common in trafficked group) often encountered, which are much more diverse, frequent and acute than experienced by other women. Black eyes, bruises and burns are very common. Another major problem of this community is their harmful health behaviour from smoking, alcohol use, addiction, which endangered their further welfare by increasing vulnerability to other health problems.

Apart from these physical problems, women and girls who are in prostitution have other mental problems. Common mental problems are chronic anxiety, depression, eating disorders, post traumatic stress disorder and sometimes even sexual dysfunction. Together, these can result in

physical, mental and moral collapse and as a consequence those afflicted do not want to go back to the work or are unable to return to a 'normal' way of life (UNAIDS, 2000a).

Apart from the scale of unprotected sex and hence potential exposure to STI/HIV, research shows that having an untreated STI greatly increases an individual's risk of getting or passing on HIV to the partner.

13. Health services for trafficked women and sex workers

Public health specialists and epidemiologists have been publishing about the importance of developing good STD services for sex workers and their clients in order to prevent HIV/AIDS. This suggests that STD services are the most relevant services for sex workers. There are a growing number of publications about all kinds of initiatives to establish or improve STD services for sex workers. Underlying a lot of the research is the view that sex workers are a potential hazard to society and a multiplier in HIV dissemination. Sex workers are often mainly viewed in the context of how their frequent change of sex partners contributes to HIV transmission. This reinforces the patriarchal attitude of protecting men (or 'society') from HIV infection, while in fact the sex workers are far more vulnerable to be infected because of their weak social position.

Compared with the massive amount of such one-sided research, relatively little research is done on the conditions of prostitution, the way sex workers think about their work, how they survive, give meaning to their daily activities or how they see themselves and their partners. Little of all the literature produced in the last fifteen years is useful in arriving at a general understanding of prostitution or in a guiding social policy. This may be an illustration of the ambiguous relation between sex workers on the one hand and most health staff and researchers on the other hand.

Research on prostitution is often only acceptable as long as it respects the concept that prostitution is a problem and that the researcher should look for solutions of this problem. This view often leads to victimisation or stigmatisation of those working in prostitution. Chivariak (1999) describes how

most aid organisations in Cambodia view sex workers as vectors of disease. This attitude is detrimental to HIV/AIDS prevention, because for any intervention to stop the spread of HIV among sex workers a relationship of trust is needed between the different stakeholders. Viewing and treating sex workers as transmitters of disease will not be a great help in building confidence.

The pillars of HIV/AIDS care and prevention programmes for sex workers have become condom promotion, STD prevention, case finding and treatment, supported by health education and health promotion. Many stress that these activities can only take place with the co-operation of the sex workers themselves and that they should be empowered to negotiate better for safe sex.

In many countries in Africa and Asia health services are not accessible to underprivileged women, but also in Europe there often is a need for good services for sex workers. Montgomery (1999) stressed that services for sex workers in Moscow are lacking and in where they do exist they are highly sex worker-unfriendly. Nowak (1999) made the same observation in Poland.

As in many countries the majority of sex workers do not see themselves as sex workers it seems wise to have general health posts in areas with a lot of poverty and with high levels of sex work activity. Khonde and Kols (1999) describe a project in Ghana where it appeared to be more effective to make public health clinics more accessible to sex workers, than to establish specific STD clinics for them. In many countries STD services are poorly developed and a visit to them is regarded as a sign of 'deviant behaviour'. When asked about the best place for an STD facility, some sex workers prefer to have a centre on the area where they are working or even in the brothel where they are active (for convenience reasons), while others prefer to have a centre in a different part of town where nobody knows them and where they can go anonymously.

The place and the image of a health facility are important, but it is not easy to satisfy everybody. It is very difficult to develop the health services for mobile populations like street sex workers. Rhebergen *et al* (1999) found many

problems in developing the appropriate health services for sex workers in Surabaya, Indonesia. In addition, it can be problematic for many sex workers to visit a facility that has been labelled as a 'place for sex workers', because they prefer to not see themselves as sex workers. In countries where prostitution is not allowed these special facilities might give the police an opportunity to trace sex workers, which of course is another reason to avoid health care services. It is also noticed that most sex workers prefer to go to private doctors. Private doctors are thought be better because they are more expensive. However, their skills are not specifically geared towards dealing with the specific needs of sex workers. There is a need for tracing private doctors and clinics that treat sex workers regularly in order to improve their attitude and skills. Gorter and her colleague (1999) describe a successful Nicaraguan project in which sex workers are handed vouchers for free reproductive health care in a clinic of their own choice, whether private or public.

Though many stress that special STD clinics for sex workers are not a good idea, it is essential that health personnel who work with sex workers are aware of specific needs and problems. A drop-in centre where services are available for sex workers can function well in some circumstances. Participation of sex workers in such drop-in centres is highly recommended (Wolffers, 1999).

In many developing countries, the point of first encounter for STD self-medication and treatment is in the informal health sector. Over the counter purchase of antibiotics at pharmacies (drugstores or chemist shops) or from drug vendors and injectionists is almost universal despite laws that regulate their distribution (Moses *et al*, 1994). The treatment obtained from these sources is frequently inadequate or ineffective, patients do not receive the benefit of prevention education including condom advice and their sexual partners are not referred or treated. In Cameroon, a survey of men leaving pharmacies found that only nine percent of men in Douala and 15 percent of men in Yaoundé received their prescription from a medical doctor (Trebucq *et al*, 1994).

In other Asian countries such as Thailand, Indonesia and the Philippines, commercial sex establishment owners contract private practitioners to provide regular (usually weekly or biweekly) on-site STD check-ups and treatment of their employees. In Tanzania, four types of STD services for sex workers were compared; brothel- based periodic visits; clinic visits outside normal hours; regular clinic attendance at upgraded clinics; and regular clinic attendance at clinics without intervention. Sex workers preferred brothel-based STD services. However, STD services at clinics outside the normal operating hours were more acceptable than STD services offered during normal clinic hours (Mbuya *et al*, 1995).

In Tamil Nadu, India, numerous surveys by non-governmental organisations (NGOs) considering the use of ambulatory clinic vans have shown that sex workers generally work in areas far away from their homes and prefer to live anonymously in their own neighbourhoods. A neighbourhood clinic, either fixed or mobile, which only provides STD services, would probably draw too much attention from other neighbours. It is unlikely that sex workers would use them for fear of being labelled. These women prefer to seek STD treatment outside their communities or in clinics that cater to the entire family and provide a broad range of primary health services (Dallabetta, 1996).

In Kinshasa, Zaire, a special women's health centre was established in an area where many sex workers lived (Laga *et al*, 1994). The clinic provided health education, free STD treatment and free condoms. The study demonstrated that a clinic-based intervention of care and prevention could reduce the incidence of STD and HIV. It was also noted that once the women realised they were receiving quality services they were more receptive to prevention messages, creating a "care-prevention synergy".

Based on an assessment of the target community's needs in the Sonagachi district of Calcutta, India, a health service centre for sex workers and their families was opened at a local youth club in the heart of the "red light" area. Although the emphasis is on sexual health, other basic health services are also provided. Effective STD treatment coupled with peer education and a condom distribution program has resulted in a reduction of STD prevalence in

the community, dropping from 80.6 percent to 59.2 percent over three years (Jana, 1994).

In Nairobi, Kenya, a small storefront clinic providing family planning services to high-risk women in the neighbourhood instituted STD care services at the request of the health-care workers. A revolving drug fund was established and community-based distributors of contraceptives were trained to refer symptomatic women to the clinic. In Tanzania, STD services integrated into primary health-care services (PHC) was the least preferred source of care among sex workers along truck routes. The sex workers preferred care at their brothels or in the clinics at hours different from the normal clinic hours (Mbuya *et al*, 1995).

Regular screening of registered sex workers, often a legal requirement is performed in several countries. However, these services are often stigmatising and of little public health value since screening tests are either inappropriate or inadequate. Sex workers generally view such services as a legal hurdle rather than a health benefit. Furthermore, this approach does not reach unregistered or "clandestine" sex workers, a group that may be at higher risk for STDs than registered sex workers. In a study conducted in the Philippines, the prevalence of gonorrhoea among unregistered female sex workers was 37 percent (Moses *et al*, 1994) compared to 7.2 percent among registered ones.

In Tanzania, peer health educators at truck stops, who were already involved in condom promotion and HIV risk reduction education, were trained to assess risk using three simple questions (Mbuya *at al*, 1995). An affirmative answer to any of the three questions was supposed to prompt the peer educator into referring the woman for treatment. However, the peer health educators were unable to apply the score properly, even after repeated training. It was surmised that the educators were important for their role in encouraging the women to seek care, but in this pilot project they were unable to refer women at higher risk based on a risk score.

In Madras, India, the AIDS Control and Community Education Programmes Trust has started an outreach program for sex workers in the

central train station area. Sex workers with STD complaints are being referred with a letter to the public hospital for free treatment. The referral letter helps to ensure that the women are treated well by the clinic staff. So far the women appear to be pleased with the services and with the attitude of the staff whom they have encountered. There are other factors, too, which deter women from seeking treatment or cause them to delay their visit. Sometimes women hope that symptoms will just go away or consider their symptoms are not a priority (Hook *et al*, 1997).

There is increasing evidence that a large proportion, and in some settings most, STD patients seek care elsewhere, such as from traditional healers, pharmacists, friends or in the marketplace. Data from Mwanza, Tanzania, and Nairobi, Kenya, show that offering accessible and affordable care, including effective drugs, can cause a shift of health-care-seeking behaviour to official medical services (Laga, 1994). In some settings, it may be preferable to opt for more innovative approaches, such as training pharmacists or traditional healers in the syndromic approach or by allowing the social marketing of STD treatment packages (Crabbe *et al*, 1993).

Form the above literature it is clear that an ideal health care service for sex workers could have a holistic approach and combine STD and infectious disease screening and treatment, contraceptive services, other general health care and health promotion

All services should be provided with an understanding of the specific needs of different sex workers or trafficked women and girls, and the impact of their working conditions on health problems. For example, if a sex worker has pelvic inflammatory disease, routine advice about abstaining from sex for two weeks is unlikely to be feasible, and therefore other options, such as encouraging non-penetrative sex, and an earlier follow-up visit, may be discussed.

13.1. STD and contraceptive services

Prevention and treatment of STD, and promotion of general health are at the heart of HIV prevention. Some areas have good mainstream services,

but these are rarely acceptable to all sex workers, and many projects have found that specific health services for sex workers are necessary (UNAIDS, 2000b).

Some sex workers prefer a service where their occupation is already known and where the professional staffs understand their needs and lifestyle. However, in other situations separate services may be considered to increase the stigmatisation of sex workers, and it may be preferable to improve the accessibility and sensitivity of mainstream services.

In Lisbon, when Project staff found that sex workers, particularly drug users, did not make use of the mainstream service, it was decided to provide free STD care from the Drop in Centre once a week, via a staff team of doctor, nurse and clinical psychologist. This proved very successful, with nearly 400 visits made to the service in 1996 (Europap/Tempep, 1999)

A specialised STD service for sex workers can be offered within a mainstream clinic, which has the advantage of the clinic's full range of expertise and equipment, but careful planning is needed of times, staffing, procedures and publicity to ensure its success.

Many projects have found that it is important to accompany sex workers on clinic visits, and many STD services welcome accompanied visits. Those unfamiliar with the services may have anxieties about attending and a companion may give them moral support. In the case of migrant sex workers, it is important that they be accompanied by a cultural mediator to translate and to explain what is going on.

It is the experience of projects where accompanied visits are standard practice that this strategy does not undermine the sex worker's motivation or independence, but rather helps to establish familiarity with the service, develops a habit of making regular visits, and empowers sex workers to acquire knowledge which can then be shared with peers.

In Villafranca (Verona) the public health service has opened its services to local sex workers, mainly non-Italian and casual workers. One afternoon a week, the public can attend free of charge and with full anonymity to be tested for HIV, STD, Hepatitis, TB; to be vaccinated, (especially Albanian women needing polio vaccination), have

gynaecological examinations, contraceptive advice, abortion counselling, etc. A street unit travels around Verona informing sex workers about this service, making appointments, and accompanying them. Peer specialists talk to them about important issues such as contraception and vaccination while travelling in the vehicle. In three months, 50 women used this service and all returned of their own accord to get the results of their tests (Europap/Tempep, 1999)

However it is provided, a clinical facility for sex workers should be free, voluntary, and should allow sex workers to be anonymous if they choose.

13.2. Follow up of partners

Sex workers will be exposed to re-infection if regular partners, with whom condoms are not used, are not followed up. It is vital that this is done in a sensitive way, which respects the sex workers' privacy and anonymity, and takes into account the realities of their lifestyle.

It is necessary to discuss with the patient the nature of the infection, the reasons why partner follow up is desirable, and to decide together the best method of getting partners to an STD service. Often the best person to contact partners is the patient, but sex workers may have good reasons why they cannot do this; for example: the partner might respond violently, the sex worker may not want the partner to know s/he has an STD, the partner may refuse to attend an STD service and the sex worker may not know how to contact the partner.

In these circumstances clinical staff or other project workers may be more successful in contacting partners. Where a partner absolutely refuses to attend, some STD clinicians may, as a last resort, give medication to the sex worker to give to the partner.

13.3. General health care

Some clinical sexual health services for sex workers include general health addressing immediate health problems, such as back ache, chest infections, drug related abscesses, minor injuries etc. Common needs include counselling and referral for drug and alcohol problems, and provision or referral for mental health issues. Such clinical services may facilitate a holistic approach to health needs among sex workers.

13.4. HIV positive sex workers

HIV positive sex workers should have the same access to confidentiality, counselling, treatment and care as all other people with HIV. Specific issues include counselling about working safely (eg. through condom use), and about alternatives to sex work in order to reduce the risk to the sex worker of acquiring opportunistic infections from clients, as well as of transmitting infection.

13.5. Social welfare provision

Any problem, from unpaid fines to drug dependence, which puts a sex worker under increased financial pressure could undermine commitment to safer sex, because the fastest way to make money is to offer unsafe sex. Problems, which erode self-confidence, can contribute to sex workers being pressured into risky behaviour.

> *Research in France amongst 355 female, transgender and male sex workers in 1995 showed that about half lived in precarious accommodation (hotel or no fixed address), and that precarious housing correlated strongly with lack of health insurance, and consequently lack of access to health care. Young people and transgenders had the most precarious living conditions (Europap/Tempep, 1999)*

Most projects offer a wide range of services to sex workers, which, while not directly focused on health care, contribute to sex workers' personal welfare, self-esteem, and ability to control their own lives, so improving their chances of being able to adopt a healthier life-style. These issues include: legal advice, housing/homelessness, child care, social benefits and insurance, health insurance, civil/human rights, education, exit routes from prostitution, empowerment/assertiveness, domestic violence, childhood sexual abuse, exploitation/forced prostitution, introduction to other services and referral, advocacy.

The provision of condoms and other materials does not always mean that safer sex is practised. Safer sex advice, workshops which may include role play, demonstrations and discussions about the suitability of different condoms are all key components of safer sex interventions.

In Finland project staff found that Russian and Estonian sex workers were used to poor quality condoms and needed to be convinced that those being offered were reliable. In some countries condoms are relatively cheap and are an established part of a sex worker's "kit". In other countries condoms are relatively expensive and may be difficult to obtain.

13.6. Health promotion

Health promotion for sex workers is currently mostly aimed at reduction of HIV infection. However issues around HIV are not always the priority for a prostitute, and other problems may be more pressing. Services which focus on HIV prevention alone may have difficulty establishing credibility, and HIV prevention work will not reach the target group. HIV prevention should be placed in a wider context, taking into account other needs of sex workers and living conditions more generally. Sex workers experience health-related problems similar to any other person as well as occupational risks, including violence, drug and alcohol misuse and homelessness.

The wider health promotion needs of sex workers can be met through information and education, access to a range of health, welfare and legal services as well as through skills training.

14. Research Framework

As I mention in a previous chapter, the main objective of this research is to understand the whole process of sex trafficking of girls and women from Nepal to India for the propose of prostitution and to identify the practices related to maintenance of health and prevention of diseases including health-seeking behaviour of those trafficked women and girls. Therefore, I used to two different conceptual frameworks to understand these two different aspects.

14.1 Conceptual framework for health seeking behaviour

It is clear from a review of current literature that no systematic framework is currently available by which to assess the health seeking behaviour in relation to sex workers as well as trafficked persons. It is also

clear that many factors are responsible for the use available health services by sex workers or trafficked persons. Therefore, this study used the following approach (table 3.1), which is similar to McKinlay's (1972) analytical orientations of health seeking behaviour maintained in early 70s, to understand the health seeking behaviour of returned trafficked women.

Table 3.1 Conceptual frameworks to understand the health seeking behaviour

The economic:	In which attention is concentrated on the impact of financial barriers to help-seeking.
The socio-demographic:	In which emphasis is on the significance of gross characteristics like gender, age, and education for utilisation.
The social-psychological:	In which emphasis is on the link between individual motivation, perception and learning, and utilisation behaviour.
The geographic:	In which the focus of attention is the association between the geographical proximity of the health service and utilisation.
The socio-cultural:	In which the orientation is towards examining associations between the values, norms, beliefs and life style of different socio-economic groups and utilisation.
The organisational or delivery system:	In which the focus of attention is on the effects of aspects of health care organisation on use of services.

14.2.The conceptual framework for trafficking

The conceptual framework that guides this research has its roots in a multidisciplinary approach informed by the research fields of women's studies, social economics and development studies, public health, law, sociology, and

social and medical ethics. Since contemporary trafficking of women and girls in and from Nepal had not been systematically studied, the researcher has had to determine how to approach and study this complex and multi-faceted phenomenon. A research framework (figure 3.1) was developed to follow the path of trafficked women from their hometown, through their experiences in the sex industry, to their present place in life. Interviewees (the women themselves, and those who subsequently work to rehabilitate them) were questioned about the women's background before being recruited or trafficked into the sex industry, about the methods used to recruit them, whether and how they were moved around while in the sex industry, how they were initiated into the roles and activities they had to carry out, how they were controlled while in the sex industry, and how they coped with and resisted the conditions under which they lived.

Interviewees were also asked for their recommendations for policies on trafficking and prostitution. Since the women interviewed most likely had daily contact with other women in prostitution, they were asked for their observations and knowledge about other women (possibly trafficked women) in the sex industry. Women were asked about their experiences with recruiters, traffickers and pimps and the men who buy them in the sex industry. They were asked about their health and well-being during sex work, and after getting out. Furthermore, interviewees were also asked about awareness on sexual health particularly about STDs, HIV/AIDS and health seeking behaviour.

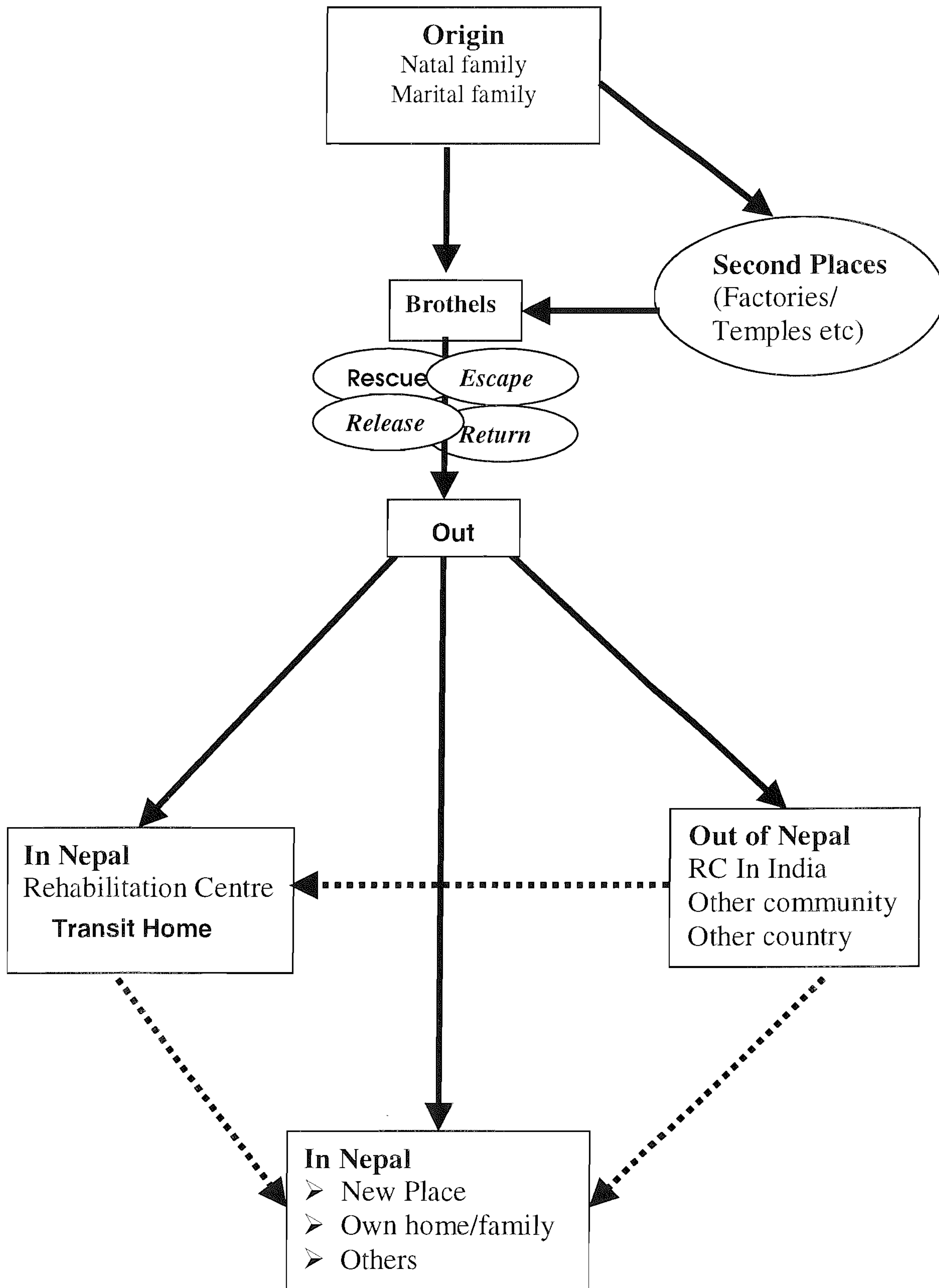
This research strategy enabled me to gather information on various aspects of trafficking in women and the sex industry from multiple sources and points of view. The questionnaire used in this study was constructed and organized by topics related to the path trafficked women may follow and the operation of the sex industry (figure 3.1). Questionnaires for each group of interviewees were constructed according to the topics on which this group would most likely have knowledge or experience (details are describe in methodology chapter).

To gather information on sex trafficking in Nepal as effectively and efficiently as possible, target sampling was used, in which individuals with

knowledge (or likely to have knowledge) on trafficking and the sex industry were interviewed. The goal was to gather information from the most informed experts on the topic to acquire an in-depth knowledge of the phenomenon of trafficking, not to do a broad survey of knowledge and attitudes.

The groups of individuals interviewed were social service workers who provide services to trafficked women and girls or may come in contact with women from the sex industry, and those providing services to immigrant populations; academic researchers and rehabilitation centre people who have studied the sex industry or trafficking of women and/or migrants; and health care workers who provide services to women in prostitution or may come in contact with women in the sex industry.

Figure 3.1 **Conceptual Framework**



15. Problems and weakness of available literature

In general terms, the available global, regional and national discourse on this theme is characterised by a poor understanding of social theory, and use of unreliable quantitative and qualitative information. There is lack of attention to research techniques, in evaluating policy the reproduction of myths and unsubstantiated facts, as well as the use of assumptions and campaigning imperatives in place of established theory and knowledge. The current situation on the quantification of the trafficking is characterised not only by widely differing figures but also by very different definitions. Data on migration of women are frequently hidden within and confused with data on trafficking. In addition to the accounts of NGOs and journalists, a relatively small amount of information is produced by anthropologists and sociologists (O'Dea, 1993; Acharya, 1998; Asia Foundation/Population Council, 2000) who have worked on limited research projects.

Perhaps the most disquieting aspect of the literature is the generally poor quality of research. The overwhelming majority of publications in the field of the trafficking is characterised by muddled, low level or misunderstood theories, badly thought out and applied research methods, poor data and inadequate analysis. Most of the literature originally consulted for this review was so poor that it was not worth including in literature review and, indeed, inclusion should not be taken as a sign of high, or even adequate, quality material. It seems that, in this field, a priori claims are made, based on rather weak evidence, about the existence and extent of facts that people in general find so desperately uncomfortable that they would rather accept the incredible than ask searching questions.

It is worth listing the more common errors of research method and analysis, because they contribute to the reproduction of unreliable or mythological information within the literature. There are few examples of rigorous research or of data presented within a comprehensible cultural context. For example, the most widely quoted statistics are that *five to seven thousand Nepali girls are trafficked for prostitution each year, and that 200,000 Nepali girls and women are currently working in the sex industry in India.*

These numbers were first quoted as an unsubstantiated estimate in 1986 and have been quoted without alteration over the ensuing sixteen-year period.

Numbers are an important part of any campaign because they endow it with urgency and an overwhelming sense of importance. Campaigns, journalism and academic literature tend to use the same unreliable statistics, either without reference to the source or citing one of the texts that have attained credibility. A case in point is Narvesen, *The Sexual Exploitation of Children in Developing Countries (1989),* which claims that there are one million sexually exploited children in Asia, although other texts take this to mean one million prostitutes. The term 'children' is used emotively and overinclusively, and may include girls who are in their mid-teens and would be of marriageable age in their own communities. It is normal for the highest figures to be given. They are always 'increasing', usually at an 'alarming' rate, reaching 'epidemic' proportions. Yet no reason is given for this except for the 'fact' that customers are turning to ever younger prostitutes because they believe them to be AIDS free. There is no evidence either way for this claim, but it has been endlessly repeated (Lee-Wright, 1990; Muntabhorn, 1992; O'Grady, 1994) until it has become a 'fact'. The evidence for these myths may simply not be provided, or given as a citation to another text that itself provides no evidence, or takes the form of hearsay evidence, the unverified statement of someone who knows somebody who knows these things are true.

One factor in the reproduction of inadequate information in the literature of trafficking for prostitution is the style of language used. Language is the means by which ideas are reproduced. The way it is used in any one context reflects the structure of the paradigm or overall theory that has given rise to these ideas. Language is never neutral. If a structure of ideas is repetitive, so the words and phrases that it gives rise to will bear the same repetitive characteristics. Literature on the girls' trafficking and prostitution is characterised by assertiveness. Uncertain verb forms such as the conditional or the subjunctive mood are seldom used. Thus writers seldom say that something 'might be the case' or 'it is reported that...'., preferring to present their case in the positive indicative, 'is', 'was, 'were'. Thus sentences often

begin 'There is evidence that...', or 'It has been found...' although the nature and source of such evidence, findings and claims are not presented.

A further immediacy is given to texts by the use of what is called 'the ethnographic present' which is the device of writing about past events in the present tense. A pastiche might be: *Maya stands outside the night-club waiting for a client. She is shivering with the cold and hopes that the next man will not be violent like the man who blacked her eye yesterday. She is twelve years old, but she has the eyes of a much older woman.* This often obscures the fact that the case study was gathered long ago by someone else and that Maya, if she ever existed, probably is a much older woman by the time the reader encounters her in the text.

Further linguistic devices are implicated in the repetitions and confusions of quantitative data. For example, in the chapter that is devoted to child exploitation in a highly respectable publication on children's rights, the author writes:

> *Undoubtedly most international trafficking is in women over the age of 16, but some children get swept up in the tide. Specific ages are rarely reported, but it seems reasonable to infer that at least some under-16s are included (Kent, 1992, p. 325).*

Leaving aside the rather loose use of metaphor in the phrase 'swept up in the tide' with its implications of the passive, helpless role of women and children, less obvious, but equally powerful, words and phrases in this passage move it to a position in which what is said is unlikely to be questioned because of its authoritative tone. 'Undoubtedly...' puts the writer beyond question, without having given any support for his certainty. He does not qualify what he means by 'most'. Likewise, 'it seems reasonable to infer', when placed alongside 'at least' appears to be 'reasonable' without giving any grounds, while 'at least' in this context appears to imply something of an underestimate. Similar, frequently employed phrases aiding the uncritical repetition of inaccurate statistics are:

> *'children as young as...' which could refer to one or two exceptionally young children in a larger sample of children considerably older;*

'up to 20 times a night'.. when referring to numbers of clients, which gives no idea of the average number of clients or the type of sex work under discussion.

Journalists tend to take even greater liberties with language, stressing the emotive aspect of the juvenile's situation and appealing to the readers' sense of outrage. The tone of journalists' coverage of sexual exploitation is often deliberately subjective and emotional. Repetitive use of shocking detail are justified in the public interest. There is usually an emphasis in journalists' information on the personal circumstances of each child, without recourse to any wider sociological information. Instead media reports of trafficking tend to explore themes such as the poverty of the family and inappropriate parental role models (alcoholic father or prostitute mother).

Nevertheless, journalists do tend to quote children directly more often than academics although, when children are allowed a voice, it seems they are muted or speak according to predetermined scripts. Adult advocates are usually given much more column space, and their opinions are given far greater weight so that it can sometimes seem as if journalists are merely quoting an adolescent to prove the point that adults are making.

Within the non-governmental sector in general, data tend to be collected and/or collated in an extremely patchy and haphazard manner. There is a great reliance on newspaper reports, individual stories, other NGOs and social workers and other 'experts' who guess at numbers and statistics. There is almost no information from the trafficked girls who work as sex workers and little exchange of information with the academic sphere. Another problem in the NGO literature is that the academic literature seems to be largely ignored or unknown. In addition, within the mainstream, campaigning literature, certain categories become blurred.

Academic literature on this topic in South East Asia is largely written by Western academics who have carried out some field research in the countries they study. In general, they conducted interviews with the trafficked girls and tend to be critical of middle class activists who appear to have less 'hands on' experience than the researchers. Some anthropologists and sociologists (Asia Foundation, 2000; Asia Foundation/Population Council, 2000; Rajbhandari and

Rajbhandari, 1997) have been concerned with looking at underlying predisposing factors and cultural patterns that might lead to the trafficking. They rarely talk about the types of clients but look at the family background of the victim emphasising the burden of duty they bear, especially girls, who are expected to make sacrifices in order to look after the family and to repay the parents for their lives.

Perhaps the most serious of these aspects is the way in which numerical data are manipulated and reproduced. For example international interest in children gained momentum in the United National International Year of the Child (1979) and was given further impetus through the adoption and entering into force of the United Nations Convention on the Rights of the Child (1989/90) yet, in the more than two decades, little has changed in terms of the way research is carried out and used by child welfare and advocacy organisations, despite considerable advances in theories of childhood and methods of researching children's issues within the academic community. What this amounts to is that the numbers provided for all groups of children in need of special care and protection have tended to remain the same, based on guestimates rather than research.

In the case of trafficking, however, guestimates have become fact, partly because they have become inscribed in rhetorical discourses aimed to raise awareness. The objective appears to be to heighten public and policy interest in the issue by stressing the scale of the problem. Yet this is neither ethically acceptable nor logical. In the first place, as stated as far back as 1983 by the United Nations Special Rapporteur on the Suppression of the Traffic in Persons and the Exploitation of the Prostitution of Others, 'The important point is not the scale of the problem but its degree of seriousness as a violation of the fundamental rights of the human person' (Fernand-Laurent, 1983). In the second place, the normal practice within the literature of providing a raw number, such as 'more then 1 million women and girls are trafficked in Asia' does not actually provide an exact idea of scale. To do this would require some knowledge of source, time, relative location and proportion.

The overall impression gained from carrying out this review of the literature on the trafficking is a permanent sense of dejá vu, because the material is so repetitive and the methods of data collection, analysis and presentation reinforce the way information tends to be reproduced. There are interesting debates and pockets of verifiable data, but these are obscured by the overwhelming weight of sensationalism, pressurised advocacy and refusal to examine taken-for-granted assumptions. The main reason is that data in this field generally arise in the context of campaigns so that knowledge is organised around campaigners requirements for particular kinds of fact, rather than the actual lives and needs of trafficked girls and women.

16. Conclusions

The reliable literature reviewed above has shown a complex network of different social, household, individual, persuading, administrative and legal factors as the determinants of trafficking. Current responses to the trafficking of women include law enforcement measures to stop the traffickers or to rescue the women from their trafficked state; assistance to women who have been rescued; and prevention programs aimed at educating communities and young women about the dangers of trafficking. Unfortunately, they fail to challenge the existence of trafficking or to support a movement of women in occupations associated with trafficking. There is lack of clarity on meaning and process of trafficking and on vulnerability of trafficking. Some organisations wrongly mingle trafficking with sex work or migration. There is a complete lack of monitoring, evaluation and documentation of current programs. Hence it is difficult to make informed judgement about the relative advantages and disadvantages of different programme processes.

CHAPTER FOUR

RESEARCH METHODOLOGY

1. Introduction

The first objective of this study is to understand the pattern, context and process of trafficking of women and girls from Nepal to India for the propose of prostitution. As mentioned in the introductory chapter there is a need to investigate the lives of trafficked women within social and cultural settings in order to understand the nature of their problems, and to identify the needs of those victims. This can only be done by investigating trafficked women in their own words, which will allow for an understanding of their lived realities and provide them with a voice that has previously been silenced.

Often in social research the investigators have a set of pre-conceived hypotheses, and information is analysed accordingly. But in new and sensitive areas of research the domain should be defined by the informants, in their language and not by the investigators. Investigators may not know the domain correctly and define the items or background variables falsely (Weller and Romney, 1988).

The second objective of this study is to identify the health-seeking behaviour and health need of returned trafficked women and girls. The taboo and stigmatised nature of sexual health problems in most cultures of Nepal (as well as the frequent repression of discussion about sexuality) will mean that gaining a 'true' picture of health seeking behaviours is particularly difficult and requires considerable cultural sensitivity. Health seeking behaviour cannot be understood in isolation from socio-cultural and other factors relevant to health and sex, including pressures to conform to some moral norm, legal repression of certain kind of sexual activity, absence of sex education, and poor quality health service in general (Mertens *et al*, 1997).

In the study of human behaviour, much of the initial description takes the form of observations and information documented qualitatively, not quantitatively. The use of qualitative data has become more common and has recently grown in acceptance within the scientific community, particularly in the

area of public health. Some of this recent change is due to the increasing sophistication of qualitative research methods and data processing techniques. However, a large part of this change is due to new questions about relationships between human behaviours and the public health problems of HIV, AIDS, and STIs. With the emergence of these public health problems, traditional quantitative data collection methods have become recognized as insufficient to meet informational requirements about human health and behaviour. The increased use of qualitative methods thus reflects an urgency to understand HIV/AIDS risk behaviours and their contexts and to develop effective prevention interventions for curbing the epidemic (Evans and Lambert, 1997).

In order to carry out a study viewing social systems and interactions within Nepalese communities, and to assess the position of women within these communities, it is necessary to select appropriate methodologies to undertake this task. I set out to use a qualitative, ethnographic case study approach (Hammersley, 1983; 1992; Yin 1994), using in-depth interviews, participant observation and collection of socio-demographic information as methods of data collection (Becker and Burgess, 1984; Hammersley, 1983; 1992). This method was favoured as it offers an orientation to understanding the processes and structures of a given social setting and allows employment of research techniques consistent with this orientation (Silverman, 1993).

This chapter firstly describes the approach of my research, and discusses the ethnographic approach with in case study framework, which was employed in this study. Secondly, it discusses the research design, mainly access to the study site, data collection tools followed by recording and analysis of qualitative data. Thirdly I discuss the validity and reliability of this research. Finally, it describes ethical issues and chapter ends with concluding remarks.

2. Approach of my research

Any kind of research that produces findings not arrived at by means of statistical procedures or other means of quantification is termed as qualitative research. A fundamental assumption of the qualitative research is that a profound understanding of the world can be gained through conversation and

observation in natural settings rather than through experimental manipulation under artificial conditions (Anderson, 1998). Denzin and Lincoln (1994) stress this view in the following words.

> *Qualitative research is multi-method in focus, involving an interpretive, naturalistic approach to its subject matter. This means that qualitative researchers study things in their natural settings, attempting to make sense of, or interpret phenomena in terms of the meanings people bring to them. Qualitative research involves the studied use and collection of a variety of empirical materials - case study, personal experiences, introspective, life story, interview, observational, historical, interactional, and visual texts - that describe routine and problematic moments and meanings in individuals' lives (p. 2).*

The keys here are the emphasis on deriving an understanding of how people perceive and construct their lives as meaningful processes, how people interact with one another and interpret those interactions in the context of the social and natural worlds, and the importance of observation in natural settings. As such, the central methods of qualitative research include interviewing people through various techniques and recording what they say, observing people in the course of their daily routines, and recording their behaviours.

Strauss and Corbin (1990, pp. 17-18) offer an even broader definition of qualitative methods in the course of developing the methodology of grounded theory: "By *qualitative research* we mean any kind of research that produces findings not arrived at by means of statistical procedures or other means of quantification." Strauss and Corbin (1990) note, however, that some researchers employ qualitative interviewing techniques to gather textual data that are subsequently coded and analysed statistically; in effect, they quantify qualitative data. Other qualitative methodologists (Bernard 1988; Weller and Romney 1988) employ systematic interviewing techniques, such as triad sorting, to produce data that are analysed quantitatively. The results of such analyses generate an understanding of cognitive categories, or how people perceive the relationship among categories in some domain, such as HIV risk behaviours.

Qualitative researchers take the participant as their starting point to understand the individual and their health situation through the processes of

interaction and empathy (Bogdan and Taylor, 1975; Bryman, 1988; Prior, 1997). Bogdan and Taylor (1975) for example, talk about the need for the phenomenologically inclined researcher to 'see things from [a particular individual's] point of view' (Bogdan and Taylor, 1975:14). Bryman (1988) meanwhile, says that:

> *"the most fundamental characteristic of qualitative research is its express commitment to viewing events, action, norms, values, etc from the perspective of the people who are being studied". (Bryman, 1988:61)*

From the above discussion it follows that qualitative methods can, appropriately applied, give the intricate details of phenomena that are difficult to convey with quantitative methods or not easily handled by statistical procedures. According to Strauss and Corbin (1990) "Qualitative method can be used to uncover and understand what lies behind any phenomenon about which little is yet known. It can be used to gain novel and fresh slants on things about which quite a bit is already known". The researchers in the social and behavioural science are concerned as well as with the issues related to human behaviour and functioning, and use qualitative research (ibid). Patton (1990, p. 38) suggest,

> *"Naturalistic inquiry is the only valid and meaningful way to study human beings".*

I also believe that action can best be understood when it is observed in the setting in which it occurs, trying as far as possible to understand the phenomena studied from the respondents' point of view. Of course, the researcher cannot abandon his or her values, and these may influence the kinds of interaction and questions asked in the qualitative interviews. Of particular relevance in the present study is the researcher's firm opinion that sexual exploitation of women for purposes of prostitution is a cruel form of exploitation. An important rule for the researcher however, is to be non-judgemental and sympathetic to his respondents.

Qualitative methodologists are mediators who attempt to demonstrate how a particular way of life makes sense in reference to another way of

understanding and creating social reality (Agar, 1986). Newman and colleagues (1991), for example, discuss the ways in which the qualitative understanding of the meaning of HIV risk behaviours from various people's own perspectives may be integrated with the epidemiological assessment of the transmission patterns of sexually transmitted diseases. Alperin and Needle (1991) and Williams and Johnson (1993) focus on the value of obtaining a qualitative understanding of social networks both for designing interventions and for epidemiological understanding of the natural history of HIV sero-prevalence rates in various locales (Carlson *et al* 1994; Siegal 1990). As Clatts observed (1991, p. 232), "It is precisely the process of traversing socially derived boundaries that becomes the primary task of the ethnographer" or qualitative methodologist. In other words, qualitative methodologists must take care to let people speak for themselves and not impose their beliefs or values on the data.

Jacob (cited in Marshall and Rossman, 1995) has categorized qualitative research in social science on discipline bases and historical tradition in six major domains. These different domains include human ethology (seeks to understand the range of behaviours in which people naturally engage), ecological psychology (stresses the interaction of the person and environment in shaping behaviour), holistic ethnography (human culture is crucial, try to uncover and document participants' perspective). The fourth domain is cognitive anthropology (assumes that participants' perspective are organized into categories of meaning that are systematically related to one another), the fifth one is ethnography of communication (linguistics are important, gather data about verbal and nonverbal interactions). The last domain is symbolic interactionism (understanding of how individual take and make meaning in interaction with other, and create symbolic categories which inform future interactions).

Atkinson et al. (cited in Marshall and Rossman, 1995) describe seven approaches to qualitative research. They are symbolic interactonism, anthropology, sociolinguisists, ethnomethodology, democratic evaluation, neo-Marxist ethnography and feminism. Patton (1990) defines ten varieties in the theoretical traditions of qualitative inquiry. They include ethnography (culture is

central, every human group that is together for a period of time will evolve a culture), phenomenology (focuses on what people experience and how they interpret the world), heuristic inquiry (focuses on interpretation of information elicited in terms of hidden meanings), ethnomethodology (focuses on the ordinary, the routine the details of everyday life), symbolic interactionism (emphasis on the symbolic meaning of human transactions), ecological psychological (the interdependent relationship between human behaviour and the environment), system theory (a system is a whole that is both greater than and different from its parts), chaos theory (deals with unpredictability and indeterminism in human behaviour), hermeneutics (interprets the meaning of phenomena from some particular perspective), and orientational qualitative inquiry (emphasis on important variables and concepts and the interpretation of findings). Ethnography is applicable in this study because it enables one to elicit information from the trafficked women in their own cultural context and gives me a chance to analyse the problem from the cultural actor's point of view (Silverman, 1993, Holstein and Gubrium, 1994).

3. Ethnography within case study framework

The background of ethnography is wide and it draws on many disciplines. That is why there is no explicit definition of ethnography. In its widest sense, ethnography is defined as a systematic process, through which models of culture or subculture are observed, described, documented and analysed (Pelto and Pelto, 1978; Agar, 1980). Ethnographic research offers an orientation to understanding the process and structure of a social setting and employs research techniques consistent with this orientation. Spradley (1980) describes ethnography as "the study of both explicit and tacit cultural knowledge" (p.8). Culture is defined as "the acquired knowledge people use to interpret experience and generate behaviour" (p.6). Whereas explicit cultural knowledge can be communicated at a conscious level and with relative ease, tacit cultural knowledge remains largely outside of people's awareness. An example of tacit cultural knowledge would be the way in which individuals of a given culture define space. Spradley (1980) further posits that because so much of any culture consists of tacit knowledge, informants or interviewees often know things they cannot talk about or express consciously. Thus, the role

of the ethnographer "is to make inferences about what people know by listening carefully to what they say by observing their behaviour" (p.11). This is why ethnographers must participate as well as observe.

Usually, it is viewed as a research approach based on fieldwork with participatory observations and open interviews. Fieldwork has historically been characteristic of anthropology, because foreign cultures without prior written documents have been the main focus of anthropological interest. Geertz (1973) claimed that cultures can be compared to written texts, and anthropologists are the writers of such texts. On this basis, ethnography is defined as a research process and a textual product (Van Maanen, 1995). Atkinson (1990) considers ethnography a scientific genre, a scientific style of its own.

The background commitments of ethnographic study relate to the role of the researcher and the degree of the informants' participation. Classic ethnographers concentrated on systematic observation of social environments to find their structures and functions. Fieldwork was a combination of the researcher's actions, such as observation, listening, asking questions, writing field notes and taking care of social relations in different environments. Writing up the ethnographic study consisted of describing in details the items of the environment where the research had been conducted (Spradley, 1979; Hammersley and Atkinson, 1983; Werner and Schoepfle, 1986). Researchers did not consider the fact that informants told them about their life experiences from their own point of view or that sometimes their descriptions possibly rather created than reflected the truth of their life (Cohen and Omeri, 1994).

Views about the roles of the researcher and the informants in an ethnographic research process were influenced by sociologists, who adopted ethnography in various ways, depending on their perspective, such as phenomenology, ethnomethodology or symbolic interactionism (Mackenzie, 1994). Qualitative ethnographic approaches typically aim to elicit meaning and understanding from situations and actions through interpretation and explanation of behaviour. It is accepted that everyone creates his or her own reality, and all knowledge is considered contextual, which means that the

informants respond according to their interpretation and understanding of specific situations. This means that research should be a cultural description which does not impose the researcher's own arbitrary and simplistic categories on the complex reality (Hammersley and Atkinson, 1983; Thomas, 1993; Mackenzie, 1994; Baker, 1997).

Ethnographers do not work in a vacuum (Pool, 1994). I kept in mind that the role of the researcher is in central focus when ethnography is viewed as an endeavour to learn what knowledge people use to interpret their experiences in their cultural context (Aamodt, 1989). One way for a researcher to increase self-awareness of being part of rather than separate from the data is reflected in his/her personal experiences and feelings throughout the process of fieldwork (Lipson, 1989) The researcher (myself) is the most sensitive and important instrument, and my interpersonal skills are therefore critically important while being on the field (Fetterman, 1989; Lipson, 1989; Van Maanen, 1995). This fits in with Pool's (1994) idea that ethnographic texts do not mirror other cultures but are products of intercultural communication.

The assumptions underlying much of naturalistic, ethnographic research emphasize the subjective reality of individuals and stresses the relativistic nature of the social world which can be understood by adopting the point of view of the individuals who are directly involved in the activities which are to be studied. Thus, the vantage point for understanding human activities lies in the frame of reference of the participant in action (Burrel and Morgan, 1979). This approach highlights the importance of knowledge as something, which is personally experienced, and which can thus be best understood from the inside i.e. from the subjective experience of individuals. As Spradley maintains: "participation allows you to experience activities directly, to get the feel of what events are like, and to record your own perceptions" (p.51). According to Taft (1988), ethnography is "naturalistic enquiry". In fact, the emphasis on subjective realities as the focus of the investigator's attention has much in common with the philosophy of naturalism which purports that "there exist multiple realities which are, in the main, constructions existing in the minds of people" (Guba and Lincoln, 1988, p.81). Since these constructions are

intangible, they can best be studied in "holistic and idiosyncratic fashion" (p.81).

Ethnography is concerned with the direct observation of the activity of members of a particular social group, and the description and evaluation of such activity. It allows for a thorough understanding of the lives and cultures of the people participating in a study (Geer, 1957), although it is acknowledged that the process of 'evaluation' must reflect the way in which the researcher interprets the data obtained from interviews and interactions.

The purpose of the present study was to understand more fully the pattern, context and whole process of trafficking in women and to identify their health seeking-behaviour, and what seem to be the necessary health care and social support for those returning, trafficked women. I felt that using qualitative, ethnographic techniques such as general observation and in-depth interviews were the most appropriate for this purpose (Hammersley, 1983). A classic definition of this technique is provided by Geer (1957):

" By participant observation we mean the method in which the observer participates in the daily life of the people under study, either openly in the role of researcher or covertly in some disguised role, observing things that happen, listening to what is said, and questioning people, over some length of time". (Geer, 1957 p28)

The advantages of using an ethnographic approach include the ability to observe directly, via fieldwork, behaviour and actions of community members, rather than replying purely on statements made by participants. Ethnography provides data, which are rich in depth and detail (Hammersley, 1992). This technique is particularly well suited to dealing with the way members of a culture see events – as seen through their eyes (Bryman, 1988). It describes and explores the individuals' perceptions. It also has an open and explicit awareness of the role of the researcher's self in the choice of topic, process of research and construction of the findings. As Denscombe (1998) points out:

"Ethnography acknowledges the inherent reflexivity of social knowledge" (Denscombe, 1998 p79).

Conducting ethnographic research may be characterized as a life journey writ small an intense, yet extended, immersion in the collection of texts and the recording of observations and experiences in field notes. According to Agar (1986, p. 12), "Such work requires an intensive personal involvement, an abandonment of traditional scientific control, an improvisational style to meet situations not of the researcher's making, and an ability to learn from a long series of mistakes." This process is interactively influenced by the ethnographer's constant thinking and rethinking of incoming data and a deepening familiarity with previously published research, secondary data sources, research problems, and theory. As Fritz (1990, p, 61) phrased this process:

> *The ethnographer is always "working with the data;" that is, thinking and wondering about meanings, relationships, and explanations. By continually constructing and testing working hypotheses, the ethnographic analyst maintains an intimate familiarity with the data, generates new interpretations of field evidence, and plots new directions for further field exploration.*

The process of conducting ethnographic research involves all of this. Ideally, its end result is the production of ethnography, a monograph, systematic description and analysis of a people's culture (symbolic meanings, beliefs, attitudes, and behaviours) that is oriented by a particular research problem and theory.

However, there are some disadvantages to using an ethnographic approach in its classical sense. One of them is that there is a potential weakness of poor reliability and little prospect of generalising from the ethnographic account of a culture or event (Hammersley, 1992). Survey approaches serve a useful purpose where representativeness and generalisability of findings are necessary.

In this ethnographic research process, my fieldwork was based on informal conversations, formal interviews and participation in some of the informants' life situations, reflection on data, and analysing it, and writing interpretations. I consider informants as active participators, who reflected their

own reality through interpersonal interaction, narratives and stories. My focus was on the interactive process, with the aim of making sense of, and gaining meaning about, each social situation (Aamodt, 1989; Anderson 1991). The central question in this ethnography was how to respond to the explanations and life experiences presented by the informants (Marcus and Fisher, 1986; Geertz, 1988; Van Maanen, 1995; Atkinson, 1990). From the methodological aspect, my focus was to point out the interpretations through which the reality of social environment was built up, as well as detailed observations and descriptions of people's social life, as well as consideration and analysis of secondary data (Silverman 1993; Holstein and Gubrium, 1994).

4. Case study

Case study is an empirical inquiry that investigates a contemporary phenomenon within its real life context, especially when the boundaries between phenomenon and the context are not evident (Yin 1994).

Yin (1994) suggests several conditions for the use of the case study strategy-

- Where the research question being posed are "how" and "why" questions: (one might also add "what" questions where the aim is partly exploratory)
- Where the researcher has little or no control over the events and situations being studied
- Where the main focus is on contemporary events within their real-life context: perhaps surprisingly, Yin offers no definition of "a case": It may be helpful here to adopt. Platt's (1988) definition of a case as "a bounded system"- a systematic account of the multi-faceted, time-limited activities of an individual, a family, a community, an aspect of a particular society, a polity or other form of organization and so on. Yin's analysis does provide an extremely useful framework for planning the research strategy. It does; however, tend to be a little too restrictive, for example in its exclusion of historical analyses.

- The inquiry is into technically discursive, complex and holistic situations in which there will be more variables of interest than simple data points.
- The inquiry relies on multiple sources of evidence, with a need for data to converge in a triangulating fashion.
- The inquiry benefits from the prior development of theoretical propositions to guide data collection and analysis

Allan and Skinner (1991) describe the case study as an approach, or a strategy, rather than simply as a research tool. In using the Case Study as an overarching method, a variety of different methods can be used as a means of collecting both qualitative and quantitative data to contribute to each case study, and the integration of a series of case studies.

Patton (1990) describes case study as "particularly useful where one needs to understand some special people, particular problem, or unique situation in great depth and where one can identify cases rich in information in a sense that a great deal can be learned from few exemplars of the phenomenon in question. "

According to Anderson and Arsenault (1999), case study is a holistic research method that uses multiple sources of evidence to analyse or evaluate a specific phenomenon or instances. According to them, education is a process; therefore it requires a research method that is process oriented, flexible and adaptable to changing circumstances and a dynamic context. Given these boundaries, a case study method is often appropriate (ibid.).

In my situation, a process oriented research method was appropriate because I had to explore mainly the processes and determinants of trafficking and health-seeking behaviour of returned trafficked women and girls. Case study can provide a better exploration of the issue. Furthermore the case study method demands flexible and adaptive contexts to conduct the study, therefore it provided me with an opportunity for in-depth understanding of the issues. Therefore I used an ethnographic approach in combination with the case study framework. An ethnographic approach marshals case studies in describing

roles, values, interactions and behaviours within a defined cultural, spatial or institutional context.

According to the nature of my field of study, this perspective seems particularly applicable in the sense that returned trafficked women and girls are considered special people. Their problems do not correspond with the problem of other women and girls. They have uniqueness, such as their hesitatation to mix with others, limited friends, social stigma, shyness etc. I tried to study their special situation within the wider society and capture their uniqueness in relation to their real life history.

The case study approach has sometimes been criticized as lacking in rigour, the propensity for researcher bias, and an inherent weakness in providing a sound basis for scientific generalization (see, for example, discussion in Yin (1994). Mitchell (1983: 207) comments that;

> *"many of the criticisms (in term of validity and reliability) of the case study approach are based on a misconception of the basis upon which the analyst may justifiably extrapolate from an individual case study to the social process in general".*

The three potential objections identified by Yin will now be examined in a little more detail.

First, case studies can be, and sometimes are, conducted with a striking lack of rigour. Yin (1994) comments, *"too many times, the case study investigator has been sloppy and has allowed equivocal evidence or biased views to influence the finding and conclusions".* However, steps can be taken to undertake case studies in a systematic and rigorous manner: moreover other research methods are also open to similar criticism. The steps taken in this research is outlined in more detail in other section.

The second criticism of the case study research strategy relates to the tendency for researcher bias. But such bias is also to be found in other strategies (for example, in questionnaire design), and again the disciplined researcher should constantly be striving to keep bias to a minimum.

Finally the issue of generalisability is worthy of a more comprehensive response. One of the fallacies about case studies is that generalizations can be derived from them on the basis that they are "samples" from which generalizations can be made to other populations or universes: this is rarely true. As Yin (1994) emphases, case studies are generalisable to theoretical understandings and do not enumerate frequencies: they provide analytic and not statistical generalizations. Or as Mitchell (1983, 2000) puts it, "extrapolation from any one case study to like situations in general is based only on logical inference".

The case study can be a floppy, imprecise piece of work that is ridden with subjectivity and bias: but the case study can, and the good case study must, be otherwise. As Yin (1994.16) concludes: *"Paradoxically, the 'softer' a research strategy, the harder it is to do".* The experience of this research is that compiling a collection of case studies is an exceptionally demanding and difficult exercise.

5. Research process and methods

5.1. Access to study site

Many countries have trafficking in women for prostitution, processes which are especially difficult to locate, identify and research. They may be hidden from public view by being kept indoors and out of sight, even if the women work in towns and cities; or they are isolated in scattered rural work sites; or they are manipulated by employers who are careful to limit their contacts with clientele and others. It is not known how large such populations of women and girls are, since counting them would be very difficult. Not a great deal is known about their conditions o living and employment.

Women and girls who have been trafficked remain part of a hidden population until they have been identified by health workers, judicial institutions, the police, workers from NGOs and aid organizations, researchers, or others. This is because they do not themselves voluntarily come forward, as they are usually prevented by fear and trauma or by the resulting social stigma from doing so. They may also fear legal consequences if they are without any

identity documents, either because they never had them or because (as is often the case) they have been taken away by the traffickers. They may fear violence from traffickers and their current employers, or may wish to keep their work activity unknown to their families. They may also have contracted HIV, with all its "shameful" connotations. Researching a population that has so many reasons to remain hidden, and so many fears, is therefore one of the most difficult research tasks.

Some research on trafficked populations has been carried out in recent years. The IOM (International Organisation for Migration) has researched trafficked women (including young girls) from Eastern and Central Europe to Western Europe and has looked at the trafficking of women westward from Albania (IOM, 2000). The ILO (1998) has looked at the trafficking in women and girls especially in the Mekong sub-region; but a report of 1998 on this subject states that although "The understanding of the nature and magnitude of the trafficking in women and girls (in this region) is increasing... Nonetheless, many unknowns still prevail, partly due to the sensitivity and illegality of the phenomenon" (IOM 1998). However, there is no guideline to access such population.

Research concerning trafficking for prostitution can take place either in areas of actual sex industry activity in "receiving" areas, or the sending areas from which girls and women are trafficked. Occasionally these areas may overlap. Women and girls may be trafficked from one sending area to a receiving area in a neighbouring country, while the sending area is also the recipient of trafficked women and girls from a third area in yet another country.

The ILO (1998) has suggested that researchers in this situation should attempt to obtain information from a number of different sources. Contacts that are predominantly concentrated in only one area, e.g. law or immigration enforcement, or labour inspection, will bias the findings. Where privacy violation is not an issue, informants should be asked to suggest other informants for interview, so that a chain-link access to informants can occur. The persons interviewed should be asked to give as much detail as possible, whether this is about the current conditions of trafficked women and girls, their

geographical villages of origin, known trafficking routes, mechanisms and means used by the traffickers, conditions in which trafficked women and girls are kept, inducements given to them, etc. In this way a composite picture of the trafficking that is occurring, and the numbers of women and girls involved can be constructed. Multiple informants from different spheres will also have the function of providing cross-checks or corroborations of data already collected.

Since trafficking and prostitution is illegal in Nepali society, interviews with most of these informants must be considered delicate and will have to take place in carefully selected venues. All informants must be guaranteed complete confidentiality and anonymity, and will undoubtedly need to feel sufficiently confident of this before agreeing to be interviewed. Interviewers will need to also give assurances of their non-judgmental intentions.

Obviously it is not an easy or rapid matter to gain the confidence of such valuable informants and research may therefore tend to be more time-consuming than anticipated. As noted above, obtaining interviews with trafficked women is highly unlikely, and will probably only be possible if these women and girls have been rescued and placed in rehabilitation or foster care, or returned to their community of origin, and if they are willing to talk about their traumatic experiences, which cannot be assumed to be the case. While still engaged in sex work, they may well be under the influence and domination of traffickers or those individuals to whom they were turned over and who are profiting from their labour. They may be too fearful to talk with strangers even if contact can be made with them. Any interview with a trafficked sex workers is therefore likely to be a "post facto" event - in other words, taking place long after the events narrated. The interviewer must also remember that talking about and reliving past experiences, undoubtedly painful, may bring to the surface in informants feelings that may require especially sympathetic listening and support.

In consideration of the above points, I decided to make initial contact with NGOs and women's associations who are working in trafficking issues in Nepal. Contact with these organizations and with the health services may be the most important source of information, in at least two ways. Some

organizations have operated among local girls and women, including those working in the sex industry for years, and who are well aware of the trafficking of women, their treatment, their socio-cultural and geographical background, their working conditions, their health status, etc. Some of these organizations may even run classes for women, and this is an excellent contact point for those among them who may consent to be interviewed in neutral locales and for specific purposes. It may be rewarding, too, to interview older women who observe trafficked women and girls coming into the sex industry or who themselves were trafficked when younger; they may provide information not only regarding trafficking routes and the conditions of trafficking but also the "debt" burden, degree of parental knowledge (or actual arrangement with the traffickers), women and girls' current geographical areas of origin and relation to their families, relations with the police and other official agencies, degree of police corruption, etc.

At the first stage, I established close contact in Nepal with different organisations that are working against the trafficking in women and girls. I contacted to many organisations such as MAITI NEPAL, WORIC, CWIN, CHILDREN AT RISK NETWORK GROUP, NAVA JYOTI KENDRA, SHANTI PUNARSTHAPANA KENDRA, and SHAKTI SHAMUHA. After several meetings and discussion with these organisations I decided to work with ABC Nepal. But at the same time I interviewed women in other centres as well.

My final choice of working with the ABC Nepal was based on the fact that they made few demands on me. I was expected to help them and to help in their office but no constraints were placed on data collection or what I should do with it when I had it. They were also one of the very few groups who had first hand experience of trafficking in a small community and because they were trusted in the village, it was much easier for me to gain acceptance because I was associated with them. Therefore, my choice of fieldwork site was based almost entirely on necessity. I had not wanted to focus entirely on a rehabilitation centre, but this was the only place where I found a suitable research community. At the rehabilitation centre run by NGOs, I was given access to all their projects and resources. On a practical level also, I was allowed to work with them.

5.2. Preliminary visit, recruitment of research assistants and pilot study

The writer, who was born and educated in Nepal and speaks Nepali, visited the country in September 2000 for preliminary fieldwork. I spent two months in different parts of the country and I selected the research sites, and I sought permission for access from different authorities. At the same time, I selected three female research assistants. Two research assistants were nurses who have long experience with gathering qualitative information. The third research assistant was a returned trafficked woman, who was working with a NGO in Kathmandu. The main reason for selecting this third research assistant was to contact other trafficked women more easily. She has very good contact with other trafficked women. She helped me to find out the places and persons, but she did not carry out any interviews. Full orientation was given to all research assistants. Dr. Monique Hennink, my field advisor, helped me to give the training and orientation to those research assistants.

The objective of pilot study was refine data plans with respect to both the content of the data and the procedures to be followed. Pilot data can provide considerable insight into the basic issues being studied. Similarly, the work at the pilot site can provide information about relevant field questions and about the logistics of the field inquiry. So pilot study helps to refine the problem and the understanding of the issues in natural settings. Pilot study helps to familiarize one with the field environment and overcome the confusion that may occur in the course of field visits, and sets up necessary preliminary practical arrangements of field visit.

Both tools (tools for in-depth interviews and checklist for collection of socio-demographic data) were piloted before study. Pilot studies were conducted in one rehabilitation centre and necessary changes were made on the basis of pilot study. Some questions about abortion were asked on our pilot study, but we did not collect the in-depth information about it. Questions related to abortion were omitted after pilot study. The subject of abortion was very difficult for Nepali women and girls to discuss since it was clearly an emotional, legal and religious matter, with most stating that it was a "sin" to have an abortion.

5.3. Tools of data collection and sample size

Questions of what are an appropriate research methods and sample are common to many disciplines (Luborsky and Rubinstein, 1995). The basic question is what to observe and how many observations or cases are needed to assure that the findings will contribute useful information. Patton (1990) has mentioned that main differences between qualitative and quantitative research lie on the sampling approaches. Patton, (1990) further says, " There are no rules for sample size in qualitative inquiry. Sample size depends on what you want to know, the purpose of the inquiry, what's at stake, what will be useful, what will have credibility, and what can be done with available time and resources"(p, 184). He has stated that, "Qualitative method typically produces a wealth of detailed data about a much smaller number and cases. Qualitative inquiry typically focus in depth or relatively small samples, even single cases (n=1), selected purposefully" (p. 169). Often in ethnographic research, different types of data collected in different situations are combined (Hammersley and Atkinson, 1983). The type of data chosen depends on the research questions.

It has been noted that random samples of undocumented individuals are extremely difficult to obtain. How much more difficult to obtain such random samples for an even more clandestine population such as trafficked women. In addition to the difficulties in access, there is so little knowledge about the numbers of women trafficked that it is unclear to whom randomized results would be compared. If researchers want answers to questions about trafficking, they will have to accept something other than the traditional methods of random sampling. I also utilized a "snow-ball" sampling method particularly for sex workers (returned trafficked women who were working as a sex worker). This method uses previously interviewed women who then provide subsequent contacts within their networks of women who were subjected to having been trafficked. In this study, observation, in-depth interview, and site documents (study of official record file and medical record of returned trafficked women which was access from different Rehabilitation Centre) were used to collect the information.

The size and location of study groups (returned trafficked women and girls) are unknown and it was not possible to conduct random or representative sample surveys. Purposive non-random sampling method was employed as a method of sample selection. Respondents, who were living on the rehabilitation centre, were contacted in the rehabilitation centre and all women and girls who meet the criteria (given in earlier section) were interviewed. Other respondents who were not in rehabilitation centre were contacted through the individual contact (snowballing).

5.3.1. In-depth Interview

Interviews have been used extensively for data collection across all the disciplines of the social sciences and in educational research. In the 1980s, there was a considerable growth in using interviewing as a method for educational research and now it is generally agreed that interviewing is a key method of data collection. There are many kinds of interviews. Hitchcock and Hughes (1989) list nine types: structured interview, survey interview, counselling interview, diary interview, life history interview, ethnographic interview, informal/unstructured interview, and conversations. Cohen and Manion (1994:273), however, prefer to classify group interviews into four kinds, including the structured interview, the non-directive interview, the focused interview and the unstructured interview (in-depth interview).

An in-depth interview is a dialogue between a skilled interviewer and an interviewee. Its goal is to elicit rich, detailed material that can be used in analysis (Lofland and Lofland, 1995). The dynamics of interviewing are similar to a guided conversation. The interviewer becomes an attentive listener who shapes the process into a familiar and comfortable form of social engagement and the quality of the information obtained is largely dependent on the interviewer's skills and personality (Patton, 1990). In contrast to a good conversation, however, an in-depth interview is not intended to be a two-way form of communication and sharing. The key to being a good interviewer is being a good listener and questioner. Tempting as it may be, it is not the role of the interviewer to put forth his or her opinions, perceptions, or feelings. Interviewers should be trained individuals who are sensitive, empathetic, and

able to establish a non-threatening environment in which participants feel comfortable. They should be selected during a process that weighs personal characteristics that will make them acceptable to the individuals being interviewed; clearly, age, sex, profession, race/ethnicity, and appearance may be key characteristics. Thorough training, including familiarization with the project and its goals, is important. Poor interviewing skills, poor phrasing of questions, or inadequate knowledge of the subject's culture or frame of reference may result in a collection that obtains little useful data.

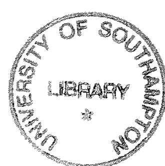
When in-depth interviews are being considered as a data collection technique, it is important to keep several potential pitfalls or problems in mind. There may be substantial variation in the interview setting. Interviews generally take place in a wide range of settings. This limits the interviewer's control over the environment. The interviewer may have to contend with disruptions and other problems that may inhibit the acquisition of information and limit the comparability of interviews. There may be a large gap between the respondent's knowledge and that of the interviewer.

Interviews are often conducted with knowledgeable respondents, yet administered by less knowledgeable interviewers or by interviewers not completely familiar with the pertinent social, political, or cultural context. Therefore, some of the responses may not be correctly understood or reported. The solution may be not only to employ highly trained and knowledgeable staff, but also to use interviewers with special skills for specific types of respondents. It is worth listing the more common errors of research method and analysis, because they contribute to the reproduction of unreliable or mythological information within the literature. Data are probably biased when (as frequently happens) researchers gain access to research subjects by means of institutions, projects and programmes. Information may thus reflect what the women and others think the project would like them to say, fear of repercussions from institutional staff, or exaggeration in order to attract greater project advantages. Far too often the only social science method employed is the questionnaire survey, which is always good method when used alone, at worst a bad tool to use with victims women, particularly where sensitive subjects such as sexuality and abuse are concerned.

A number of qualitative interviewing techniques exist, ranging from informal interviews to semi structured interviews and life histories (Agar 1980; Bernard 1988; Clatts 1991; Denzin, 1970; Fontana and Frey, 1994; Glaser and Strauss, 1967; Pelto and Pelto, 1978). In general, open-ended interviewing serves as a means of determining how people talk about or perceive various aspects of their lives and how they categorize things. After preliminary analysis, these data may be employed to create a more focused set of questions that pertain to a particular research problem or topic (Agar 1980). As Agar (1980) emphasizes repeatedly, the researcher must carefully encourage individuals to talk about themselves; to do so, respondents must believe in the sincerity of the interviewer's learning role and that the interviewer attributes significance to their beliefs, behaviours, and patterns of perception. The skills required to draw an individual's interpretations, values, and beliefs out into the open require professional training and practice (Sitton *et al.* 1983).

In the ethnographic research approach, informants are selected on the basis of their knowledge of the phenomenon studied (Spradley, 1979; Agar, 1981; Leininger, 1985). Especially the key informants should have good, relevant knowledge of the domain of the study and be able to interpret the meanings of their own cultural phenomena (Pelto and Pelto, 1978). Because the aim of ethnography is not to generalize the findings, the number of informants is usually small. Leininger (1985) states that the researcher can utilize the views of others when choosing the sample.

The sample for this study was selected according to criteria specified in the research proposal. In the first phase, eight key informant interviews (4 directors/chief of NGOs working with trafficking issues, 2 co-ordinators of RC (Rehabilitation Centre), and 2 health workers) were carried out. In second phase 42 in-depth interviews were carried out with returned trafficked women (who were trafficked to India first but were now living in Nepal). Seventeen interviews were taken in one RC, 9 were taken in another RC, 4 were in missionary home (run by a Christian organisation, that provides the shelter and other services for HIV positive women), and the remaining 12 interviews were undertaken in community level. Out of these 12 interviews, 6 were currently



working as a sex worker, 2 were living with their family and 4 were engaged their own small business.

All 8 key informants interviews (4 directors/chief of NGOs working with trafficking issues, 2 co-ordinators of Rehabilitation Centre, and 2 health workers) were carried out by myself. Out of 42 in-depth interviews carried out with returned trafficked women, 20 interviews were taken by myself and rest 22 were taken by two research assistants. There was no third person presence during the interviews because of the sensitive nature of the study but all 8 key informants interviews and 40 in-depth interviews were tape-recorded. Two in-depth interviews were not tape-recorded but details note were taken. All tape-recorded interviews were transcribed into original languages (Nepali) than translated to English. All transcription and translation were double-checked.

5.3.2. Observation

Participant observation is a qualitative research technique that usually guides ethnographic fieldwork (Adler and Adler, 1994; Agar, 1980; Bernard, 1988; Pelto and Pelto, 1973, 1978). It means becoming a part of peoples' lives to the extent that it is practically, legally, and ethically possible and, while interacting with them, observing their behaviours and conversations. Participant observation, then, is a dialectic process that cycles back and forth between assuming the role of a participant and the role of an observer. Data from observations and conversations are usually recorded in field notes from recall after the researcher has left the social situation. These may include sketches or maps of activity areas.

It is important to emphasize that appropriately conducted participant observation techniques require professional training and the allocation of the lead time necessary to develop rapport with the people being studied. Developing rapport means creating and maintaining complementary relationships with people. Building relationships can contribute to the execution of qualitative interviews in more controlled settings. Wolff and Pant (1975) comment that the direct observation has the advantages of putting researchers into first hand contact with 'reality'. It is usually possible to observe only a small number of individuals or groups. Marshall and Rossman (1995) note that

observation entails the systematic noting and recording of events, behaviours, and artifacts (objects) in the social setting chosen for the study.

I observed two rehabilitation centre in Kathmandu. I intended to see many events and activities as they occurred, without neglecting the temporal and spatial context in Nepalese Rehabilitation Centre. I worked in both rehabilitation centres during office hours and I kept note of different encounters in rehabilitation centre, where daily activities, individual behaviour, interaction with office staffs, and freedom within rehabilitation centre can be seen. I spent a month in one rehabilitation centre and one and half month in another rehabilitation centre. That observation made it easier for me to develop the interview schedule and to administer it later on. I tried to record every possible information that I made. Observation helped me to visualise what the trafficked women experience, from the existing Rehabilitation Centre environment.

5.3.3. Socio-demographic Information

In addition to participant observation and interviews, ethnographers may also make use of various documents in answering guiding questions. When available, these documents can add additional insight or information to projects. Because ethnographic attention has been and continues to be focused on both literate and non-literate peoples, not all research projects will have site documents available. It is also possible that even research among a literate group will not have relevant site documents to consider; this could vary depending on the focus of the research. Thinking carefully about participants and how they function and asking questions to informants helps to decide what kinds of documents might be available.

Possible documents include: budgets, advertisements, work descriptions, annual reports, memos, school records, correspondence, informational brochures, teaching materials, newsletters, websites, recruitment or orientation packets, contracts, records of court proceedings, posters, minutes of meetings, menus, medical records, case files and many other kinds of written items.

Privacy or copyright issues may apply to the documents gathered, so it is important to inquire about this when researchers find or are given documents. If researchers are given permission to include what you learn from these documents in his/her final report, the documents should be cited appropriately and included in the bibliography of the final paper. If the researcher is not given permission, it should not use in any way.

In addition to interviews and observation, some socio-demographic information, data related to trafficking and medical histories were collected and recorded by using a close-ended checklist (appendix 5). In total, 206 trafficked women's socio-demographic information and medical histories were collected from six different rehabilitation centres. Permission was taken from each centre before data collections. I choose this method mainly because this is the only information that was available in Rehabilitation Centres and it allowed me to build consistent and parsimonious profiles of the people trafficked. In total, 206 trafficked women's demographic information and medical histories were collected from 6 different rehabilitation centre.

5.3.4. Triangulation

Triangulation is a method to get an accurate and reliable picture of situation we are trying to understand by collecting different kinds of information from different perspectives (e.g. Insider/ outsider), from different sources and with different tools. Denzin (1978), has identified four basic types of triangulation: (1) data triangulation – the use of a variety of data sources in a study; (2) investigator triangulation- the use of several different researcher or evaluators; (3) theory triangulation - the use of multiple perspectives to interprate a single set of data; and (4) methodological triangulation - the use of multiple methods to study a single problem or programme. I applied all these triangulation approaches in my study.

5.4. Recording interview data

Interview data can be recorded on tape (with the permission of the participants) and/or summarized in notes. As with observations, detailed recording is a necessary component of interviews since it forms the basis for analysing the

data. All methods require carefully crafted interview guides with ample space available for recording the interviewee's responses. Three procedures for recording the data are commonly used in ethnographic research.

In the first approach, the interviewer (or in some cases the transcriber) listens to the tapes and writes a verbatim account of everything that was said. Transcription of the raw data includes word-for-word quotations of the participant's responses as well as the interviewer's descriptions of participant's characteristics, enthusiasm, body language, and overall mood during the interview. Notes from the interview can be used to identify speakers or to recall comments that are garbled or unclear on the tape. This approach is recommended when the necessary financial and human resources are available, when the transcriptions can be produced in a reasonable amount of time, when the focus of the interview is to make detailed comparisons, or when respondents' own words and phrasing are needed. The major advantages of this transcription method are its completeness and the opportunity it affords for the interviewer to remain attentive and focused during the interview. The major disadvantages are the amount of time and resources needed to produce complete transcriptions and the inhibitory impact tape recording has on some respondents. If this technique is selected, it is essential that the participants have been informed that their answers are being recorded, that they are assured confidentiality, and that their permission has been obtained.

A second possible procedure for recording interviews draws less on the word-by-word record and more on the notes taken by the interviewer or assigned note-taker. This method is also called "note expansion." As soon as possible after the interview, the interviewer listens to the tape to clarify certain issues and to confirm that all the main points have been included in the notes. This approach is recommended when resources are scarce, when the results must be produced in a short period of time, and when the purpose of the interview is to get rapid feedback from members of the target population. The note expansion approach saves time and retains all the essential points of the discussion. In addition to the drawbacks pointed out above, a disadvantage is that the interviewer may be more selective or biased in what he or she writes.

In the third approach, the interviewer uses no tape recording, but instead takes detailed notes during the interview and draws on memory to expand and clarify the notes immediately after the interview. This approach is useful if time is short, the results are needed quickly, and the evaluation questions are simple. Where more complex questions are involved, effective note-taking can be achieved, but only after much practice. Further, the interviewer must frequently talk and write at the same time, a skill that is hard for some to achieve.

In this research, the first approach was adopted. Forty formal interviews were audio-taped and transcribed in the original language (Nepali) then translated to English. Two interviews were not audio-taped, but detailed note was taken. All the interviews were taken in Nepali languages. In addition, information from informal encounters was recorded in field notes. Likewise, key informants and other members of the research team often brought to the ethnographer information gleaned from the street, RC, health centre and this, too, was recorded. Using multiple sources of information and having repeated contact with those people interviewed are means of improving the validity of the data. Interviewees were offered anonymity, though they often opted to provide their full names and a means for contacting them, and relied on the ethnographer to protect this information. For those choosing anonymity, first names were kept alongside their study identification numbers to facilitate further data gathering and analysis. Interviewees were invited to use an alias when they offered a name, but they were asked to use one they would remember if they had further contact with the researchers; if no name was given, the researchers made up a name simply to help recall the person.

5.5. Analysing data

There is much written on data analysis using ethnographic methods, and it is not my purpose here to go into great detail about this matter. It should be noted, however, that while computers are often used to enter, code, and help analyse the data, the analysis is not simply a matter of combing through the interviews in more or less detail. Instead, data analysis begins with the first

interview and as more is learned and new questions and problems develop, the sampling and interviewing is adjusted accordingly.

Although the conduct of qualitative interviews may appear scattered, unsystematic, or even daunting to professionals unfamiliar with the techniques, what the researcher does with the textual data once they are collected may appear even more so. Textual data are sometimes quantified, but the analysis of texts usually differs significantly from quantitative or statistical analyses. In general, what is required for the analysis of texts and observational data is some means of discovering systematic patterns or relationships among categories (Agar, 1980).

The most important initial means of discovering patterns is to gain familiarity with the texts by reading and re-reading the documents. There is no substitute for this time-consuming, intensive dimension of data analysis. It is often facilitated in part by the laborious task of transcribing audiotapes or verifying initial transcriptions. Further examination of patterns is usually performed by some method of indexing or coding of categories. In most instances, the categories emerge from the data in the form of patterns or relationships that are repeated across a range of respondents. In other instances, categories may be employed because they are relevant to a particular research problem or theoretical interest.

The next problem to resolve is what to do with the patterns and relationships once they are recognized. In the case of the methodology of grounded theory, for example, the patterned relationships among conceptual categories assigned to the data by the analyst are articulated in a more formal statement or theory (Glaser and Strauss, 1967; Strauss and Corbin, 1990). In other cases, patterns and relationships may be analysed with respect to a specific theoretical perspective. Several additional strategies raise the issues of validity, sampling, and the complementary relationship between qualitative and quantitative methodologies. The criteria for evaluating the results of qualitative research are quite different from, but no less systematic or scientific than statistical hypothesis testing.

To begin, a hunch that a meaningful pattern has been discovered is just an initial step in the qualitative research process. Systematic patterns and relationships are continuously formulated, tested, and modified as qualitative data are collected (Agar, 1980; Glaser and Strauss, 1967). Moreover, the researcher must always be conscious of the nature of the developing sample in relation to the known and emerging conceptions of the characteristics of the general population.

Once the information is gathered, researchers are faced with the decision of how to analyse the data. There are many ways to analyse ethnographic data (Mahrer, 1988; Spradley, 1979; Taylor and Bogdan, 1984), and thematic analysis is one such way. In this research I used the thematic analysis to analyse my data.

Thematic analysis has been described by many authors (Benner, 1985; Leininger, 1985; Taylor and Bogdan, 1984). From the conversations that take place in an interviews or those that are encouraged for the sake of researching a process, ideas emerge that can be better understood under the control of a thematic analysis. Thematic analysis focuses on identifiable themes and patterns of living and/or behaviour.

The first step is to collect the data. Audiotapes should be used to study the talk of a session or of an ethnographic interview (Spradley, 1979). From the transcribed conversations, patterns of experiences can be listed. This can come from direct quotes or paraphrasing common ideas. The next step to a thematic analysis is to identify all data that relate to the already classified patterns.

The next step to is then to combine and catalogue related patterns into sub-themes. Themes are defined as units derived from patterns such as "conversation topics, vocabulary, recurring activities, meanings, feelings, or folk sayings and proverbs" (Taylor and Bogdan, 1984). Themes are identified by "bringing together components or fragments of ideas or experiences, which often are meaningless when viewed alone" (Leininger, 1985, p. 60). Themes that emerge from the informants' stories are pieced together to form a comprehensive picture of their collective experience. The "coherence of ideas

rests with the analyst who has rigorously studied how different ideas or components fit together in a meaningful way when linked together" (Leininger, 1985, p. 60). Constas (1992) reiterates this point and states that the "interpretative approach should be considered as a distinct point of origination" (p. 258). When gathering sub-themes to obtain a comprehensive view of the information, it is easy to see a pattern emerging.

A further step is to build a valid argument for choosing the themes. This is done by reading the related literature. By referring back to the literature, the interviewer gains information that allows him or herself to make inferences from the interview or therapy session. Once the themes have been collected and the literature has been studied, the researcher is ready to formulate theme statements to develop a story line. When the literature is interwoven with the findings, the story that the interviewer constructs is one that stands with merit. A developed story line helps the reader to comprehend the process, understanding, and motivation of the interviewer.

6. Validity and Reliability

Validity and reliability is another issue in qualitative research and need to be address properly. Goetz and LeCompte (1984) describe the high degree of internal validity inherent in ethnographic research. They note that participant observation provides the "opportunity for continual data analysis and comparison to refine constructs and to ensure the match between scientific categories and participant reality" (p.221). It is also "conducted in natural settings that reflect the reality of the life experiences of participants more accurately than do more contrived or laboratory settings" (p.221). They argue as well that informant interviews are "less abstract than many instruments used in other research designs"(p.221).

Taft (1988) describes validity as being a "quality of the conclusions and the processes through which these were reached" (p.61). However, he argues that the exact meaning of validity depends on "the particular criterion of truth that is adopted" and that "in ethnographic research, the most appropriate criterion is credibility" (p.61). He further indicates that credibility can be

enhanced by and is dependent on the apparent accuracy of the data and the way the study is communicated to the audience.

In reference to external validity, the aim of many ethnographic studies is not to make generalizations on the basis of the data gathered. The aim is to uncover an idiographic knowledge of the world. Guba and Lincoln (1988) posit that this type of "knowledge is best encapsulated in a series of ‘working hypotheses’ that describe the individual case" (p.82). Kennedy (1979) argues that, in ethnographic research, the onus of generalization lies not with the researcher but with the reader of the research report. Clearly the study of a single case with no replications limits the strength and the range of generalization arguments considerably.

In an ethnographic research report, the researcher is expected to present clearly his/her motives, the background commitments and the approach of the study, and how the data is collected and analysed, because this enables the reader to evaluate the research process (Lipson 1989; Mackenzie, 1994). Due to this, I have explained my practical starting points and theoretical aspects, the purpose of the study, the research questions, the methodology and the research methods based on them. By applying the ethnographic approach with data collection methods suitable for it, I found answers to my questions.

For evaluating ethnography, or any qualitative research, Lincoln and Cuba (1985), Guba (1990), and Thorne (1997) have presented particular criteria. The critical question is, can or should the same criteria be used to determine validity and reliability for qualitative research as are used for quantitative research? Leininger (1985) argue that different criteria are required to appraise the validity and reliability. In quantitative research, validity refers to the degree to which an instrument measures it is supposed to be measuring (Polit and Hunger, 1978); measurement is the focus. In contrast, Leininger (1985) contend that validity in qualitative research "refers to gaining knowledge and understanding of the true nature, essence, meanings, attributes and characteristics of a particular phenomenon under study. Measurement is not a goal; rather knowing and understanding the phenomenon is the goal" (p 68). With respect to the criterion of the reliability, in quantitative research again is

the focus primarily upon the measuring tool or on its ability to gauge "the degree of consistency or accuracy with which an instrument measures an attribute" (Polit and Hungler, 1978 p 445). In qualitative research, however, reliability focuses on "identifying and documenting recurrent, accurate and consistent (homogeneous) or inconsistent (heterogeneous) features, as pattern, theme, values and worldviews, experiences, and other phenomena confirmed in similar or different context" (Leininger, 1985 p 69). Reliability as internal and external consistently and recurrently is important, the extend that the phenomena under study consistently reveal meaningful and accurate truths about particular phenomena.

I assessed the validity and reliability of my research by Leininger's (1991, 1995, 1997) criteria for evaluating ethnographical research. The criteria mainly concern qualitative data collection and they are: credibility, confirmability, meaning-in-context, recurrent patterning, saturation, and transferability.

Credibility refers to the accuracy or credibility of the findings, or it can be described as a "truth formulating process" between the researcher and the informants (Lincoln and Guba, 1985, Leininger 1991, 1995, 1997). Most health workers and some key informants from the RC knew my background and remembered me from the time I worked in Kathmandu Metropolitan City as a health worker, but for the majority of the trafficked women I was " a *thulo manchi* (prestigious man) making a research about health matters" or "a *thulo manchi* writing a book of us". The majority of the informants were excited about the interview: a *thulo manchi* coming to their house (RC) for the first time in their lives and making questions, which sometimes turned out to be on sensitive topics, such as sexual partner, condom use etc. Usually, I or my research assistants first discussed the everyday life of the informant and then moved on to specific themes. A few informants felt free to present their views ever since the beginning of the interview, but it often required 2–3 meetings, not necessarily in the form of an interview.

Collecting data from a variety of sources increases credibility (Robertson and Boyle, 1984). The main parts of the data were collected

through interviews and participatory observation, which are essential data collection methods in qualitative ethnography (Leininger, 1985). I also used the site documents to gain more information. It will be difficult to locate and interview a single identifiable group of respondents or a representative sample of this sub-population. Also, most informants are unlikely to be trafficked women and girls even though the research is about such women and girls. The reliability of research under these circumstances will derive from the number and variety of interviews carried out with a variety of informants and from the degree of agreement or internal consistency of the information obtained. This is especially important given that the informants will be drawn from a number of different but interacting populations. Each interview should be approached with a list of tentative questions, so as to elicit information on the same topics that other informants were also asked about.

At the first stage of data collection, I had prepared some guideline, which I supplemented with open-ended questions based on my observations and diaries. In the second stage of the data collection, I used themes and open-ended questions. Participant observation was valuable because it meant studying people in their natural environment and included behaviour and the circumstances in which the behaviour was seen (Spradley, 1980; Robertson and Boyle, 1984). In terms of credibility, in the second stage of the study, I had to pay attention to my research assistants. They had an important role in getting into contact with the trafficked women and facilitating interviews.

Confirmability in this study means reaffirming what I saw, heard or experienced about the phenomenon, and the study findings should be based on the empirical data, not on my opinions (Lincoln and Guba, 1985; Leininger, 1991, 1995a, 1997). There were altogether 42 informants, 8 key informants with different backgrounds, including age, ethnicity, family background, education level and location. Some of them were interviewed several times. The same questions were presented to many informants, although the questions also differed according to background and position of the informants. Also, the number of research assistants (2) was relevant in terms of confirmability. I discussed the findings, after listening the tape, with 1–2 key informants at the end of fieldwork. Throughout the end of fieldwork, I shared

my observations, interpretations and initial conclusions with the research assistants, interviewees and some other key informants.

Meaning in context means that the data become understandable with relevant meanings to the informants within their familiar and natural living and environmental context. To be able to meet this criterion, the researcher has to understand the situations and activities described and be able to transfer them to a wider context (Leininger, 1991, 1995, 1997). My research assistants and myself met and interviewed people in different environments and situations, and aimed at getting wide knowledge of the community itself. My former knowledge and experience of the culture enabled me to find the meanings in their context. The use of local language would have made the data more vivid. When writing the research report, I made a special effort to keep the information given by the informants unchanged.

Recurrent patterning refers to documented evidence of repeated patterns, themes, and acts over time reflecting the consistency of life ways or patterned behaviours (Leininger, 1991; 1995, 1997). These criteria require collection of the data over a long period. I spent nearly one year in the data collection process. In order to meet this criterion, I spend relatively long periods at the research site (Kathmandu). Furthermore, I interviewed different people in different situations and environments. By doing so I gained information which enabled corroboration about different aspects.

Saturation refers to content-rich knowledge about the phenomenon studied. It means that the researcher has conducted an exhaustive investigation and there is no further data or insights coming from the informants or situations (Leininger, 1991, 1995, 1997). I continued data collection in at the end of my study until the key informants did not produce any new information.

Transferability refers to whether or not the findings of the study will have similar meanings and relevance in another similar situation or context (Leininger 1991, 1995a, 1997). The purpose of a qualitative study is to elicit in-depth knowledge about the phenomenon studied in an ecological context. My study based on Kathmandu and data was collected in a RC in Kathmandu.

This does not represent the whole nation, and my findings may not be generalisable to other populations. However, some of the key findings such as mode and route of trafficking, health consequences of trafficking can be transferred to some other cultural context in Nepal to some extent.

7. Ethical Considerations

Because appropriately conducted qualitative methods are highly invasive of intimate aspects of peoples' lives, great care must be taken in the protection of research participants. Most qualitative researchers are committed to abide by a set of guidelines of professional ethics (Agar, 1980; Punch, 1994). Three points are basic to these guidelines. First, the purposes of the research and potential risks to the subjects must be made explicit to them; in addition, people must have the right to choose whether or not to participate. Second, the researcher must determine that no harm can come to the individual study subjects as a result of their participation in the research. Third, the researcher must ensure that the resulting research and publications cannot be used in such a way that they may bring harm to the participants as a group.

Central to achieving these goals is the use of an informed consent form in which the guidelines of the research and the person's role in it are described. Particularly in cases where illegal and highly personal behaviours are the subject of research, an assurance of confidentiality is of crucial value for protecting highly sensitive data. In the case of fairly controlled interview situations, the use of a signed informed consent form is recommended. In the case of participant observation situations in which the qualitative methodologist is interacting with people in more public settings, it is incumbent upon the researcher to make the objectives clear, to respect an individual's wish not to participate, and to leave the scene if necessary. Compensating participants for the time devoted to answering research questions is an important consideration (Weppner, 1977; Wiebel, 1990). Once ethical issues are considered and a guideline for informed consent decided upon, data collection may begin in one of two general forms, either separately or in combination: participant observation and interviewing.

Since ethnographic research takes place among real human beings, there are a number of special ethical concerns to be aware of before beginning. In case of this research, since I am dealing with highly sensitive group in sensitive issues, special attention was given on ethical issues. I first had the permission from the administrators of the research council of Nepal and in the second stage I obtained the formal permission of the concerned Rehabilitation Centre.

When finding the informants, I kept in mind the fact that the trafficked women, as autonomous individuals or members of their families, had the right to decide whether to permit an invasion of their personal privacy for research purposes (Fetterman, 1989; Lipson, 1994). My subjects were sometimes very sensitive from the cultural point of view, and my position as a male student from a modern western university required special consideration. I told the informants the purpose and goals of my research, but did not attempt to persuade the informants of the profits to others of participating.

I advised and guided the research assistants, as members of the community, not to coerce or manipulate the informants and to keep the information discussed confidential (Gregory, 1990, House, 1990). After the interviews, I exchanged views with each research assistant about the course of the interview, its atmosphere, and the reactions and actions towards them. This helped me to develop as a researcher in the course of the fieldwork and to maintain mutual trust between the informants, the research assistants and myself.

Likewise, I had access to a great deal of privileged information that had not been given to me directly. The centre had kept notes and case histories of many trafficked women and girls in the village and I used these to check with what they had told me. Although much of this information was simply factual, there were other, more sensitive accounts, such as records of counselling sessions or medical problems. Again, I used some of these notes and I obtained permission from the people that they referred to. The centre did not keep these notes for any sinister purpose and no one outside had access to them and they were simply there to help when staff changeovers occurred.

There is always a tendency to 'study down' in anthropology and to do research among the marginal and the dispossessed who cannot reply or argue with your analyses. Although this is changing now, with many researchers looking at the articulate and the powerful, in my own research, I certainly have been guilty of focusing on the least articulate and the marginal. I feel a responsibility to them because they will never be able to read what I have written about them and never be able to criticise or correct mistakes that I have made in retelling their stories or in my final analysis.

Finally, there is a problem with knowing what to do with this data outside an academic context. The subject of trafficking in women and girls is so emotive for many people that there is no acceptance of its study for purely academic reasons. Solutions have to be offered and ideas for change and plans of action need to be formulated. Yet, even after a year in this study, I could see no practical ways that solutions could be implemented other than via the sort of large structural economic changes that only a government could (but would not, of course) perform. Proper housing, education, employment opportunities need to be provided, but in a country without a welfare state, this is hardly likely.

Ethical approval from Research Council in Nepal and individual rehabilitation centre were taken before study. Furthermore, participants, who were involved in the study were fully informed about the nature of the study, research objectives, benefits and discomforts, the confidentially of the data. Their full verbal consent for their voluntary participation in the study was also obtained.

8. Conclusions

To conclude, the key features of qualitative methods as outlined above are summarized. First, qualitative research is largely an inductive process by which a scientist attempts to gain an understanding of the patterned meanings, perceptions, beliefs, values, and behaviours of a particular group of human beings in relation to a research problem. Although not always the case, a qualitative methodologist is unlikely to begin and end a research effort with a deductive theory, construct a questionnaire, and test hypotheses (Agar 1980). Because qualitative methods are designed to capture a people's way of

conceptualising their lives, strategies for living, and argot in relationship to contexts at varying levels of specificity, these data are crucial for the design and evaluation of meaningful (both to the respondents and the scientist) questionnaires, interventions, and prevention initiatives (Brooks, 1994). In short, qualitative research is necessary to make public health goals culturally meaningful and effective at the local level.

Second, in their most generic form, qualitative methods include participant observation and the collection of texts through interviews. Both of these methods require that the ethnographer adopt the role of one who has something to learn from the way other people perceive the world and behave. In addition, the analysis of qualitative data is systematic and rigorous when conducted appropriately.

Third, in relation to girls trafficking and health consequences in particular, qualitative research implies a progressive, phased research design in which a research team ideally moves from gaining in-depth knowledge of a particular phenomenon or target group to the construction of meaningful, culturally sensitive, quantitative questionnaires (Serrano et al. 1993). Given the adequate time required, hypothesized patterns or relationships discovered through the analysis of textual and observational data may be further evaluated through quantitative methods as well (Booth et al. 1993). On the other hand, the process of formulating questions related to broader theories of human behaviour, such as addiction, also can be enhanced by qualitative or ethnographic background knowledge.

Fourth, ethnographic research is necessary to monitor rapidly changing trafficking process and health behaviour (Carlson and Siegal,1991). Such data are crucial for providing a rapid response to changing interactions among different people at risk. Finally, it was mentioned that the inductive nature of qualitative research means that some of the specifics of the research process cannot be formulated in advance. It is precisely the creative discovery process inherent in qualitative research that makes it both exciting and of tremendous scientific value. Ideally, qualitative researchers, or ethnographers, are skilled in discovering connections or relationships within and among different domains.

Through gaining holistic knowledge in different domains, they are able to specify what contextual features are relevant to understanding a particular research problem. This requires them to mediate not only social and cultural boundaries in the field but also disciplinary boundaries in the course of their work.

CHAPTER FIVE

THE CONTEXT, DETERMINANTS AND PROCESS OF TRAFFICKING

1. Introduction

As mentioned in the introductory chapter the first objective of this study is to understand the context, methods and process of trafficking in women and girls from Nepal to India for the propose of prostitution. The research team interviewed eight key informants, and 42 women and girls who had been trafficked into the sex industry in India and who were currently living in Nepal. Furthermore, socio-demographic information of 206 returned trafficked women and girls (including the 42 in-depth interviews) was collected. In addition, the activities of two rehabilitation centres were observed.

Based on the objectives outlined in the previous chapter on methodology, this chapter mainly describes different themes surrounding trafficking issues, which have emerged from an ethnographic analysis of the data. The main focus will be on background information of returned trafficked women and girls, means and methods of trafficking, factors affecting the trafficking, life in brothels, methods of return, and treatment upon return both by the authorities and by relatives. I also analyse the current intervention models for the prevention of trafficking, and the care and support of trafficked persons. Subsequent chapters will deal with other health issues covered in this study. The names of women and girls given in this chapter are not real.

2. Background Information of trafficked women and girls

Socio-demographic information, mainly ethnicity, religion, marital status, age at the time of trafficking, education status and geographical distribution of trafficking are summarised below (tables 5.1 and 5.2). At the time of interviews, 30 were living in a rehabilitation centre, six were working as sex workers, two were living with their family (husband) and four were doing private business (running small shops). Although about 25 ethnic groups were recorded, they were categorized into four broad groups. The major ethnic groups were Mongoloids (35.8%) and Dalit/untouchable (31.4%). Majority (72.1%) were Hindu by religion and unmarried (61.8%). Of the total cases, a high proportion

(80.0%) was non-literate, 15.5% had primary education and only 4.5% had secondary education.

Table 5.1: Selected socio-demographic characteristics

Variable	Grouping	Interviewed group		Total study population (including interviewees)	
		%	Number	%	Number
Ethnicity	Brahmin/Chhetri	21.4	9	16.7	34
	Mongoloids (Gurung, Magar,Rai, Tamang)	35.7	15	35.8	73
	Dalit (Untouchable)	26.2	11	31.4	64
	Others	16.7	7	16.2	33
	Total	100	42	100	204
Religion					
	Hindu	73.8	31	72.1	147
	Buddhist	21.4	9	24.0	49
	Others	4.8	2	3.9	8
	Total	100	42	100.0	204
Marital Status at the time of trafficking					
	Unmarried	61.9	26	61.8	123
	Married	35.7	15	37.2	74
	Other (D/W/S)	2.4	1	1.0	2
	Total	100	42	100.0	199
Age at the time of trafficking/leaving home					
	Below 15 years	31.0	13	34.8	69
	16-18 Years	54.8	23	49.0	97
	Above 19 years	14.3	6	16.2	32
	Total	100	42	100.0	198
Education status at the time of trafficking					
	Non-literate	85.7	36	80.0	160
	Primary/non formal education	11.9	5	15.5	31
	Secondary Education	2.4	1	4.5	9
	Total	100	42	100.0	200
Current Education Status					
	Non-literate	33.3	14		
	Primary/non formal education	50.0	21		
	Secondary Education	16.7	7		
	Total	100	42		

At the time of first trafficking, most were girls in the lower age ranges, with 34.8% aged below 15 years and 49.0% aged between 16 to 18 years, compared to 16.2% aged above 19 years. Their mean age was 16.35.

Table 5.2: Distribution of trafficking by district, zone and region

Variable	Grouping	%	Number	Variable	Grouping	%	Number
District	Chitawan	11.7	23	**Zone**	Bagmati	32.0	63
	Sindhupalchok	11.2	22		Narayani	16.8	33
	Nuwakot	8.1	16		Lumbani	12.7	25
	Nawalparasi	6.1	12		Gandaki	8.1	16
	Rupandehi	5.6	11		Sagarmatha	7.1	14
	Kaski	5.1	10		Koshi	7.1	14
	Udayapur	4.6	9		Mechi	4.1	8
	Morang	4.1	8		Janakpur	4.1	8
	Kathmandu	4.1	8		Rapti	3.0	6
	Makwanpur	3.0	6		Dhaulagiri	2.0	4
	Jhapa	3.0	6		Seti	1.5	3
	Sunsari	3.0	6		Bheri	1.5	3
	Khotang	2.5	5				
	Sarlahi	2.5	5		Total	100.0	197
	Gorkha	2.0	4				
	Dang	2.0	4	**Geographical region**			
	Lalitpur	2.0	4		Mountain	11.7	23
	Kabre	2.0	4		Hill	43.7	86
	Kailali	1.5	3		Tarai	44.7	88
	Dhading	1.5	3				
	Ilam	1.0	2		Total	100.0	197
	Bardiya	1.0	2				
	Parsa	1.0	2	**Political Region**			
	Kapilbasthu	1.0	2		Eastern	18.8	37
	Parbat	1.0	2		Central	51.3	101
	Bara	1.0	2		Western	23.9	47
	Ramechhap	1.0	2		Mid-Western	4.6	9
	Tanahu	1.0	2		Far-Western	1.5	3
	Salyan	1.0	2				
	Baglung	1.0	2		Total	100.0	197
	Lamjung	1.0	2				
	Dolakha	.5	1				
	Bhaktapur	.5	1				
	Banke	.5	1				
	Dhanusha	.5	1				
	Sindhuli	.5	1				
	Rasuwa	.5	1				
	Total	100.	197				

Natal family address (before trafficking) was collected from returned trafficked women and girls. This information was available from 197 returned trafficked women and girls although there were 206 in the total population studied. There were trafficking cases from 37 districts out of the 75 districts in Nepal. High prevalence of trafficking was seen in Chitawan, Sindhupalchok,

Nuwakot, Nawalparasi, Rupandehi and Kaski district (more than 5% of total cases). Similarly, a relatively high prevalence was seen in Bagmati and Narayani Zone. Geographically, more women and girls were trafficked from Tarai and hill areas and more than fifty percent were from the central region (table 5.2).

3. Recruitment, Movement and Initiation

3.1. Methods and Means of Trafficking

Recruiters and traffickers used a variety of methods and means to draw Nepali women and girls into prostitution. In many cases, families, neighbours and friends play an active role in forced trafficking by fraudulent marriage and false job offers, or simply luring girls away from home on outings or errands, kidnapping and selling them. In our interview study population (n=42), the majority of respondents reported false job promises and/or looking for jobs (54.8%) and fake marriages (19%) as the major inducement offered by the traffickers. Sometime traffickers used multiple methods, such as an arranged marriage first, and then an offer to visit new places. In the total survey (n=195), offering a job was the major (62.6%) motivating means used by recruiters or traffickers (see Table 5.3). Therefore, the major tactics used by these recruiters to recruit women and girls into the sex trade are classified into four groups and analysed separately.

False promises of jobs

Trafficked women whom we interviewed were usually drawn into prostitution and trapped by the false promises of recruiters or agents who promised to give them jobs out of town or villages. In most cases the recruiters promise the young women good jobs with high salaries in urban cities. The women and girls usually see this offer as an opportunity to be financially independent from their parents, and the recruiters then bring the women with them to the other towns.

Jobs in carpet factories are the most common offer reported by trafficked women and girls. Carpets are Nepal's most important export and, along with tourism, one of its most essential industries in Nepal. Unfortunately,

Kathmandu carpet factories have been important recruitment centres for Indian brothels. Girls and boys from poor rural hill families are recruited from their villages and sold or apprenticed to factory owners. Brokers working within the carpet factories select likely girls and entice them into leaving the factory with offers of better jobs elsewhere, a relatively easy task since many carpet workers are themselves caught in a state of debt bondage where they receive no wages. The brokers then arrange for their transport to India, frequently with the complicity of friends and family members. The first illustrative case, *"Dolma"* represents simple false job promises.

> In 1990, when she was fourteen, *Dolma's* stepfather took her from their village in Sindhupalchowk to Boudha, a suburb of Kathmandu, where a friend of his got her a job in a carpet factory. A few months later, in 1991, a young male co-worker who had been introduced to *Dolma* as her "nephew" suggested that they leave the Boudha factory and go to Kakarbhitta, a town on the Indian border, where, he claimed, working conditions were better and they could earn more money. *Dolma* agreed, and was taken out of the factory by her stepfather, her stepfather's friend and this young man. After six days, travelling by bus and by train, they arrived in Bombay and he sold her there.

In addition to actual recruitment from the factories, false offers of employment in other Indian and Nepali cities are a common ruse used to entice potential girls. Sometimes older men promise the girls employment in the city. *Sabitri* another returned trafficked girl, told us that;

> *...One day I heard that there was another factory near by, which paid higher wages than the factory I was currently working at. So I went to the other factory to ask them if they had a job for me. "You're in luck," said the manager. "I need someone to accompany me and my wife to Hetauda (another city), to collect wools for weaving. It will pay very well." I immediately agreed and took this job. I did not think anything strange about it, especially since I would be travelling with his young wife. After a long journey I was found myself in Bombay. Later I found that I was sold on for Rs 40,000 by the manager.*

In the study it was also found that poor migrant women and girls whose families have moved to Nepal's urban areas in search of employment became the victims of trafficking. Three girls whom we interviewed had similar stories. One of them was *Sunmaya,* aged fifteen, was trafficked to India in 1991 by a co-worker in a carpet factory, and rescued in January 1992.

> *Sunmaya's* parents were migrants from Bara district who had come to Kathmandu to work in a carpet factory. *Sunmaya's* parents placed her in a primary school near the factory, but she was expelled from school for her

suspected romantic involvement with the factory manager. Back in the carpet factory, *Sunmaya*, who had just turned fifteen, became friendly with an older girl who told her there were better paying jobs available in a carpet factory in Raxaul, just across the Indian border. The two girls talked it over with *Sunmaya's* parents and decided to go to Raxaul. She borrowed bus fare from her new friend. After three days of travelling by bus and by train, the two girls arrived in a city. *Sunmaya* thought it was Raxaul. It turned out to be Bombay.

In many cases the broker works from inside the factory, selects a girl and convinces her to go with him and then takes her to the border and sells her. Tara was one of the victims of her friend. Tara was born and brought up in the Sarlahi District of Nepal. When she was 12 years old she was taken to Kathmandu to weave carpets in a carpet factory. She worked in two carpet factories for five years.

.........I met Hari while I was working in factory and we became very close to each other. He told me that he would get me a good job. When he mentioned that I could earn a lot more money I instantly agreed to go with him. I went with him. After 3 days we reached a big hotel in a new city. "Why am I here," I asked. "You are going to do some cooking and cleaning work," he replied. A little while later they told that I had been sold by the man.

In other cases the *dalal (broker)*, having found out which families are desperate enough to let their daughter leave, directly approaches the parents. Here also *dalal* will offer employment as domestic help in a big attractive city and pay the parents a certain sum. Often parents are completely ignorant of the *dalal's* true intentions. Sometimes, due to their destitute situation, the hunger and extreme poverty, they prefer not to question the offer.

Fraud Marriage

Fraudulent marriage offers are another common ruse employed by recruiters. In some cases, the traffickers actually go through a marriage ceremony. In others, the marriage offer itself is enough to lure a woman away from home. The girl is lured either by false promises of marrying the *dalal* who pretends to have settled down in India. Or she is told about a wealthy future husband for whom the *dalal* is arranging the marriage. Village girls and their families are often deceived by smartly dressed young men who arrive in the village claiming to have come from Kathmandu and offering marriage and all the comforts of modern urban life. They go through a local ceremony and leave

the village never to be seen again. The following case is typical of this kind of deception.

> "*Rita*", thirty-two, returned from India in1994 after working for ten years in a Bombay brothel. She is a high-caste Hindu from a small village in Lamjung District. Rita was married when she was fifteen. After two years of marriage, she became pregnant and her husband went to India in search of work. Her mother-in-law mistreated her so Rita returned to her parents' home. In 1984, when she was twenty-one and her son was four, a neighbour (who was also a relative) told that Rita's husband had been gone a long time and probably was not coming back. She asked Rita if she would be willing to remarry, because there was a man from India who wanted to marry her. Rita agreed.
>
> Soon after, the neighbour came to the house and told *Rita* that the man was waiting for her on the bridge at the main road and that he wanted to elope. It was around noon; Rita told her family that she was going to the fields to work and went instead to the bridge. She brought her son with her. The man was waiting for Rita as the neighbour had said. They caught a bus to Pokhara, the nearest town. In Pokhara he offered Rita a cigarette. After smoking the cigarette, she remembers very little and thinks she may have passed out. Rita said she remembers boarding another bus and then waking up in a large cement room with a ceiling fan and three beds with curtains around them. The man who brought her there took Rita's son and said he would show him around town. They never returned and she never saw her son again and Rita had been already sold.

A similar story was found in *Sanu*'s case. Sanu's family had migrated to Kathmandu several years ago, because her father could not find any job in their home district. Once they moved to Kathmandu, her parents started working in a wool factory in Kathmandu, and soon she got a job in a carpet factory in Gworkho, (a suburb of the capital). While working there she came into contact with a man called *Pratap*. He visited her home, and soon he proposed to marry her.

> *..... One day I eloped with him. He brought me to the bus park and explained that he would take me to his aunt's house in another district for a few days. On the way he offered me a bottle of coke. After drinking it I felt sleepy and woke up in a train that soon reached Delhi...*

Similarly *Radha* was one of suffers from fake marriage. She easily agreed to marry with unknown person because of her family problem.

> *I was born in Nawalpur, Sarlahi District. When I was fifteen years old I was married to a farmer. I lived with my husband for about one year and then returned back to my mother at home. My husband came to collect me and my mother insisted that I went with him. I was then sixteen years old and had become pregnant. I could not work well, therefore my husband did not treat me kindly and so again I returned back to my mother, where I gave birth to a son.*

My husband still did not come to find me even though he knew that he had a son, so I stayed with my mother. I was enjoying my life with my family and when my son was four years old I heard that my husband had remarried.

On the day of Shivaratri (Hindu festival) I went to the River to light a candle, where I met one of my relatives from my village who was with a few other men. My relatives introduced me to one of the men and asked me if I would marry him. I did not take the offer seriously. "Don't be silly," he said. "I can't get married, I replied. I have a son. Besides, I hardly know that man." But my relative kept insisting. "Come on," she replied me. "At least think about it. He lives in Hetauda (another city) and is a great person. You should not worry about your son." I did think about it and the idea of remarrying gave me hope that perhaps happy days would come again. I agreed and I went with him. He took me to the Indian restaurant and after this I cannot remember anything else. When I awoke I found myself in the world of brothels. I had been sold for Rs 30,000.

Visit offer and others

In many cases a girl is lured by the trafficker or agent/dalal, often a local young man who works in Kathmandu. For the illiterate, hard working, naive village girl this is often the first time in her life she receives so much attention instead of the usual neglect. After enough trust is established she is then offered a lucrative job in Mumbai as a maid servant or even as an actress or she is explained about an opportunity to set up a small business. In most people's minds, Bombay (Mumbai) stands for glamour and prosperity, golden chances and escape from miserable lives. *Priya's* story is typical of this kind of trafficking. It indicates that not only girls from poor families, but also girls from middle class are trafficked. *Priya* was born in small village in Morang district. She was the youngest daughter in a middle class family with four brothers and a sister. She was a "pompous" daughter who did not care about what her parents and brothers told. The school where she was studying was nearer to her house but she hardly ever went, even when she did go she would pay little attention to the teacher.

.....My brothers used to worry about me and I used to quarrel with them. All my family would scold me, telling me to study harder but I did not listen. Even when they yelled at me I would just ignore them because I did not want to be a teacher, I was interested to be an actress..... you know! To be a good actress, you don't need to study and you don't need to go to school....

One day, my friend Sita, her husband and myself went to watch the movies together. After the film they asked me if I would go to India with them. I could not refuse their request, as I was interested to be an actress and I also felt indebted to them for always welcoming me into their house.

We caught a train and spent three days travelling. Eventually we reached our destination- Bombay. At first we stayed at the 'Amar' hotel but were soon taken to another place, where the women were decorated with expensive jewellery, clothes and scents. There we met a fat lady who Sita's husband introduced to us as film director. She seemed very kind and generous and we were impressed. Sita's husband told the" film director" to let us rest and said that he would come back after he had been shopping. He never returned. Later we were told that it was brothel and the lady was gharwali and we had been sold for Rs60'000 by the man.

Recruiters sometime seduced young girls by posing as potential boyfriends. The recruiters pretend that they are interested in the young girl and want to get know her better.. The recruiters ask the young women's names, addresses, and people they know. When the women become comfortable with the poseurs, the recruiters offer to treat them at restaurants nearby. As the recruiters gradually gain the women's trust, they will ask the women to accompany them on a visit to a relative in another town, or attend a party in towns nearby. In many cases the girl elopes with her new 'friend' without even telling her parents. Twenty one years old "Ujeli" told us that,

.......my parents are agricultural labourers in a town in the hills. I was able to attend school up to class 4, but then had to join my parents working on the fields, then I left the school. At the age of 15, I went with a friend to watch a movie and met a young man called Kancha Lama with whom I became friendly. After some time he suggested going to a bigger southern town to buy cheap cloth with which to start my own small business. I went with him without asking my parents. Instead, he took me to India.

Abductions

Simple abductions also occur, although they are less common than cases of deceit. Some women and girls mentioned that they, or other women in the brothels where they worked, had been drugged by their abductors. The following is the reported experiences of young Nepali girls who were abducted by her relatives and friends.

Dilmaya was taken to India by neighbours, a mother and daughter, whom she knew quite well. They told her that they had to go to a market far from their village to pick up something and asked her to come along. Dilmaya often went places with them, but usually they travelled by bus. That day there was a taxi waiting for them. They travelled a long way, and it was very late when they finally arrived in *Badi Bazaar*. They got in another taxi and arrived at a village house like her own. She was put in a room and the door was locked. Dilmaya had

no idea where she was. A woman called "Asa" told her that the woman she came with had gone out and would be back later, but she never came back. After three nights, Asa made Dilmaya travel with her by taxi and then train to another town. When Dilmaya pleaded with her to let her go, she was told *"No, you have been sold and have to work. All Nepali girls have to work."*

Sometimes girls were abducted by their own family members or other relatives.

"*Kali*", age twenty-six, returned to Nepal in 1994 after spending nine years in India. She was drugged and abducted by her stepfather's elder brother and his son and trafficked to India when she was seventeen. Kali had been visiting her uncle and his two children, who lived in Biratnager (a town very near the Indian border). Once when she was visiting he suggested that they make a trip to Jogvani (Indian city). The uncle, his wife and eldest son went along. Along the way they stopped for tea. Kali was given milk. The milk smelled bad, but she drank it anyway. The next thing she remembered was waking up slightly on a train and then perhaps again in a taxi. When she really woke up she was in a big hall with a lot of lights, which turned out to be a hotel lobby, but she does not know the name of the hotel. Her cousin and uncle were with her. They told her that they needed to go to Bus Park to buy the return ticket and left her alone in the hotel lobby. While they were gone *Kali* overheard two men speaking Hindi; they were talking about taking someone to a brothel. She asked the men what they were talking about and who they were taking to a brothel. She asked where her relatives had gone. Another man told her she had been sold.

Table 5.3: Major motivating methods and means of trafficking

Variables	**Interview study population**		**Total study population**	
Major motivating means	%	Number	%	Number
Fraudulent Marriage	19.0	8	13.3	26
False promises of Jobs	54.8	23	62.6	122
Offer of Visit /Movie/ Holyday	14.3	6	17.4	34
Force and other	11.9	5	6.7	13
Total	100.0	42	100.0	195

3.2. Family Involvement in trafficking

We interviewed some girls who were sold by their own family members. Family involvement was seen in many ways. *Bindu* was sent to India with her relative by her mother. *Bindu* told us that;

I came from Dura family and I was offered as a Deuki by my mother to Tripura Sundari Temple and lived in the temple then. I fell in love and married a police man, had a daughter from him. After three years he left me. I married again with another man and had another daughter. But this husband also left me. I returned to my mother's house with my two daughters. In 2046 BS (1991 AD), Phupu

came from Delhi for Dashain festival (Nepali festival). She was very closed to my mother. My mother requested her to take me with her in Delhi. I went with her to n Delhi. In fact she was gharwali (brother owner) and she had her own Kothi (brothel) in Delhi. I started dhanda (in the sense of sex work) from next day.

In some cases the girl is an orphan and lives with relatives who do not care about her well-being. Selling her to a trafficker, whether in ignorance or in full awareness of the journey's end, is a lucrative way to get rid of their responsibility.

.....my parents died when I was very young, and I was brought up by a relative in a small town. I had no chance to go to school. When I was 12 years old a step uncle, a widower of 45 to 50 years, took me to Kathmandu to live in his household and to help with the chores. Soon he proposed marriage to me but I refused. He insisted to go with him to a small town in the south of Nepal to look after his young children. Again I resisted, but his elder brother persuaded me to go. From that southern town the step uncle brought me to Mumbai and sold me to a brothel....

Similarly, Anju was sold by her maternal uncle.

I am from a Mushahar caste and had happy childhood, but my mother died when I was 10 years old and my father was distraught and unable to take care of us-6 children. I had to beg with my 3 months old sister. Subsequently my one brother and one sister were taken to live with my maternal aunt, 2 others went to parental aunt. My one younger sister and me were left with my father. When I was 16 my maternal uncle took me to India telling me that we were going to do shopping for a family friend's wedding and sold me.

3.3. Causes of trafficking

After having examined the process or methods and means of trafficking it is essential to examine the causes or factors that contribute to trafficking. There are at least eight factors emerging from the background of respondents that made women vulnerable to trafficking 1) Poverty and lack of economic opportunities; 2) Low level of education and lack of information about the process of recruitment; 3) Family pressures and family problems; 4) Aspirations of the women, often accompanied by a growing sense of personal and economic autonomy; 5) Alleged success stories of those who migrate for income abroad, 6) Social and cultural factors, 7) Political factors, and 8) lucrative business and high demand in India

Poverty and lack of economic opportunities

The majority of respondents came from poor families, with 38 respondents originally from rural and only 4 from urban areas. Generally, respondents came from big families ranging from 3 to12 siblings. All of them came from financially strapped families, with parents who had little education, and who were either constantly under or unemployed. A number of them came home with very little money. Families with employment mostly worked in the informal sector, or in small, low-income enterprises. Some had small farm lots that were nonetheless incapable of feeding the family. Most of the respondents' mothers stayed at home to care for the children and do domestic chores. The majority of respondents had moved from place to place in search of better economic opportunities. They left their original birthplace and moved to urban areas where the trafficking syndicates often operate. Most respondents started working at an early age. Migration for work is now commonly perceived in Nepali society as a kind of a quick-fix solution to the growing impoverishment at the household level.

Education and lack of information about the process of recruitment

There are correlations between age when trafficked, low level of education and lack of information about the recruitment process and systems of migration, which rendered respondents dependent on and vulnerable to recruiters. Many were very young when trafficked, and only 5 out of 42 attended elementary school, and only one had attended to secondary education, none of them finished high school. The reasons given for not finishing school included financial problems, having to leave home and work, having to enter other jobs, and having no desire to study. Given their low level of education and lack of access to good information, it was easy for the recruiters to deceive the women.

Family pressures and family problems

Some respondents stated that their families were dysfunctional, i.e., that they came out of families in constant conflict, and had left home between the ages of 12 and 17. Many of the respondents said that they had got less attention from their parents and some stated their parents had separated. At an early age, most of the respondents were forced to assume a good deal of

responsibility for the upkeep of big households. Four respondents had experienced the death of one or both parents when they were quite young. Nine lived with their grandparents or other relatives. Seeing so much poverty, many of the respondents felt compelled to do something about it. When they went urban city, most of the women ended up supporting their parents, the entire family and sometimes even distant relatives or extended family. Interviews with returned trafficked women and girls show that often family disintegration, many times accompanied by domestic violence, death of a parent or spousal abandonment, increases a girl's vulnerability to the traffickers.

Aspirations of the women

It is important to underscore the fact that while poverty was an overwhelming reason for migration for income, women also reported growing aspirations for personal and economic autonomy that influenced their desire to go abroad/urban city. One respondent stated:

> *......I also wanted to earn some money so I could go back to school and continue my studies.......... So I went to Kathmandu......."*

Some women felt that working in India would give them the chance to travel and see another country. One of them said,

> *".........they said Bombay was beautiful, like Japan. I wanted a house of my own, [and to] save for the education of my child.........so I went to India."*

Some girls wanted to be independent and went to urban city for jobs and they ended with Indian brothels.

> *My two brothers earned their own livings but they never gave any support to my sister and me. I thought "If boys can work, why can't girls?" "Of course I can earn my own living; I should not have to depend on my parents. "So I asked my mother if it would be alright if I went to Kathmandu to find a job. My mother agreed to this idea, although she knew that she would miss me when I went away.*
>
> *In the city I hunted for some sort of job in shops and hotels but no one wanted to employ a village girl with little education. Eventually I managed to find a job working in a carpet factory. I worked day and night, even working on Saturday and holidays so that I could send money and clothes to my mother.*

Alleged success stories of those who migrate for income

Families who have children or relatives abroad are perceived as lucky. The picture that is painted of overseas migration, especially when the value of the Nepali currency is very low compared to the value of the Indian rupee. The possibility of marrying a rich man, and ultimately of comfortable residence in the capital city is attractive, if illusory. Some respondents saw migration as the ultimate way out of poverty, access to social mobility, and a test of their abilities. Many unsuccessful Returnees do not tell their sad stories, particularly women who have been sexually exploited. Prostitution is a stigma, and unsuccessful returnees do not want to be pitied.

Most of the respondents in this study did not realize, prior to migration, that many returned trafficked women who were allegedly successful brought home scars of abuse, violence and other consequences. The tendency to paint a more positive story about migration for work serves as a push factor to parents and other. The stigma attached to prostitution and the embarrassment of being a failure as returnees have effectively silenced the voices of survivors of trafficking and prostitution. If more survivors felt free to speak out, then the real stories of abuse and exploitation of women who were trafficked might present a more honest picture of what happens to many who migrate abroad and possibly serve as a deterrent for others.

Social and culture factors

The most outstanding factor among social and cultural influences is the low status ascribed to girls and women. Girls have a low social ranking and hence less consideration is given to their basic needs. This has been described in detail in Chapter 1.

> *If my parents had cared for me as they did to my brother, I would not have to experience such trauma....*

It becomes obvious, especially at marriage, that society perceives females as commodities, first owned by the father, then by the husband and the in-laws. And girls are clearly treated as a commodity when they are being trafficked. Their value is perceived mostly as economic and not social.

It is difficult to assess how much the traditional forms of prostitution of the *Badis* and *Deukis* system are a factor in the trafficking of non-Badi and non-Deuki girls. Traditional, religious prostitution is mentioned by Pradhan as one of the socio-cultural roots of the problem (Pradhan, undated). However, Badi and Deuki girls are discriminated against by society, and Badi sex workers are considered even lower in status than other Sex workers. These forms of traditional prostitution do seem to have much impact on trafficking. In the women in my study. We found only one from Badi and one from Deuki girls were had been trafficked.

Political factors

Political factors are not related to the roots of trafficking, but contribute considerably to the rampant spread of the trade. Lack of political commitment, lack of implementation of existing laws related to trafficking and open border are commonly cited reasons of trafficking by activists. One activist said that

> .... *Politicians have absolutely no commitment to deal with this problem and as in many other issues they only pay lip services.........*

Another activist said that laws that refer to trafficking are inadequate and implementation is ineffective. Local administrative authorities do not give the required assistance. And another factor that contributes to the high number of trafficked girls is the open Nepali/Indian border where no identity card is required. Girls who had been lured to India reported that border police are easily bribed by traffickers.

Lucrative business and high demand

Trafficking of women provides a very lucrative business for those who are involved in this trade. According to activists in Kathmandu, Nepali girls can be sold to brothels at a high rate since there is high demand of Nepali sex workers in Indian brothels.

4. Ways of trafficking, Traffickers and Destination

Women and girls were either trafficked directly from their own home/community or from working places such as carpet factories. Different

kinds of people were found to be involved in trafficking. In many cases family members, uncles, cousins, stepfathers also act as trafficking agents. Of 42 trafficking victims interviewed by our team, 15 (35.7%) were trafficked to India with the help of family members or relatives. Likewise, 42.9% were trafficked by known persons but not relatives, and 21.4% were trafficked by unknown persons. In the total study population (n=198), 22.2% were trafficked by a relative, 46.5% were trafficked by known persons but not a relative, and 31.3% were trafficked by unknown persons (table 5.4). It is clear that recruiters were both strangers or new acquaintances, and siblings or relatives. For those who did not state clearly who recruited them, it can be gleaned from their stories that the recruiters were persons they trusted

Traffickers are most typically men in their twenties or thirties or women in their thirties and forties who have travelled the route to the city several times and know the hotels to stay in and the brokers to contact. Traffickers frequently work in groups of two or more. Male and female traffickers are sometimes referred to as *dalals* and *dalalis,* (commission agents) who are either employed by a brothel owner directly, or operate more or less independently. In either case, to stay in business they need the patronage of local bosses and the protection afforded by bribes to the police.

Women who are already in the sex trade and have graduated to the level of brothel keepers, managers or even owners travel through the villages of their own and neighbouring districts in search of young girls. Though not very typical, the following story encapsulates the essence of the dream of success and glamour that these women symbolize to the simple village girls. Female traffickers are referred to as *didi* or *phupu didi* (literally, paternal aunt) or *sathi* (best friend). Local women who have returned from India are also employed as recruiters. In many districts, according to local activists, the majority of *didis* are returned sex workers from neighbouring village. Usually these *didis* return to the villages to participate in local festivals and to recruit girls to bring back to the cities. These women are exceptionally well-placed to identify potential trafficking victims because they already know the local girls and their families.

I was born in happy Tamang family. I was married to a boy of 18 at 16, as arranged by my parents. I went to live with him but my husband and father-in-law did not like me. They were not happy with my hard work. My mother-in-law did not give enough food to eat and my husband beat me regularly. He blamed me that I was not good for his mother. I could not tolerate those entire problems and I returned to my parents. After 2 years of my marriage, my husband brought a sauta (a co wife) who gave a birth to a son and I was then completely rejected from them. In the mean time, one woman who had came home for vacation promised me and my 3 other friends good jobs in Calcutta. We ran away with her and she took us to Calcutta. But instead of giving good job she sold three of us to different brothels.

Not all *dalals* work independently. An unknown number are connected to different kinds of networks that operate on various levels of organisation and size. Some syndicates include government officials, border policemen, politicians, and others.

The majority of women and girls whom we interviewed were trafficked to Bombay (78.6%) and others were trafficked to Delhi, Calcutta and other Indian cities. Similarly, more than eighty percent were trafficked to Bombay in the total study population (table 5.4).

Table 5.4 ways of trafficking, traffickers and destination

Variables	**Interview study population**		**Total study population**	
	%	Number	%	Number
Ways of trafficking				
Direct	49.5	17	55.6	90
Indirect	59.5	25	44.4	72
Total	100.0	42	100.0	162
Trafficker				
Relatives	35.7	15	22.2	44
Known but not relatives	42.9	18	46.5	92
Unknown persons	21.4	9	31.3	62
Total	100.0	42	100.0	198
Destination				
Bombay (Mumbai)	78.6	33	84.3	167
Delhi	11.9	5	8.6	17
Calcutta	7.1	3	5.6	11
Other Indian city	2.4	1	1.5	3
Total	100.0	42	100.0	198

5. Life in Brothels

A major portion of the in-dept interview was focussed on life in brothels. Key informants, returned women and girls were asked about social and physical environment, working condition, debt bondage and income within brothels. Key finding are presented here under different sub headings.

Nepali women in India's red-light areas remain largely segregated in brothels located in what are known to their Indian counterparts and their customers as *"Nepali kothas"* or compounds. The concentrations of Nepali vary from city to city, but appear to be highest in the Mumbai neighbourhood of *Kamathipura*. Brothels vary by size, physical configuration, ethnicity of sex workers, and price. Most of the Nepali girls and women are associated with *gharwalies* (brothel owner). Depending upon the *gharwali*, the number of girls and women per brothel ranges from 5-10 to 150-200. On an average there are 90-100 girls and women per brothel at Mumbai. But in all cases, movement outside the brothels is strictly controlled, and inmates are subjected to both psychological and physical abuse. The cheapest brothels, nothing more than dark, claustrophobic rooms with cloth dividers hung between the beds, are known among Nepali as *"pillow houses."* Certain lanes, like the 11th and the 13th, are known particularly as Nepali *gallis (street)*. The living condition of Nepali girls and women in brothels is very poor. A social worker who was familiar to Indian brothel system told us that;

> There are several grades of sex workers, based on beauty, hard work, "talent." The tops are call girls. Then comes "bungalow," which is a higher grade of regular brothel, then comes "pillow house," which is the lowest. Most girls start out in pillow house and work up if they do well......some girls receive training, how to approach customers, languages. During training girls are beaten and locked in a room like a jail, but a very small one, until they stop fighting. At first a girl gets two or three clients a day, then it escalates....

Women and girls were unfamiliar about brothel system. All the trafficked women have no previous experiences of prostitution and had no intention, upon trafficking of engaging in this trade. *Jamuna* recounted her early days in a brothel;

> *When they brought me here, it was in a taxi. I kept looking around, wondering what kind of work was going on in this area of this big city. Everywhere I looked,*

I saw curtained doorways and rooms. Men would go and come through these curtained entrances. People on the street would be calling out, "Two rupees, two rupees." I asked the other Nepali women if these were offices; it seemed the logical explanation. In two days I knew everything. I cried.

Similarly, *Sarmila* told her terrible experiences in the brothel and cried in front of us.

.........on my first working day, a big fat man came to my room. Knowing that I was still a virgin he had paid a large amount of money to rob me of my virginity. I ran and locked myself in the bathroom but the brothel-keeper came and made me open the door. Again the fat came into my room. I begged and pleased with him and eventually he left, giving me Rs10. I was saved. The next day, however, a young boy of sixteen or seventeen years came and I lost my virginity......

Another returnee expressed her feeling with us and she told us that;

When I entered the brothel I saw many girls who looked younger than twenty-years of age. I did not know what they were supposed to do. They looked very strange to me. I had never seen girls wearing so much make-up and bright red lipstick. Their clothes were different too. They all had on very short skirts with lots of jewellery. They were not typical Nepali girls. The brothel-keeper told me to take a bath, get make-up and put on some clean clothes. "What is my job?" I asked. "Why am I here? What's going on? I want to go home." "You will do what I tell you," said the brothel-keeper. "You will find out in a few hours." "I don't want to stay here," I replied, this time more forcefully. "Let me go now. I don't want to stay here." But the brothel-keeper just laughed and walked away. I looked at the other girls for help." There's no way out," they said. "You're going to be working as prostitute."

Many customers seek out Nepali prostitutes specifically, because of their looks and their exotic reputations. The segregation of Nepali girls and women in these *gallis* exposes them to a wider range of clients, and a wider and more unpredictable range of sexual expectations, treatment, and disease. Nepali are sought out by customers who think their "golden" skin make them more attractive. One social worker referring to brothel owners who said that Nepali' faces and bodies stay youthful longer. The Nepali also suffer from a reputation of sexual compliance among both Indian sex workers and customers, who say Nepali can be induced to engage in higher-risk sexual acts, such as anal intercourse and sado-masochistic sex, than their Indian counterparts, who may have more control over the terms of sexual contact. Consequently, brothel managers and their clients view Nepali women in prostitution as a special case, and madams routinely receive special requests for Nepali. According to one returned women, who worked very long time in Indian brothel said that

foreigners from outside India, particularly the Middle East, also viewed Nepali as special within the sex industry.

Most girls and women start out in cheap brothels where they are "broken in" through a process of rapes and beatings. They are frequently then resold to other brothels where they can bring in more money for the owner. Some women are also resold as punishment for escape attempts. An activist in Nepal who is familiar with the Indian brothel system and has counselled many returned women and girls in Nepal said;

> *...... there were special interior lanes in areas like Falkland Road in Bombay where rooms and even whole buildings were maintained especially for torturing newly-procured women. Younger girls and children are reportedly hidden in attic spaces in these buildings.........Both psychological and physical means are used to "break in" new girls purchased for the brothels......*

Psychological abuse, threats and intimidation are an integral part of the process and are used exclusively with girls who are purchased as virgins and can therefore be sold for higher prices if their "training" does not include rape. This psychological abuse continues well beyond the first customer, however, with brothel staff using conflicting messages to break down the victim's resistance and build dependency.

When the psychological approach does not work, the brothel staff resorts to physical abuse, or allows customers to do so. This abuse can include beatings, gang rapes, and torture with burning cigarettes.

In pillow house girls can have as many as thirty customers a day. But they earn no money until they have paid off their debt. After they have paid off their debt, one part of their earnings goes to *gharwali*, one part to "local taxes," and one part to herself.

It is two or three years before a girl is allowed out of the brothel and then, after they have confidence she won't try to escape, she is allowed to go to the cinema or shopping with a guard from the brothel. Even if a girl manages to escape, she knows nothing about the city. She will fall victim to local people or the police.

Women and girls were sold at prices ranging from Indian Rs. 4,500 ($ 90) to 60,000 ($ 1200). Majority (60.7%) of women and girls were sold for Rs. 25,001 to 50,000; about one third (31.8%) were sold below Rs. 25,000 and 7.1% were sold on above Rs. 50,000. On average women and girls were sold at Indian Rs. 36,000 (table 5.5).

Once sold, they belong to the Indian brothel owner until they can "pay back" the amount paid for them. The majority of the women and girls in the study were forced into prostitution within one day of their arrival. There was one girl who stayed just 4 days and there were some women and girls who worked up to 10 years. The average duration of stay at Indian brothels in the study population was 33.45 months (table 5.5). Interestingly, there is significant (p=0.000) relationship between duration of stay in brothel and mode of return (table 5.6).

Table 5.5: Life in brothels

		Percent	Frequency
Duration stay in brothels in month			
Less then 12 months		28.0	54
13- 36 Months		38.9	75
37 - 60 Months		21.8	42
More then 60 Months		11.4	22
Total		100.0	193
Average duration	33.45 Months		
Minimum stay	4 days		
Maximum stay	120 Months		
Price Range in Rs (Indian Currency)			
0-25000		31.8	34
25001-50000		60.7	65
50001 to over		7.5	8
Total		100.0	107
Average price	36130.84		
Minimum	4500.00		
Maximum	60000.00		
How did they come out from brothels or mode of return			
Rescued		79.9	151
Escaped		12.7	24
Released by owner/self returned		7.4	14
Total		100.0	189

5.1. Debt Bondage and earning in the brothels

Every Nepali girl or woman whom we interviewed said that the brothel owner or manager forced her to work by invoking her indebtedness. This supposed debt, and the threats and beatings that accompanied it, were the major obstacles between her and the possibility of freedom. For most of the women interviewed, the debt was the amount of money the brothel owner said she paid a broker when the girl was purchased, plus the costs of medical care and protection money or payoffs to police and local thugs.

A Programme Director in Nepal, who was familiar with the brothel system said that girls were also charged 10 percent interest on their purchase price. In many brothels in Delhi, owners even compelled girls to sign forms stating that they were voluntarily working as maid servants and also as bonded labourers until they repaid the loans they had purportedly undertaken. Although occasionally the gharwali may pay for food, clothes and medicine, these costs are frequently added to the debts. In any case, a girl's indebtedness to the gharwali is based on the *gharwali's* own expenses.

A woman's earnings depend on the type of brothel in which she is employed, her age and appearance, and the nature of the sex acts she is compelled to perform.

> ...all the women and girls where I worked were dependent on tips for food to supplement the meals provided by the brothel, but that as a newcomer without regular customers, and an older woman at that, she got few tips...Alka said

Another girl told that although she was never allowed to handle any money in the pillow houses where she worked, she heard from other women that the owners charged Rs.50 [$1] for five minutes. In the bungalow, where she took the money from customers beforehand and turned it over to the management, the rate was Rs.150 [$3], again for a very short time.

Although most business is conducted in the brothel, and is charged by the minute or hour, customers can pay extra to take women outside. A girl will be sent to a client's house or a hotel for the night. If a customer buys a woman's services for a longer period her debt resumes upon her return. One customer paid a large amount of money and kept a woman in his home for one

or two weeks. He returned her to the brothel, where she worked to repay the remaining debt.

> *......one day, gharwali asked me to go with one fat man to his home. I refused first but she told me that I will get more money then ......I went. I spent one week to his home and than he took me back to the same kothi (brothels)..........*

A girl who has managed to escape, but finds that she has no way to support herself may negotiate her return to a *gharwali*, resulting in a fifty-fifty division of her earnings. Sometimes the woman attaches herself to a local thug to support her in her negotiations with the *gharwali*. However, this type of an agreement frequently results in indebtedness of a different sort, since the girl is often convinced to take a loan from the *gharwali* to see herself through.

None of the returned girls or women we interviewed knew about the monetary arrangements between the brothel owner, the agents and their families. Because the women did not know how much exact money had been exchanged or how much they earned, they did not know the amount of their debt. But later on all were frequently reminded that they had to work to pay off their debts, and many were threatened or beaten for not earning enough. One returned girl said;

> *I worked in three low-grade brothels or "pillow houses" and later in one fancier brothel commonly called a "bungalow." In the pillow house I had ten to twenty customers a day and, except for regulars, customers who paid Rs.25 [50 cents] for five minutes. I also worked for four months in a bungalow which charged Rs.100-Rs.300 [$2-$6] per hour. Some customers would pay to take the girls out all night, or sometimes for days at a time. If they were taken out to a hotel they paid at least Rs.1,000 [$ 20].*

Although she does not know how much she was originally sold for, this informant was told that each time she was sold it was for a higher price. None of the owners ever told her how much she had to repay, but the brothel managers kept track of how many customers each girl served per day and claimed to figure that against their debt.

Some of the women had a vague understanding that they would have to work for a specific length of time to pay off the debt, and that there was an agreed-upon amount of payment given at the end of the time. We were told both by returnees from brothels and other people from a rehabilitation centre

that there were rules in Bombay brothels about how long girls should work and how much they would be paid.

"*Santhi*" had heard there was a rule that the brothel can keep you three years, but after three years they have to give you Rs.20,000 ($400), gold and clothes. But they did not give her any thing like that. Most of the money she brought out with her was her tips, and she managed to send a box of clothes to her father. After she was there seven years, her father came to see her, but the owner said she had to stay another two years before she could leave. After two more years, her father came to the brothel and brought her out. When she left the brothel she was given Rs.5,000 [$100] which she turned over to her father.

"*Radha*" was told that she had to pay off her purchase price of Rs.30,000 ($600), and that was used to force her to work when she did not want to. She worked in the same brothel for ten years and was never told she had paid off her debt. She told us that;

> *"Nobody was allowed to leave after three years like people say they are."*

Radha had no idea what the brothel charged her customers because the money was given to the owner. She had nine or ten customers a day and worked from 11 a.m. to 11 p.m.

Sometimes customers gave the girls tips, which they were allowed to keep. The owner provided one meal a day and they had to pay for the second meal with their tip money. They also had to pay for clothes and make-up with tip money they saved. The owner paid for treatment at a private clinic when they were sick, and added it to their debt. They received injections once a month, but many of them did not know what they were for, and they were given pills to induce abortions. The price of the monthly injections was also added to their debt.

According to "*Maya*," brothel inmates got about five days leave after an abortion before they had to start working again. One woman she knew had aborted twice. The cost of abortions, plus interest, was added to the debt. One owner said that the abortions had cost her Rs.1,000 ($20) each time and then

she was charged interest on top of this, increasing the woman's debt by Rs.4,000 ($80).

> ......*I felt sick. I was sick and no medication was given to me. The brothel-keeper was only happy if we could attract a long line of customers. If we refused to work we would be beaten and tortured*..............

In addition to the money earned by parents from the sale of their daughters (a few hundred rupees if she is sold to a local recruiter, or several thousand if the family sells her directly to a broker), male relatives also make periodic trips to India to collect the girls' earnings. According to a social worker, In villages in places like Nuwakot and Sindhupalchowk, if a village has several women in Bombay brothels, a prominent member of the village may be appointed to travel to India, collect the money they earn and bring it back to their parents. For the girls, this means that not only are they under pressure to pay off their debt to the brothel owner, but out of whatever earnings they do receive, in the form of tips primarily, they are expected to help support their families.

5.2 Illegal Confinement

There are other aspects of the work in brothels which reinforce its non-voluntary nature. One of these is illegal confinement. Debt bondage is enforced by the near total confinement of the women and girls to the brothel premises. Women and girls are generally not allowed to leave the brothel or its immediate surroundings without escorts and are threatened with a range of consequences, including arrest by the Indian police or capture by other brothel owners, should they attempt to do so. The women and girls we interviewed explained that they would be beaten severely if they tried to escape.

With few exceptions, the Nepali women are unable to communicate with anyone outside of the brothel and some are even forbidden to take Nepali clients out of fear that the latter might be more likely to help the women escape. Even conversation with customers is sometimes forbidden. A social worker told us that;

> *"Only girls who pay off their 'loan,' have gone on a holiday to their village and come back, are allowed to leave the brothel alone. Before that they are not allowed out alone."*

In many case, no one in the brothel was allowed to go out unescorted. Everything was brought by vendors into the brothel to sell food, clothes, even videos. They were allowed no contact with their families. Ganga, one of the experienced returned girls, who could not read or write herself, said that none of the women in the brothel were permitted to write or to have pens and paper.

> We were never allowed out for fear...... we would run away. Everything was brought to the house, and shopkeepers charged very high prices... very expensive... bad quality....

Only few of the interviewees were in occasional communication with their families, none of them were in regular contact with their friend and family. One woman was lucky enough to find a customer who was willing to send word to her family.

> A Nepali man I met in the brothel wrote a letter to my family telling them what had happened to me, and after few months my brother went to Bombay to try and see me there, but he was not allowed to do so. My family then brought charges against that trafficker and brothel. I was then sent back to Nepal with help of social workers. The trafficker was arrested and then released on bail after a month and a half. The case was proceeding, but I do not know what has happening now and I was not informed of its progress.

Fear of beatings, arrest or recapture by other brothel agents keeps many girls away from trying to escape. One girl told us that ;

> The brothel where I worked had a window so that all the girls could be observed by the management. When I was seen trying to escape, I was beaten. Whenever there was a police raid the owner would hide all the girls; those who tried to come out would be beaten.

She further added that only newcomers tried to run away; the older ones would not try to escape. May be they know that those who run away would be sold to another brothel by men on the street, so they don't run. The girls were also afraid of the police. (It should be noted that many of the Nepali girls in India are visible because of their physical characteristics including facial features, and accent or language).

> One day, one of my friends who had escaped was taken into custody and raped by the police. The next day the police brought her back to the brothel and told the owner to bring out all the new girls and leave only the "licensed" ones. The owner gave the "Ghush" (money) to police and they went away.

Some returned girls gave different views. The women and girls who had certain links with brother owner faced relatively less problem.

> I was lucky Mira said. Saraswati was a nice woman, better than most of those bitches. My sister worked here before, so when I came here 3 years ago, I did not have a very difficult time. The fist few months, Saraswati only sent me a couple of clients a night. She let me and Maya to go out, and we went to so many movies. She gave me nice dress......

5.3. Working Conditions

Tips provide the only source of income for most newcomers to the brothels. Without tips, girls are entirely dependent on the brothel owner for food, sometimes only one meal a day, and the women have to supplement the meagre food and clothing provided by the brothel by using their own tips. Most owners permit girls to keep tips, which amount to only a few rupees per customer, but in some cases even this avenue of earning is restricted.

> "*Devi*" did not get many tips because newcomers got fewer regular customers. The brothel owner provided them with two meals a day, but the food was not very good. With tips they could buy tea and snacks.

> "*Sita's*" owner gave the women in her brothel one meal a day. They had to pay for the second meal. They also had to pay for clothes and make-up. For all these things they would save up their tips, and buy from vendors who would come to the brothels and who charged very high prices.

None of the women we interviewed was allowed to refuse customers. In some cases they were not even allowed to speak to them. Their days were spent waiting in line for customers or serving them, and they were beaten and humiliated for refusing.

In the bungalow where *Devi* worked, the girls stood or sat in a row in their make-up and the customers, who also stood in a queue, chose the girl they wanted. They were given only a very short time with each customer and sometimes, if customers tried to ask newcomers too many questions, they ran out of time before they had time to have sex. If the owner found out that a customer had been asking a new girl about herself, the girl would be beaten. In the pillow houses in which *Devi* worked, the day started at 10:00 a.m. and they worked until late at night. In the bungalow, the day started at 4:00 p.m. and went until 2:00 a.m. The girls were expected to stand or sit in line the entire

time, whether or not there were customers. They were given no time off, even when they were menstruating. *Devi* said the happier you made the owners, the nicer they were to you, so sometimes if she was menstruating she took the customer's money first and then told him she was menstruating. If she was lucky, he would go away. Girls very rarely refused a customer, because those who refused were beaten.

Kamala also said the women in her brothel were not allowed to refuse customers. They were made to sit in a room and the customers would choose the girl they wanted. If the girls refused, they were hit and verbally abused by the owner in front of the customer: "If you won't go, maybe your mother will."

> *Every afternoon I had to stand on the roadside to negotiate prices with the customers. The first time I had to do this I could not believe what I was doing. I remember thinking how I felt like an animal, not a human being. This was not only my job. There were many other girls doing the same thing as me in full make-up, trying to encourage men to use our brothel.*

Besides being compelled to serve customers, brothel owners sometimes force workers to perform personal housework or childcare chores. *Pravati* said that the brothel madams lived in separate rooms with their husbands and children. *Pravati* and the others were sent to clean these rooms. Every Saturday they had to clean the room, wash the family's clothes and bathe the children. *Devi* said that besides sleeping with customers, the women and girls in the brothels were expected to do housework for the owner, including washing the floors at the owner's house and doing her laundry, which they brought to the brothel to wash.

6. Back home from brothels (The return)

Three major processes of returning home were identified in this study. They are rescued, escaped, and released or self-returned. Of 42 women interviewed by our team, the majority (73.8%) was rescued by police and/or social workers. Similarly, 16.7% women and girls escaped on their own or with the help of other people. Only 9.5% were released by a brothel owner and/or self returned (with consent of brothel owner). The same ratio was found in the survey data (n=199) as well. Nearly 80% were rescued by police and/or social workers, 12.7% girls and women escaped on their own or with the help of

other people and less than 10% were released by a brothel owner and/or self returned (with consent of brothel owner).

6.1 Rescued

As mentioned above, majority of girls who were able to leave the brothel were either rescued by the police or social workers. Mainly, girls were being rescued and put into an Indian rehabilitation centre before returning to Nepal, or were then shifted to a Nepalese rehabilitation centre before returning to family.

The women and girls whom we interviewed were mainly rescued by police.

> *Kalpana* was finally rescued, after suffering for one and a half year in the brothel, when the Indian Police came to investigate the red-light area. She was taken to a hostel in India where she stayed for six months. Here she learnt to read and write before being brought back to Nepal. She was very happy to get back to her homeland.

Similarly *Sunmaya* was rescued by the Indian police.

> *......Twelve days later the Indian Police raided the brothel. I was rescued and taken to a remand home in India where I stayed for five months and then brought back to Kathmandu......*

A number of cases were rescued by social workers. *Parbati* was rescued with the help of social worker.

> *One day a man called U.P. Laure visited the place. Seeing how sad I was he asked me what was wrong. I told how I had been tricked into coming to this place and how I missed my young son and mother. I would pray a great deal to god, asking him to give me a chance to see the faces of my mother and son again. U. P. Laure asked me for my address and said that he would write a letter to my family. God must have been happy with me because he sent that kind man to help me. He bought me home to Nepal and I am now back with my mother and son.*

It is illegal for girls below eighteen years to work in a brothel in India. Brothel keeper always ask young girls to say their age is more than 18 years so that, if police raid the brothel. Such an event happened to *Suntal,* who was underage. The brothel keeper told her to say that she was twenty-one years old and had been working there for the past two years. *Suntali* wanted to escape though and so she did not do as she was told. When the police asked her how old she was she told them the truth,

> *"I am not yet eighteen years old, I am being forced to worked here against my will," I said. This worked and the police took her away from the brothel.*

6.2. Escaped

Some girls and women were able to escape from brothel with the help of others. *Neela* was escaped with the help of her regular customer.

I had one regular customer who was always very kind to me. He treated me with respect and realised that I was a human being. Seeing that he was my only chance of escaping from the brothel, I told him that I wanted to marry him. I do not think that I really expected this plan to work but when he agreed with the idea saying that he really wanted to marry me I was amazed.

He helped me to escape from the brothel and took me to live in his house which he shared with his brother. I stayed with them for three months but unfortunately his brother did not like me being there because of my background. He also thought that the situation was very improper as we were not married due to us both being under eighteen years, the legal age at which marriage can take place. My boyfriend felt that we would have to separate for a short while and so he took me to a shelter for destitute women in Bombay. Then, I was eventually brought back to Nepal I was really sick. I was first taken to a rehabilitation centre. I remember arriving there and hardly being able to stand up. I was immediately taken me to hospital where I was diagnosed with TB and HIV Positive.

I tried to run away from brothel many times but my attempts were always unsuccessful. There were always guards working for the brothel-keeper who could catch me. When they caught me they would throw me to the ground and beat me with sticks and pulled my hair.

6.3 Released by brothel owner and self returned

When a girl is too old to attract customers she is released from the brothel. Some are thrown out when they are tested HIV positive, others only when they have full-blown AIDS. Consequently, they lead a miserable existence on the streets with no alternative to begging and prostitution. Sometimes girls and women were allowed to come back to Nepal for short time. Some of those girls do go back to Indian brothels and some stay in Nepal. *Kanc*hi was sold by her family member but after working five years in brothel, she was able to come back to Nepal.

I worked in my phupu's kothi (brothel owned my her sister) for five years in Delhi. I came to Nepal to see my mother in last Dashain, and then I decided not to go back.... Now I am doing my business here....

A small number of women who accepted their lives in the brothels become brothel owners themselves. Social stigma is conducive for taking up this position. Due to a lack of alternatives their survival strategy pushes them into the role of the former tormentor, intermingling the roles of victim and exploiter. As mentioned before, they occasionally return to their villages, parade their affluence and lure new girls into the trade.

Table 5.6: Total duration stay in brothels in month * mode of return

Total duration stay in brothels in months	How did they come out from brothels (% within mode of return)			
	Rescued	Escaped	Released by owner /self-returned	Total
Less then 12 months	41 (27.2)	12 (50.0)		53 (28.2)
13- 36 Months	67 (44.4)	5 (20.8)	2 (15.4)	74 (39.4)
37 - 60 Months	29 (19.2)	6 (25.0)	5 (38.5)	40 (21.3)
More then 60 Months	14 (9.3)	1 (4.2)	6 (46.2)	21 (11.2)
Total	151 (100.0)	24 (100.0)	13 (100.0)	188 (100.0)

P=0.000

Interestingly, there is significant relation (p=0.000) between duration of stay in brothel and mode of return. Those girls who worked less then 3 years have less chance of being released by brothel owner, or return with consent of the brothel owner. Those girls who already stayed more then five years do not try to escape (Table 5.6).

6.4. Problems to return

There are several facts that prevent women and girls from escaping their situation. There is strong social values and stigma around prostitution. *"Ke garne chori cheli dimma jastai hunchha, ekchoti futepachhi, futyo, futyo."("What to do? Unmarried girls are like eggs, once broken they never rejoin, you cannot join them).* Generally, from the interview data, it can be stated that constraints consist mainly in:

Fear of being rejected by their families: Frequently, not only society at large but also parents condemn their daughters morally and repudiate them.

> Sita and her friend who had also been lured to Mumbai were found after a few days by the police that had been informed by Sita's suspicious relatives. Sita did not return to her family though. She lives at a rehabilitation shelter and continues her studies. She does not want to go back to her family.

Fear of arrest or recapture: Many girls are discouraged by the brothel owners' false tales of prostitutes who were arrested after returning to Nepal. In addition, some of the girls who managed to escape were caught and submitted to more torture and/or were sold to other brothels in India. Brothel owners made it plain to the girls that this fate might also await them.

Fear of stigmatisation: They are fully aware that society looks down on them and therefore offers no hope for a dignified life.

Vulnerability to harassment, abuse and rape: In many cases, the girl will be considered as available to anybody, a sexual object, a prostitute for her whole life.

Lack of skills: Most girls are illiterate or semi-illiterate and never had a chance to acquire any skills that might provide a basis for employment. It is difficult to say how many percent of girls and women want to return. This study was conducted in Nepal and we interviewed only returned girls and women. A survey conducted in Mumbai reported that about 90% of the girls did not want to return to Nepal, more than half of them because of perceived lack of employment opportunities (IHO 1993). If women who return home have managed to earn money, they are more easily accepted back into their communities, and may eventually marry. Those who escape the brothels before they have paid off their debts, who return without money, or who are sick and cannot work, are shunned by their families and communities. Many will return to India.

7. Discussion and conclusions

The analysis of the content of the finding above will be discussed below in terms of the different factors affecting different stages of the trafficking in women and girls in Nepal. Until the last decade, the majority of girl trafficking from Nepal to India was confined to some districts surrounding the Kathmandu

valley and small areas alone the Indian border (Frederick and Kelley 2000, Pradhan, 1996; Rajbhandari and Rajbhandari 1997; Ghimire, 1998). Most Nepali women and girls in the brothels of Mumbai were from the Tamang ethnic group (Rajbhandari and Rajbhandari 1997). In contrast to the previous finding, my study shows that the ethnic and regional composition of working women and girls has changed. Women and girls from more than 25 ethnic groups from 37 districts were found to be trafficked in Indian brothels although, some ethnic and cultural group residing in certain areas have a particularly high prevalence rate. The ethnic and regional determinants are less explicable when they are compared to the similar ethnic groups residing in northern India with similar matriarchal social setting of the communities i.e. the puzzle of why so many girls are trafficked from Nepal into Indian brothels remains a puzzle. Socio economic and educational factors may be relevant.

There are numerous methods that are used to traffic girls into prostitution. It can be classified into two contrasted categories. The first fits the popular account promulgated by NGOs, and involves a girl who is kidnapped or coerced, sold against her will, and transported into bondage or slavery in an Indian brothel. But there is another important type, not previously described in the literature which involves family-based trafficking. In many cases the woman and girl or her family have no understanding about prostitution, and these can be classified as "traditional" trafficking. Then, there are the girls who reach Indian brothels with their family's complicity and knowledge about prostitution – but even in these cases the girl herself may be coerced or deceived, and once she learns her fate is unable to escape from the Indian brothel in which she is now imprisoned. It is often very hard to draw a division in moral terms between these two categories, but difference can be seen after analysing the methods and means of trafficking. As Newar (1998) noticed the high number of 'missing' girls from certain villages suggest that sending daughters to India has "become an accepted social custom, albeit a secretive one". Whether voluntary trafficking has occurred in these cases, with the woman herself aware that she is to be prostituted, is unclear form Newar's account.

There are however families with many of their female members practising prostitution in India, a niche they occupy because of caste status or because of

traditional custom. Some of these women came home with an Indian man for couple of weeks and then went back to the brothels.

In some cases it was found that although parents may sanction a daughter's migration and may even accept money in advance for her labour, they do not fully understand her risk of entering the sex trade (or of otherwise being exploited). Likewise, parents may accompany daughters to the carpet factories in Kathmandu but may not be aware of, or involved in, any subsequent trafficking. This is very interesting finding which is consistent with previous finding (Bhatta, 1990).

It is very hard to figure out the number concerning the question: "How many girls and women were actually tricked or forced into the trade or how many went into the business of their own free will?" because it is not clear what is choice and what is compulsion and where is the dividing line. As O'Dea (1993) noticed the expression "own free will" seems out of place in this context. The influence of poverty, family pressure, caste and gender discrimination have to be taken into account. It might have been mere resignation due to lack of a viable alternative. A girl's choices are definitely severely limited. In the Nepali context, 'voluntary prostitution' is often considered a paradoxical term (Meena Poudel undated). However, it does not serve the reality of trafficked girls to push their cases into a dichotomous system that only admits voluntary or forced prostitution. There are too many forces at work to be able decide.

The nature of the vulnerability to being trafficked (as opposed to migrating safely) has been explored in this study. My study does not completely agree with the simplistic explanation sometimes voiced in the literature or by NGOs with statements such as: *"All trafficked victims in Nepal usually involve a happy, innocent, and naïve village girl who is suddenly tricked or kidnapped by a stranger and sold into sexual slavery".* The present study has challenged this picture as an oversimplification, and I question the assumptions of village and family life underlying many representations of trafficking. The present study clearly indicates that many (though not all) women are trafficked by people known to them. Like other women in prostitution, many come from disturbed and difficult family circumstances, including divorce, alcoholism,

sexual, physical or emotional abuse, or death of a breadwinner. Lacking crucial social supports, such women may be particularly desperate to change their situations.

Some of the published research expresses the opinion that the 'highway syndrome' (the pull factor of an allegedly romantic lifestyle in India) is one of the instrumental factors in trafficking. Heavy import of foreign media including pornography, and films have allegedly contributed to involve people in 'immoral' activities. But no concrete evidence was found in this study to support this opinion. However, urbanisation along the highways; industrialisation - especially the carpet industry in Kathmandu and migration from rural to urban areas make women vulnerable to the trafficking. Additionally, an increasing commercial sex culture within the receiving country encourages pimps and brokers to run their business more effectively and aggressively. Inflation and complicated life style, with great desire to achieve all sorts of material goals influence people to take bribes, and encourage the immoral acts.

At the local level, trafficking stems from deep-rooted processes of gender discrimination, lack of female education, ignorance and naivete of rural populations, poverty and lack of economic opportunities in rural areas with consequent marginalization of particular social groups. These local level processes are in turn shaped by macro-level economic and social forces that are changing the way markets operate and the kind of labour that is required. Many of the factors contributing to trafficking are aggravated by national and local level political apathy and lack of law enforcement mechanisms.

Nepali women are expected to work hard in the household. Studies have indicated that to get rid of the poverty-stricken economy of the household the women and girls are always in search of economic opportunities within and outside the country. The pimps hit on this vulnerability of poverty. The female crude economic activity rate in Nepal is far lower than in men as reported by the three censuses of Nepal (Shrestha and Pant, 1995).

Migration is playing an increasingly important part in Nepal's economy and social structure. As these factors lead to an increase in migration, more

women and girls are found to be trafficked in the process. This finding is consistent with previous finding by O'Dea, 1993; Acharya, 1998; ILO/IPEC, 1998; ABC Nepal, 1996; Rajbhandari, 1997; Asia Foundation/Population Council, 2000. Many misconceptions or over-simplifications of the underlying causes of migration obscure the resources that are available to trafficked persons and their resiliency. For example, poverty is often cited as the reason for migration or accepting employment conditions of debt bondage, despite the common occurrence of migrants actually paying for transportation or transit services.

The Nepali literature on trafficking and prostitution often argues that the Indian sex market has a great demand for Nepali women. Even among the Nepalis, the fair Mongoloid faces are in great demand (Rajbhandari and Rajbhandari, 1997; Pradhan, 1992). However, the present study does not accept this hypothesis. If the Mongoloid faces were in great demand, the trafficking from other, similar areas of Nepal (areas in Nepal where more Mongoloid groups reside) would also have flourished i.e. some similar regions with similar cultures and ethnic profiles have an apparently a low prevalence of trafficking.

In Nepal, high level decision makers, lawmakers and politicians at the local level are often accused of being the protector of the traffickers. Many authors have blamed the lack of enforcement aspects of the legal provisions. Policies are sound in Nepal but not the implementation. Political commitment is required to implement public policies. Stating 'quite often' Pradhan (Undated) has written that the local administration or the police in certain districts have released accused traffickers because of the direct command of ministers and politicians. Political leaders and higher authorities in bureaucracy are accused of releasing the arrested traffickers from custody and taking political and monetary benefits from them (Pradhan, 1996; Rajbhandari and Rajbhandari, 1997; Thapa, 1990). Friedman (1996) noticed the some political leaders are alleged to have association with pimps and brothel keepers. However, there is not any tangible evidence from cases in the present study to support this argument. But malpractice in political and administrative levels in both places of origin (Nepal) and destination (India) of trafficking were reported by victims.

Administrative measures are weak and bribery prevails throughout Nepal and India.

Destitution and desire for fun are quite opposite to each other, but they both make women vulnerable for trafficking and her involvement in prostitution. Bedi (1990) identified these motives among the major themes of the studies conducted on prostitution in India. Most of the cases reviewed in earlier literature report that women falling prey to selling of sex reflect the consequence of destitution, inclination, seduction, abandonment, alcoholism in a family member, ill treatment by family members, bad company, persuasion, conscription and violation. Sexual promiscuity, illicit sexual relations, sexual urge and unfaithfulness of the partner or husband are other alleged causes of women's involvement in prostitution.

Much Nepali and Indian literature has mentioned hardships and poor economic structure of the household that leads women to vulnerability of trafficking and their involvement in prostitution. The case studies (ABC Nepal 1998, Rajbhandari and Rajbhandari 1997) indicate that poor economic conditions are the most common factors identified by the women. But the possibility of their involvement in other sectors of economy is not detailed. The pimps and brokers' assurance about earning without investment allures women in the initial stages, and once they are in the sex market the bonds of debt rather the keeps them in the profession, as my case studies show. Women once trafficked and forced to be in prostitution often do accept their fate later, because there are no options or alternatives left.

As I mentioned above, some of the more frequently cited factors leading to trafficking are poverty, lack of employment opportunities, low social status of the girl child, a general lack of education and awareness, corruption of officials, an open 1500 kilometre border with India, lax law and a weak law enforcement machinery (Asia Foundation/Population Council, 2000; Pradhan, 1996; Rajbhandari and Rajbhandari, 1997; Thapa, 1990; Friedman, 1996; O'Dea, 1993; Acharya, 1998; ILO/IPEC, 1998; ABC Nepal, 1996). All these reasons, no doubt, contribute towards the problem. However, it still does not explain why only certain communities are affected, although all share similar socio

economic conditions. Why certain geographic, ethnic and ecological factors are more responsible in determining the magnitude of trafficking are some questions, which I will attempt to answer.

The root cause of trafficking is multiple and complex. However, this study suggests that both trafficking and migration operate primarily through personal connections and *social networks* (such as an aunt who returns to the village and takes her niece back to the city), and through unregistered brokers who may or may not be strangers to the locality. Women and girls voice opinions like *"....my sister worked there before, so I went there......"* further prove the social networks in sex trade. Furthermore, the majority of women and girls were persuaded by their friends, family members or people living in their community. Most women and girls entered the trade when someone from their home village brought them to the city with the promise of jobs.

They report that women and girls are attracted by reports of the wealth and fun to be had in the city and are easily duped into trusting the mediator. Likewise, some women are deceived into false marriages with the broker and are subsequently sold into the sex industry. Trafficking in women and girls represents the weaker family structure. Although the Nepali kinship bond is reportedly a strong one, and paradoxically perhaps many of the brokers and pimps are reported to be the relatives of the victims. Even the husband and fathers of the women concerned are in some cases found to be involved in such flesh trade activities.

This study also notices that brokers are increasingly operating within organised trafficking networks that cover certain regions of Nepal and use sophisticated methods. For example, it is becoming increasingly common for trafficking to take place in stages, with women moved around to work in different sites before finally being sold into sex work. Carpet factories in Kathmandu are a common transit point.

A more refined analysis suggests that in many circumstances large disparities of income and wealth entice individuals to migrate, rather than absolute poverty pushing individuals away from their home communities. Clearly a number of "push" factors do exist that encourage individuals to

migrate, including economic aspirations (to look for opportunities to better one's life) and a breakdown of family or social structure, in addition to the more frequently cited reason of absolute "poverty."

Debt bondage, prohibited under The U.N. Supplementary Convention on the Abolition of Slavery, the Slave Trade and Institutions and Practices Similar to Slavery, is defined as a situation in which debtors pledge their personal services against a debt they owe, but the person to whom they owe it fails to deduct the value of their services from the debt, or the length and nature of those services are not respectively limited and defined. The debt bondage which supports the trafficking nexus is also tantamount to forced labour, defined by the ILO as, "All work or service which is exacted from any person under the menace of any penalty and for which the said person has not offered himself voluntarily." Slavery and forced labour are prohibited by other international law and under Nepali and Indian laws.

India enacted the Bonded Labour System (Abolition) Act in 1976, which outlaws all forms of bonded, and slave labour. In addition, article 374 of the Indian Penal Code makes it a crime to compel unlawfully any person to labour against his or her will (Human Right Watch, 1995).

Regardless of the victims' origins, their reports of abuse in Indian brothels are remarkably consistent, and do indicate conditions of slavery and servitude which contravene Indian law.

It is still not known how many trafficked persons return without NGO assistance and what type of reintegration strategies they employ. There is some evidence in this study that some women decide to settle in urban areas, setting up small businesses or, if they are sex workers, staying in the sex trade directly or indirectly as madams or brokers. At the same time this study also noticed that women from communities where sex work is a common practice may find it easy to return home where they may marry and/or set up small businesses. Further research on the coping and livelihood strategies employed by trafficked women would assist in development of more effective and meaningful reintegration strategies.

Society has traditional values that degrade brothel returnees, but brothel-returnees have also a psychological stigma that makes them hesitate to face common people. But should not be conceived that the brothel girls do not want to go back home; however social norms and possible reaction of the home community have became the obstacles to restore a normal life for them.

Today, the majority of NGO interventions are directed at few 'danger districts' surrounding the Kathmandu valley. These interventions are designed on the premise that the girls are duped or forcibly abducted into prostitution, and that their families are passive innocents. Until very recently, NGOs and donors have ignored the obvious: that the 'danger districts' cannot possibly supply the vast number of Nepali females that fill the brothels of India.

The existence of specific and clearly defined networks of trafficking has implications both in terms of efficient use of resources and in terms of the effectiveness of the activities. In addition, the messages from NGOs in the form of leaflets etc are likely to be futile for the illiterate populations amongst whom they are distributed.

Movement in and out of coercive and exploitative circumstances is a dynamic process that is well recognized in irregular migration, smuggling and trafficking. Interventions that intercept trafficking at its outcome point, rather than at the time or place when it first occurs draw attention to the problem of identifying when movement within or between countries becomes exploitative and not voluntary, and could serve to protect an individual's right to migrate. A human rights analysis draws attention to the protection of equality and the promotion of non-discriminatory migration.

There is over-emphasis in the literature on the legal response (Asia Foundation/Population Council, 2000). The legal response to trafficking, either through international conventions or state sponsored regulations can never be a complete response nor a solution. An over reliance on legal mechanisms can produce results that are counter-productive. When laws are created to be as broadly encompassing as possible, an overgeneralization occurs that actually restricts the application of the law and reduces its impact. Legal measures to restrict trafficking that lack specificity in terms of gender and age have been

shown to mischaracterize the harm done by trafficking, and actually compound restrictions on the movement and employment of younger women instead of protecting these rights (Huntington, 2002).

Additionally, rescued or escaped women's rehabilitation efforts require a positive reflection of the society toward her for the rest of her life. In some cases, the hiding of brothel-returnees would not be helpful and would not create general social acceptance. Traditional values and norms are hindrances to rehabilitation efforts. Society does not easily accept the return of women once trafficked and involved in prostitution. Social reintegration becomes much more painful for the person once involved in prostitution and rehabilitated later, which may force women to stay in the sex trade even they came back to Nepal. It is to be noted that a significant proportion of women have reported their unwillingness to go back home after they are made sex workers.

NGOs working against girl trafficking tend to focus only on the group of girls trafficked in the most exploitive way and publicise this picture. Existing intervention hardly covers the family-based trafficking which the present study has identified. Partial truths, from whatever side, do not help the issue. A certain caution is required in assessing the situation, otherwise intervention strategies may be wasted.

CHAPTER SIX

AWARENESS ABOUT SEXUAL HEALTH AND HEALTH SEEKING BEHAVIOUR

1. Introduction

As mentioned earlier, the second objective of this study is to find out the awareness about sexual health, health maintenance practices and health seeking behaviour of returned trafficked women and girls. Findings from the different research activities and methods as detailed in the methodology section have been combined and presented as a coherent whole, with specific sources of information acknowledged where appropriate. Findings from the in-depth interviews with returned trafficked women and girls (n=42), key informants including health workers (n=8) and other information from field notes are presented using thematic analysis and some descriptive statistics. In the same way, results of observations in the rehabilitation centre are not discussed in details but some findings are included where it is directly relevant.

Sexual health and health seeking behaviour are broad and complex topics. For the purpose of this thesis, this chapter presents and discusses the finding on following issues; (i) awareness and access to information about sexual health and condom use practices, (ii) local understanding of health and health problem, (iii) choice of healthcare providers and utilisation pattern, (iv) factors affecting the health services utilisation and (v) therapy management.

2. Socio-demographic information

We interviewed women and girls came from diverse range. Most of the socio-demographic information such as ethnicity, religion, marital status and address are already presented in chapter five. Only selected socio-demographic information, which are not presented in previous chapter are presented here (table 6.1). Among the 42 returned trafficked women and girls interviewed, 30 were living in rehabilitation centre, six were working as sex workers, two were living with their family (husband) and four were doing private business (running small a shop) in urban city. For the purpose of this analysis

and discussion these women and girls are classified into three groups, depending on the type of places they live and their current profession. Those women and girls who were living in rehabilitation centre are classified as "Rehab group", those women and girls who were working as commercial sex workers are classified as "Sex workers group" (or CSWs) and those women and girls who were married and living in their family or doing their own business are classified as "Reintegrated group". This classification is important in relation to health seeking behaviour because their background has some effect on health seeking behaviour and therapy management.

Table 6.1: Selected socio-demographic characteristics

Variable	Grouping	Interviewed sample (n=42)	
		%	Number
Group (Current occupation)			
	Rehab group	71.4	30
	Sex workers group	14.3	6
	Reintegrated group	14.3	6
Current age			
	Below 18 years	9.5	4
	19-25 Years	47.6	20
	Above 25 years	42.9	18
Current Education Status			
	Non-literate	33.3	14
	Primary/non formal education	50.0	21
	Secondary Education	16.7	7
HIV Status			
	Positive	19.1	8
	Negative and unknown	80.9	34

It is important to note that the age and education status presented in the previous chapter is age and education status at the time of trafficking but the information (age and education) presented here is current status (at the time of interview). The mean age of women in our sample was 25.29 years. About one-third were non-literate, half had primary or non-formal education and only 16.7 percent had secondary education. None of them had higher education. Of 42 interviewed, eight (19.1%) women and girls were HIV positive. The majority

of women living with STIs and HIV/AIDS who were interviewed had learned about their serostatus either during an illness, or in the Indian brothels or in the rehabilitation centre.

3. Access to Information about sexual health and condom use

During the individual interviews, all women and girls were asked about access to information about STIs, HIV/AIDS and past condom use practices while they were in an Indian brothel. Furthermore, the CSWs were asked about current condom use practices while they were working as a CSW in Nepal. Several interesting differences were found while working in Indian brothel and working in Nepal.

We found that CSWs in Nepal were more informed, had high levels of awareness and used condoms more frequently than when they were in India. Returned women and girls told us that they had very poor access to information regarding sexual health issues while they were in Indian brothels. According to social workers in Nepal there was no official educational materials like pamphlets, posters or public service announcements for television or radio in the Nepali language in India. Most Nepali women and girls were illiterate and did not speak or read sufficient Hindi or Marathi. They could not communicate with non-Nepali speakers customers. We found that only a small percentage of the Nepali women and girls who had worked in brothels in India had any knowledge about the transmission of HIV/AIDS while they were in Indian brothel. Similarly, a number of factors were identified for not using the condom in Indian brothels.

> "*Sunmaya*" said she had heard about AIDS, but only that it was a dangerous disease. She thought you only got infected by blood, but she wasn't sure what kind of blood was meant.

Some women and girls were unaware about the dangers of AIDS. 25 years old returned woman "*Parbati*" said;

> Condoms were not available in any of the brothels in which she worked and that the girls did not seem to know anything about AIDS. She thought if they really knew about the dangers of AIDS they would have tried to run away.
>
> *Parbati* had only heard about AIDS on the radio since she returned to Nepal, but did not understand much about it. She thought it might be transmitted if you ate

> the food of someone with the disease. She said that in the brothels, old sex workers used to give the younger girls their leftovers because they got more to eat, but *Parbati* did not like to eat their food. She had not been to a doctor since she got back, but she is not afraid of diseases. She feels fine.

Another girl had similar story

"*Kalpana*" never asked clients to use condoms because she did not know condom could prevent AIDS. She said that she had heard about AIDS but did not know anything about it.

According to a social worker, brothel owners and managers paint a rosier picture of AIDS awareness in Mumbai, and one of the ways health organizations in Bombay attempt to convince local brothel owners to use condoms was to appeal to their desire to turn a profit. Women exposed to these programmes know the dangers of AIDS and claimed to use condoms, but in practice, customers frequently refused them.

Sita, who worked more than 8 years in Indian brothels and came to Nepal on 1999, told us that customers were falling off in great numbers since early 1990s to 1999. Three to five a day was a large number during the time while she left the brothels. She thought that it was because of the AIDS. She knew about HIV/AIDS. There was a poster about AIDS on the brothel where she worked.

People who worked with returnees in Nepal said that there was HIV testing in some Bombay brothels, and that some brothels did appear to discard girls who tested positive. But girls are not always told of their status.

> After "*Neela*" was arrested in a raid on the brothel where she worked, she was placed in a shelter for children and her blood was tested for HIV. She was told the doctors wanted a blood sample because she might have a contagious disease, but they never told her what disease they were testing for. Afterwards she was told by the shelter staff that she had tested positive for HIV and that all the other girls had tested negative. *Neela* said she knew nothing about HIV before her test was positive.

A great majority of the women and girls were not using condom because their clients disliked it. *Jamuna*, who worked 5 years in Calcutta, told us that;

See!! how to use condom? When I started to work I had no ideas about condom use.... Once I learned about condom, most of customers did not like it. They (customers) told me many times that cap (condom) was useless....

Another reasons for not using condom in Indian brothels was unavailability of the condom. Condom was not readily (easily) available in most Indian small brothels.

Nelam said condoms were not available in the brothel where she worked although customers sometimes brought their own.

Ganga said when she began working in the brothels condom was not available, but after three or four years, girls began buying them themselves and would offer them to the customers. They knew nothing about AIDS, but "if customers used them we felt clean." The girls in the brothels where *Ganga* worked also tried to make a profit on condoms, buying them for 50 p. (about a cent) a piece and selling them for five rupees. Most customers refused to use them.

Efforts to influence buyers to use condoms were ineffective, because women and girls in brothels had no power to demand that the buyers did so. Buyers would become angry and report the women to brothel owner or pimps. *Suntali* worked in Delhi for 4 years and she was aware about condom use but she gave up to ask the customer for condom use since she faced problem with her customer.

One day I had one customer who was very drunk and he came into the room and I said to him, that 'see, you must use a condom, I won't sit with you without a condom.' He became very angry and started shouting... so I told him to leave half the money and go. He wanted all the money though... so we had a fight and he hit me (showed us her earlobe where the earring had been torn out). Then he left...............

Some women reported that although they knew about condom, they did not have the power to ensure that men use condoms, and the sex establishments did not enforce a condom policy. Nepali women and girls in Indian brothel were controlled by brothel owners and they had less power and skills to negotiate with brothel owners and customers. *Asamaya,* who worked 3 years in Bombay, had heard about condom, knew its benefit but she never asked customers to use condom. She was so scared with brothel owner.

If the gharwali (brothel owner) objects then it's very difficult. She scolds and beats them if they take too long with customers, but it takes time for them to explain about condoms... so how to use it..........

Another factor was that having entered into a commercial contract, women felt obliged to fulfil the client's wishes. *Tara* told us that;

> *I don't like to ask customers to go - they are poor men and they have come all this way to have some pleasure and spend some money. If we don't' let them enjoy, poor fellows, their money is wasted - we feel bad to send them away.*

A social worker described the situation for the sex workers in Indian brothels and told us that,

> If a customer comes and he gives her Rs. 25 but won't use a cap (condom) - what will she do? Can she send him away? For their stomach (ie. in order to eat) she will sit with him without a dhal (condom)

Some respondents stated that they were not afraid of getting STIs and HIV/AIDS because their buyers were "clean" persons, although they refused to use condoms. Condom use with regular customers was influenced by the CSWs' views of the man's 'loyalty'. Some believed that customers who came to them every week would not visit anyone else. *Aruna* told us that she worked in big brothel at Calcutta and she clamed that she used condom with all her customers. When we asked more questions we found that she was not using condom with her regular customers.

> A: 'I use condoms with all my customers'
>
> Q: 'Really with everybody?'
>
> A: 'Well, those who come every week once or twice I don't because I know they are not going anywhere else.

Interestingly we noticed that women and girls who returned from Calcutta were more informed about HIV/AIDS and STIs than returned from other Indian cities. Not surprisingly, older women were more aware and better informed than the younger.

As noticed above, only few returned trafficked women and girls reported that they had used condom while they were in Indian brothels. But interestingly, a great majority (five out of six) of the same women and girls who were working as a sex workers in Nepal were using condom. *Kanchi,* who worked 2 years in India and came back to Nepal on 1999, was working as a sex worker in Kathmandu, told us that;

> I never used the dhal (condom) while I was in India. Thanks god! I am fine... now, I use dhal with every customers. Most customers bring the condom with them and I keep some extra with me. If they (customers) refuse to use it (condom) then I don't sleep with them.........

But not all sex workers in Nepal were like *Kanchi. Sarawati*, who returned from Delhi and working as a sex working in *Patan*, told us that she used condom with some of her customers but not all the time.

Some returned trafficked women and girls, particularly those who were working as sex workers in Nepal have their own diseases prevention practices if the customers refuse to use a condom. Their disease prevention practices were correlated with the different aetiological categorizations of disease, and were related to individual, social and economic factors. 26 years old *Sarita,* who was working as a sex worker in Kathmandu told us that;

> **Q**: 'What do you do if a customer refuses to use a condom?"
> **A**: "I explain to them but if they absolutely refuse then I look at the *linga* (penis) and press it, and if any 'water' comes out or if there are any *ghau* (ulcers) than I tell them to go. I won't sit with them' (a euphemism for intercourse). If it looks OK, then I put oil on because this will 'cut the poison', and some men like oil to be put on. I always wash myself afterwards with '*Neeva*' soap (a derivative of Neem tree). I am a very clean person. I have never had any of these diseases. '

The above quotation describes the three main hygiene related strategies for prevention of disease: examination of the customer, use of mustard oil as protection and lubrication, and personal cleanliness. In addition to washing with soap, washing the genitals with one's own urine was also reported. Interestingly, the CSW speaking above had been suffering from chronic pelvic inflammatory diseases (PID) for two years, but did not associate her ailment with her profession.

We also asked a question about female condom to all returned trafficked women. None of them (returned trafficked women and girls) had heard about female condom. We did not study details about contraceptives but one health worker in Nepal reported that they (sex workers in Indian brothels) used different contraceptives. Recruiters and managers forced contraceptive injections or tablets on women in some brothels. Most likely, this was Depo-Provera although women did not know with what they had been injected.

Although we asked some questions about abortion in our pilot study, we did not collect the in-depth information about it. The subject of abortion was very difficult for Nepali women and girls to discuss since it was clearly an emotional, legal and religious matter, with most stating that it was a "sin" to have an abortion. Some women stated that if they became pregnant as a result of prostitution that they would continue the pregnancy to term.

4. Understandings of health and health problems.

It is important to understand how women view the aetiology of an illness as this affects the subsequent behaviour and the sort of treatment that women will seek. So all returned trafficked women and girls (n=42) were asked about their understanding on health and health problems. Some key similar themes were emerged from individual interview. Those findings are analysed and discussed below.

Returned trafficked women and girls held a holistic view of health in which dietary balance, avoidance of 'addictions' (such as drinking and smoking) and emotional stability were seen as essential to well being. As illustrated by the following quotation from a sex worker, the women and girls in Nepal, exhibited a holistic orientation to health:

> *If the women are happy, making money and eating well, they will stay healthy. It is only if they are worried that they get sick. In this "line" (of work) you have to take the breath of many customers and if you cannot tolerate it, then you will become sick.*

In this holistic view, health was not regarded as a discrete (medical) domain but was related to the various life circumstances seen as influencing it. It was illustrated by the fact that when women were asked initial open-ended questions about "women's health problems", they commonly listed all the various problems from which they suffered. Invariably these lists were not confined specifically to health problems but included other domains such as "worries", family and relationship problems. Within these domains, women noted that the social discrimination of themselves and their children, family and their own financial security were their most pressing concerns.

> If the women are *moto* (fatty), *rato* (red) and working well, disease can't catch them....

Health in the restricted sense of bodily well being did not appear to be among the women's priorities except in so far as it was understood as inherently related to these more general concerns.

Following these initial general listings, probing was carried out to explore "health" problems in general terms and "women's health" problems in particular. When asked specifically about health problems, women most commonly complained of general "weakness", "body ache", "head spins" and gastric disorders. A woman told us that;

> *See! I worked very hard last week so I have body ache and I am feeling weakness........many women in our community do smoke cigarettes so most of them got gastric pain....*

Women and girls used different terms and name to understand the different sexual transmitted infections. The common and mostly used terms are summarised on table 6.2.

Table 6.2 Glossary of terms for sexually transmitted diseases and other related problems.

Type (disease or condition	**Local Terms**	**Translation**
Sexually Transmitted Diseases (STDs)	*Youn rog* or *Line diseases*	Diseases of genital Diseases related to sex work
Pelvic inflammatory diseases (PID)	*Pelvic ko swoth or tallo pet dukhne*	Lower abdomen pain
Syphilis*	*Bhiringee*	Bad disease
Gonorrhoea*	*Dhatu rog*	Diseases of semen or sperm
Genital Ulcer	*Anari ko ghau*	Ulcer in genital part
Dysuria	*Pishav garna garrow hune*	Difficult to urination Burning urination
Vaginal discharge	*Pani Jaane*	Water going (vaginal discharge)

* Some women and girls used the English terms for syphilis and gonorrhoea, presumably having learned them from doctors. However, women were not always clear about what exactly the terms referred to.

Sexual health or sexually transmitted disease as a tangible (medical) domain was not explicit in women's disorders; rather, as illustrated in the quotation above, women talked of such problems as related to their occupation. Specific disorders such as syphilis, gonorrhoea and genital ulcer were explicitly regarded as occupational hazards, usually being referred to as *line disease* (from "line of work") and seen as being caused primarily by lack of hygiene ("dirt") or by rough/ violent intercourse.

When asked specifically about women's sexual health problems, vaginal discharge, burning urine, menstrual disorders and lower abdominal pain were most commonly mentioned. In contrast to "line disease" such as syphilis and gonorrhoea, however, these problems were recognized as potentially affecting all women and were related to popular conceptions of illness and disease causation, rather than being attributed explicitly to sexual transmission. These complaints were conceptualised in accordance with Nepali's humorally based indigenous medical traditions, which emphasise health as a state of dynamic balance both within the body and between the body and the environment (Niraula, 1994). Ailments were thus often discussed in terms of hot/cold. The concept of 'hot' and 'cold' plays a central role in the aetiology of an illness for the women in Nepal. Here hot and cold do not refer to the actual temperature states but to abstract qualities. A 23-year-old woman expressed her understanding in following way:

> *.....'today it is burning when I pass urine. My husband says my body has become hot after taking all those medicines for my chest'*

Foods, bodily states and illness are described as either hot or cold. The 'hot/cold' concept is central to the Ayurvadic medical system.

> **Hot foods**: meat, fish, eggs, ginger, papaya, mango, tea, groundnuts, bananas, piper, alcohol, cigarettes
> **Cold foods**: milk, yogurt, green leafy vegetables, rice, pineapple,

Furthermore, 'wet' and 'dry' bodily states (affected by factors such as climate and diet) were also conceptualised in terms of the internal mechanical functioning of different tubes or channels through which vital substances flow. During the interview, we noticed that if there is scanty periods (if their periods

only last a few days), women take it very seriously and many feel that it is very bad sign. 27 years old *Devi* told us that;

...we get very upset if it doesn't come out properly because we feel that the period must wash away all the dirt that's inside. I have heard that if there is very little bleeding, you will go blind. That is why I went to the clinic'

Thus, conditions such as vaginal discharge and burning urine were attributed to an excess of internal humoral heat, whereas menstrual disorders and abdominal pain were generally associated with blockages or shifts in internal physiological structure causing pain. However, sex workers linked such disruptions in bodily/internal balance to the particular lifestyles and circumstances associated with their work, such as being unable to follow proper diets, having to drink alcohol (a heating substance), suffering internal blockages and pain due to an accumulation of semen, or internal vessels shifting as a result of intercourse with particularly forceful customers. Concerns over the damaging consequences of white discharges were widespread, and we noted that it was often difficult to ascertain whether female patients' fear concerned actual pathological discharge or normal cyclical variations.

5. Choice of healthcare providers and utilisation

Women and girls who had experienced (past or present history) any reproductive or sexual health problems (please see the questionnaire guideline for details) were further asked three more main questions (Where do/did they seek care? What are/were the reasons for their choice? And, what are/were the constraints to receiving health care?).

The women in our study sample consulted a wide range of healthcare providers for both sexual and general health problem. On average, a woman went to three to four healthcare providers, mainly allopathic doctors (general practitioners, gynaecologists), ayurvadic doctors, chemists and druggists working in 'medical shops', and traditional healers. The initial choice of service was mainly influenced by its perceived appropriateness in relation to the category of disease, convenience, quality (privacy and good doctor patient relation) and financial and social factors although many other considerations combined to affect service preference. Their choice of a particular provider was

also based on recommendations from friends, relatives or social contacts who had been successfully treated for any other general health problem.

The most commonly consulted peers were those living in the same house. “Reintegrated group” sought advice from their peers and sometimes from members of their natal and husband's families. In the case of CSWs the *Deedi*, (older landlady, often an ex-CSW) was an important source of advice and sometimes took on the role of mother to the girls living in her house. Similarly, “Rehab group” sought advice from rehabilitation centre manager/warden or her senior friends.

Advice givers themselves would seek advice from their own social networks in the case of uncertainty and the patient might consult numerous individuals. In majority cases women's health decisions were influenced by their personal 'lay referral network' and her position within it. A woman's age, social position, and household composition all played a part in determining patterns of consultation and decision-making.

Allopathic doctors

The majority of women and girls we interviewed had visited allopathic doctors (either private or public) at least once in their quest for treatment. Women identified these allopathic doctors either through their relatives, or through previous experience with these providers. Women in our sample consulted many allopathic doctors, varying from family practitioners in their localities to qualified gynaecologists in tertiary hospitals. Allopathic doctors asked details about the gynaecological problem and generally tended to conduct a pelvic examination. Although women reported that the pelvic examination was an unpleasant procedure, a majority of them said that it was not painful. A 35-year-old woman describing her experience of undergoing a vaginal examination said;

> They had used an instrument and taken some samples. I was uncomfortable and I did tell the doctor. She said that it was necessary and then she told me to relax. Only three allopathic doctors asked for any laboratory procedures or tests: in one case, an abdominal ultrasound, when the woman complained of lower abdominal pain, and a culture of the vaginal discharge in the other two.

In many cases the first provider was almost always an allopathic doctor and chemists and druggists working in medical shops except in few cases where treatment was initially taken from a *Dhami/Jharki* (traditional healers) and an Ayurvadic doctor. Certain services were seen to be effective for particular conditions and would thus be differentially consulted allopathic doctors. For example.

> **Q**: 'why did you go to this doctor and not some other doctor?'
> **A**: 'because he is a 'Line' doctor' (ie. a doctor who specialises in the treatment of 'Line' disease - those associated with commercial sex work).

With respect to choice of allopathic services, in spite of the availability of the public hospital and community urban health clinic in Kathmandu, use of the private sector was extremely common, particularly among sex workers.

> A big doctor in private clinic will catch the problem more quickly so it is worth paying more----the doctors in the hospital don't look at you properly, there's always a big crowd.

Women related the severity of their condition to their choice of service. Help would generally be sought from Government hospitals for major problems requiring surgery as costs were too high in the private sector. Otherwise treatment was sought from the more convenient private practitioners and community based clinics.

In a medically pluralistic society, one might have expected higher consultation rates of other medical systems. Here, efficacy of treatment in relation to the illness category's the crucial factor determining the choice of medical system. Allopathic was preferred primarily for its speed of effecting cure.

> With these other things it takes too long to get relief. Allopathic is quick so we don't mind speeding money on medicines. If you take the medicines at night, by the morning you will be better.......

Chemists and Druggists

Most of women and girls we interviewed had visited chemists and druggists working in medical shops more frequently. Self-treatment with

allopathic medicines purchased directly from pharmacies was a very common practice, mainly for the management of mild or chronic complaints.

> The hospital is so far away. Then I have to make a ticket and stand in a big line. I have to go by eight o'clock in the morning, the doctor comes at 10, and then it depends on my position in the line as to whether I get seen or not. Then he will write and give a few medicines, but not all of them so I'll have to buy some from outside anyway. Then there is the expense of going all the way there, and in the time it takes to wait I could have had two or three customers, and when will I have time to cook?

For relatively minor problems such as period pain, coughs, colds or mild fever, women might first seek help from chemists and druggists in medical shops who would advise tonics, cough syrups, analgesics and sometimes one-off doses of antibiotics. Even with more serious illness, they might first consult to these providers and then seek help from doctor if symptoms persisted (though only two of the sample did this in practice).

This practice has potentially serious implications with respect to reproductive health problems, given that under-treatment can lead to antibiotic resistance and the development of pelvic inflammatory disease (PID). Indeed, many women in the community were found to be suffering from, and self-treating, chronic lower abdominal pain, which is indicative of PID, suggesting previous under-treatment of STIs.

Ayurvadic doctors

Some women and girls in our study had visited to ayurvadic doctors for chronic problem. Interestingly, none of them had visited an ayurvadic doctor the first time. Ayurvadic treatment was perceived as suitable for chronic and long standing disorders. Women with long histories of leucorrhoea or menstrual disorders often reported consultations with ayurvadic or traditional healers in the past, particularly if visiting their natal villages. But the food restrictions associated with these therapeutic regimes served to make them unpopular.

> The ayurvadic doctor tells me to refrain from many things, like don't eat this, don't eat that, like don't take *garam cheese* (things with hot composition), fish, egg, chicken. These things were forbidden for me to consume. He asked me to stop eating all this. Now if I stop eating all this then, what will remain in my body? Lentils and vegetables. So I stopped the ayurvadic treatment as well.

Spiritual/Traditional healers

Some women were also visited to traditional healers when the problem is related to mental health. We interviewed a woman who frequently had consulted the spiritual/traditional healers for her problem. Her relative referred her to a spiritual healer for her chronic insomnia (loss of sleep). At one place, she was given an eggshell to eat which did not help her. Describing her visit to second place, this 28-year-old woman said;

> I went to a big religious person who sits in Bhaktapur. His female assistant saw me and then she said that there is nothing. What you have to do is take eggshells, boil them in water, and then take the membrane out. Then grind the shell and make a powder. Take a pinch of this powder every day in the morning and one in the evening. I did that even. But nothing happened with that either. It helped for a few days and then it started again.

Sometimes women consult to Traditional birth attendance (TBA) for other gynaecological problem as well. Another 26-year-old woman described the treatment that a TBA gave her:

> I went to this *dai* near my house. She used to put this medication in my vagina. She used to immerse cotton balls in a dark reddish liquid and put that in my vagina. She used to put it in and take it out herself.

Home remedies

Using home remedies were very popular among the returned women and girls. Women in our sample were told of many home remedies either by their relatives or friends. A 29 years old woman, who was suffering from vaginal discharge, told us that;

> Somebody told me that to eat two bananas and take milk on top of that before sleeping. It will cure your problem 100%. But nothing happened. It stops for a few days and then it starts again.

There are many home remedies and herbal medicine that the women used to cure their problem. Most women told us that they used to use many herbs while they were in their natal home (village) and they also told that those herbs are not available in Kathmandu.

Whatever medicine they had used or wherever they had been for their problem, the main help-seeking "trigger for action" was an inability to work and perform daily tasks. Indeed, health workers noted that acute, incapacitating symptoms such as pain and fever most often led women to seek medical advice. Severe pain and fever prevented women from working and going about their daily tasks. Treatment for incapacitating symptoms was usually sought immediately, often on the first day. CSWs in particular were desperate to attain a cure as every day in bed meant money lost. For symptoms not immediately incapacitating, women tended to wait few days to few months before seeking help. They sometimes tried to manage the condition first with pain killers, home remedies or dietary modifications, and would wait to see if it improved spontaneously.

If the condition did not improve, help was sought due to concerns about long-term harm, as vaginal discharge or loss of blood was considered to be extremely weakening and therefore likely to compromise daily functioning. Conversely, retention of blood as a result of scanty or absent menstruation was thought to lead to a dangerous accumulation of "dirt" in the body which, should it reach the head, might cause blindness. In such condition women sought treatment more quickly.

In two rehabilitation centres where I observed, both have their own general practitioners (Allopathic doctor*). Doctors visit the rehabilitation centre regularly (once a week) and check all sick women on that day. If there is any acute problem the rehabilitation centre warden (in-charge) take them to nearest public hospital. Therefore the "Rehab group" has less choice than others.

The CSWs and reintegrated group had greater financial and social autonomy in terms of decision making than "Rehab group". Decisions in "Rehab group" were taken by the rehabilitation centre's people rather than the individual concerned. Thus a "Rehab group" first had to muster the courage to tell a warden or manager about her problem. CSWs were also reluctant to visit a doctor alone, but could do so if necessary. An older woman who had previous experience of ill health, health services and treatment options was in

a better position to make informed decisions than younger women in all groups.

"Rehab group" rarely sought treatment alone; young women had little contact with the outside world and felt the need for an older person or somebody from rehabilitation centre to act as their advocate. 22 years *Suntali*, who was living in a rehabilitation centre suffered from Dysuria and she explained her problem with us:

> **A**: 'today it is burning when I pass urine. My friend says my body has become hot after taking too much *Khursani* (chilly) yesterday.
> **Q**: 'what are you going to do?'
> **A**: 'who will take me to doctor? Our *deedi* (RC warden) is so busy'
> **Q**: 'do you ever go to a doctor by yourself?'
> **A**: ' no, our *deedi* comes with me and then she can talk nicely to the doctor and explain everything.

If symptoms did not abate, the decision to seek help would be affected by the perceived harm thought to be caused by the condition, especially with problem, such a leucorrhoea or menstrual disorders which may be cyclical and non acute and where the definition of normal and abnormal may be blurred. A 25 years old sex worker told us that;

> **Q**: ' what made you decide to go the doctor?'
>
> **A**: ' I was becoming weaker and weaker, so then I thought I should go".

In the cases of ambiguous symptomatology and where the condition did not impinge upon activities of daily living (such as some forms of leucorrhoea), "Reintegrated group" were more likely to put off treatment seeking due to lack of time, lack of self-esteem and lack of someone to accompany them.

In the case of chronically painful or incapacitating conditions (eg. dysmenorrhoea, excessive or irregular menstrual bleeding or chronic lower abdominal pain), women would usually seek timely help during acute exacerbation's but if no 'cure' was found, they tended to self treat with pain killers or drugs bought from previous prescriptions until symptoms worsened again.

Overall, all three groups of women were extremely health conscious and sought treatment within few days after acute onset of symptoms. CSWs sought

treatment more quickly and more often than "Reintegrated group" and "Rehab group". We came across no evidence of dangerous delaying of health care seeking with respect to acute symptoms. In fact, the major problem identified by the study concerned the pharmaceutical management of illness once treatment had been sought. Nonetheless, a number of factors influenced the nature of treatment seeking.

Privacy and confidentiality:

Privacy was a major factor that was commonly mentioned and that appeared to affect utilization of the health services. They told us they would not attend the some clinic because their friends or other people would be listening. *Sabita,* another returned trafficked girl told us that;

> I don't like to go there because everyone is sitting around. I don't want to talk in front of everyone, because then they will go off and when they are standing at the pump for water, they will talk and make faces and tell people not to mix with her because she is a bad person.

During observations in different health settings, it was noted that most of the health facilities did not offer complete privacy. Even the private practitioners would often conduct their consultations in front of those waiting. It is thus possible that anonymity is more important than privacy per se.

Convenience:

General convenience (including geographical location) was another most important factor affecting initial choice of service as well as utilisation of health services, and this was an area in which private practitioners had a district advantage over other services. Most women in all three categories noted that private practitioners were on their door step, were open on a daily basis (unlike the community clinic and government hospital) and held evening surgeries (women could thus be accompanied by their male partners who were out at work during the day). They would also make home visits, were available 24 hours a day and could always be called upon in the emergency. In addition, waiting times were minimal making the entire visit quick and easy - a factor that is of crucial importance to CSWs who are always pressed for time. *Durga*, who was working as a sex worker in Kathmandu told us that;

> The doctors in the hospital don't look at you properly. There's always a big crowd and a heavy queue. You have to circle around lots of places and get sent here and there, or they tell you to come back the next day. But if someone is ill, they want treatment then, not tomorrow. If I go there early in the morning I don't get home till 2 O'clock.

Women usually find it difficult to manage for time off work to seek treatment for STIs and other health problems. This results in delay in seeking treatment or in self-medication. Few women told us that they did not attend the public clinic because of inconvenient opening time. *Harimaya*, who was running small teashop, told us that;

> Look! How to go that clinic (the urban health clinic run by Kathmandu metropolitan city)... they open 10-2, this is my good business time.. if I miss this time I will lose my income.....

Access is one of the main concerns in utilisation of health services. Unlike rural areas, the studied areas (Kathmandu valley) was extremely well served with a wide variety of healthy facilities within 25 minutes walking distance, except for few Government hospital which required a short trip by bus/taxi. Seeking help further a field was thus not necessary unless a specialist consultation was required. However, in interviews, distance and the time taken to reach a service were still mentioned as important factors for the non-utilisation of some health services.

The psychological and Interpersonal factors

The quality of the relationship between service providers and individual consumers was found to be of paramount importance in health decision-making. The reputation of the service, positive or negative first experiences with a service, and development of doctor-patient relationships all influenced treatment choices to some extent.

Doctor-patient relationships were found to follow a generally existing pattern in Nepal of establishing ties of reciprocity between service provider and consumer in which the provider offers a reasonably priced but high quality service in return for regular patronage. Patients felt that if the doctor knew them well, they would receive preferential treatment. For the same reason,

patients claimed that ties via their social networks (a 'source') would serve the same purpose. With reference to a Government hospital, *Geeta*, told us that;

> If you go with a known person then it's OK - then the doctor will look at you, but if you don't' have a 'source' the doctor will say he has no time and will send you away quickly. But if you have a source you can go back and ask the doctor about things you don't understand.

Doctors were primarily judged in terms of rates of cure, assessed by the efficacy on medicines prescribed.

> We go to the doctor whose medicines work for us. (19 years old *Yangi*)

> Not all doctor's medicines suit me. I only go to aged doctors. They have a lot of experience. Their medicines react in my body and I get cured. (17 years old *Dolma*)

A good doctor-patient relationship also affected the perceived efficacy of treatment. A positive or negative first experience with a service was crucial in determining subsequent utilization. Services were initially judged in terms of diagnostic prowess. (With reference to a first visit to the urban health clinic), another woman told us that;

> 'I went there with this pain here in my lower abdomen and they didn't examine me or ask proper questions, they just gave me tablets for gastric...... But if I have gastric..... my pain will be here (points to epi-gastric region). I've still got the tablets lying here in my room. I got really angry and told the doctor I won't come again. They should have examined and felt my stomach but they didn't even look at me. '

Conversely, if women had had positive initial experiences, then they would be likely to return to the same place again and would also bring their friends as well.

Price of care and affordability of health services.

Utilization rates of free health services were related to economic status. Although private practitioners were popular, free community based medical services were also well utilized mainly by "Rehab group". It was not possible to perform an exact analysis of expenditure on each illness episode as it is out of scope of this research and in practical level some women could not remember the exact sums involved and sometimes did not know, as their husbands or other people had paid.

Economic status also affected the uptake of medical advice if it comprised expensive diagnostic tests or surgery. This was particularly the case for CSWs with symptoms of PID. Government hospitals were cheaper than the private sector but still involved large expenses as most medicines and diagnostic tests had to be purchased outside. Women thus put off major medical interventions until their symptoms became unmanageable. In two cases of PID that we followed up, both women were delaying ultra-sound diagnostic tests because of the cost. For all groups, major surgery was expensive both in terms of direct costs and indirectly, as they would not be able to work for weeks afterwards.

Another important factor affecting utilization patterns was the relative status afforded to private doctors and the medicines they prescribed, and, in turn, the social status gained from being seen to visit a doctor privately.

> **Q**: 'why did you go to private doctor and not to free place?'
> **A**: 'my husband says that he's got the money so we'll spend it on a good place.'

Private doctors were generally regarded as providing a higher quality service and the medicines they prescribed were seen as more effective (perhaps because they tended to prescribe expensive, newer, broad spectrum antibiotics and powerful pain killers). The more expensive the service and the medicines, the better the quality was thought to be:

> A 'big' doctor will catch the problem more quickly so it worth paying more.

The quotations below illustrate why women may prefer to go private:-

> **Q**: 'why do the girls spend money going to a private doctor when somewhere like Bir hospital is available free? They could have saved that money"
> **A**: 'they want to maintain a standard, that's why they wont' go to Bir hospital. If they are earning well, they won't go to free place. For prestige they won't go'

Thus prestige, the lay referral system, a demand for high quality treatment and perceived efficacy of the service all combine with economic considerations to influence choice of service and utilisation.

Gender of the doctors

All the women and girls were asked if the doctor's gender made any difference to their choice of service. All women said that it would be less embarrassing to consult a lady doctor, especially if an internal examination was required. However, a doctor's gender did not appear to affect utilization of services significantly. It was noted that CSWs were not embarrassed to talk about their condition or to be examined. A sex worker told us that;

> See, doctors are our mothers and father. Any women if she goes to the hospital will hope for a lady doctor because you think 'what I have, she has also'. But whether it is a man or a woman, it is still a doctor.... They are here to make us better, to do good for us. If we are ashamed and don't tell them our problems, then the disease will stay with us.

However, there are some women who prefer to be checked by a lady doctor. Majority of women from "Reintegrated group" told us that they would prefer lady doctor. They only went to a male doctor if there was no alternative. A woman told us that;

> If there is no lady doctor they will have to go to a gents. People round here mainly go to male doctors because there is not lady doctor near by them.

We noticed that popularity of doctor depends more on his/her interpersonal skills and clinical acumen than on gender. A women told us that;

> It depends on the doctor's 'hand' (i.e. skill). The doctor who tries to feel with the girls and tries to help them will get more patients. They may give the same medicines, but the person who is nice to the girls will be loved. Whoever's hand has the power and the renown will have many patients. .... In hospitals some sisters are rude and shout at us, but others are nice and respectful. Those who try to understand will be loved.

Stigmatisation:

Although the focus of the fieldwork was on health seeking behaviour, stigmatisation and its consequences within the health care utilisation were found more prominent. Therefore, key issues on stigmatisation and its effect on utilisation are analysed and discussed here. A wide range of different forms of STIs and HIV/AIDS-related stigmatisation and discrimination were prevailed in Nepal and was more acute for returned trafficked women and girls.

Differential treatment was reported as occurring immediately after (and sometimes even before) disclosure was made. As *Sarita*, the 28-year-old HIV-positive, who was recently discharged from hospital, recounted:

> *The staffs were looking after me well, but after they tested my blood for HIV their behaviour changed and they separated our vessels, pushed me to a corner of the room and talked about me in hushed tones. I couldn't understand why their behaviour had become so cold. I do not think I will go to any hospital again.....*

Another girl said;

> My blood was tested and from that day they stopped giving me injections. They didn't tell me why.

In Kathmandu, individuals diagnosed with HIV/AIDS in private hospitals were frequently transferred to government hospitals where conditions and the quality of care are often far worse. Elsewhere in Kathmandu, a few private hospitals were reported as accepting people living with HIV/AIDS as patients – although this acceptance came with a price.

During the course of the study, we visited KARUNA BHAWAN (rehabilitation centre, where most of HIV people lived) and interviewed a nurse, who was working with HIV positive returnees. She told us that;

> *You know! How HIV-positive patients were marked? Medical files in the majority of hospitals in Kathmandu are theoretically kept in the safe custody of the ward nurse.*

She further added that;

> *Less obvious, but nevertheless stigmatising, practices were seen in every hospital in Kathmandu. In a some hospital, staff reported keeping tubs of disinfectant under the beds of HIV-positive patients in which eating vessels, clothes and linen were soaked prior to being washed separately.*

In the course of the study, numerous examples were given by social worker where medical and nursing staff breaking the confidentiality of an HIV-positive diagnosis and telling family members and relatives before the patient herself. A woman interviewed in Rehabilitation centre revealed the following:

> The doctor didn't inform me. He informed my mother and asked her to inform me.

There was considerable evidence that once the news had reached relatives the outcomes were far from supportive. Young women in particular reported being blamed and rejected by in-laws and other family members. Men were dealt with far more supportively and positively. 35 years old *Maya's* story clearly shows the high discrimination for HIV positive women. *Maya* was returned to Nepal on 1995 from a Bombay brothel and got married on 1996 with a Nepali man. Unfortunately, both were HIV positive and her husband died on 1999. After her husband's death she moved to rehabilitation centre and she was living in rehabilitation centre. She explained her feeling with us:

> *My in-laws blame me for their son's death. They have severed all relationships with me. They never discriminated with their son but to me they say, 'You also have AIDS. Stay happily wherever you are.' I took great care of their son – never felt dirty cleaning him up. But they always say 'You married him and our son got bedridden'. I have lost faith in everybody. So I left my home and came in this centre...*

HIV positive returnees were not only stigmatised from health workers, quite often they were discriminated by social workers and rehabilitation centre. In the case of less-educated or economically poor women, other family members might be informed first so they could help explain the situation to their relatives. Sometimes worker (counsellor) in rehabilitation centre argued that this was done so as to protect the woman from shock and possible self-destructive behaviour. As a worker in rehabilitation centre explained:

> The patient, as it is, is half-dead. If he is told of the test results, she might commit suicide.

A HIV-positive interviewee reported experiencing strong pressures to keep their serostatus secret within the rehabilitation centre. The shame of admitting to colleagues and friends that you have HIV, coupled with the perceived likelihood of being dismissed on discovery, combined to silence the majority of respondents. As one HIV-positive 23-year old woman put it:

> You know how the society is..... They want your reputation to be sullied. I know if my HIV status comes to be known to them, they will call me names, laugh at me, jeer at me, and I'll have no other option than to commit suicide..... I shudder at the very thought. I do not want to go any hospital now.. if I go to

hospital they take by blood and test it again then they will tell everybody..... I will die anyway.. so... why should I go......

Sometime women with sexual health problems felt stigmatised by these problems. A woman described the emanation of vaginal discharge as being a cause of her low self-esteem. We found that returned trafficked women and girls were suffering from double stigma. Returning from an Indian brothel is one stigma and suffering from STIs or HIV/AIDS is another stigma.

6. Therapy Management

The factors outlined above indicate how patients make decisions about which services to use. This is a relatively straight forward process, especially in a context of enormous service availability. The following section describes the far more complex process of 'therapy management', that is, the process whereby women define and negotiate illness and its pharmaceutical management.

Observations in the rehabilitation centre, illness narratives from returned trafficked women and discussions with service providers revealed that the most problematic aspect of quality service provision was not only services utilisation but also the correct pharmaceutical management of illness. Different problems were identified on therapy management. Among them the major problems were: women and girls would switch services in the middle of treatment ('shopping for a cure'), would follow dose schedules erratically (partial or incomplete doses), would cease treatment as soon as symptoms resolved and would prescribe incorrect treatment from the service providers.

We noticed that many women change the health care providers more frequently. The main reason reported by women for changing healthcare providers was not obtaining relief as women expected.

'my healthy body the doctor has made sick. I couldn't get up from my bed and my head is spinning. He was trying to kill me. I had to go straight to Dr Thapa... and he gave me these 'small' capsules and now I am better.'

Other reason for changing the health care providers was referral by one provider to another, usually changing over to a female provider from a male

one. When we asked the following questions to 25 years old *Goma,* she replied to us that;

Q. Why and when did you change over to the other providers?

A. He is a male doctor. He just gave me medications. He told me to go to a lady doctor (gynaecologist). He said go to any hospital you want to but go to a lady doctor (gynaecologist) and have a check-up (vaginal examination).

As consumers within a medical market one expects patients to make choices according to locally defined criteria. Thus, it is not surprising if patients who are dissatisfied with one service seek help elsewhere. A major course of this dissatisfaction, particularly among these marginalized groups, was found to lie in a discrepancy between practitioners' and patients' expectations of allopathic medicine in terms of efficacy and speed of cure. Women had extremely high expectations of allopathic doctors and their medicines. The fast action of antibiotics with certain conditions was extrapolated to cover all acute ailments and patients where disappointed if recovery was not immediate.

Expectations were particularly high in cases of pain and fever (where medicines may work temporarily to ease the symptoms but 'cure' may take longer). We observed many cases of patients waiting just one day before seeking out another practitioner because the other's "medicines were not good". Doctors were thus placed under tremendous pressure to achieve instant cure if their clientele were to be retained. Observation of medical records, particularly private prescriptions, showed that this led to clinically irrational prescription practices, either by recommending multiple therapy regimes to cover all possible causative ailments (a form of 'market led' syndromic management), or resorting to use of expensive, powerful, broad spectrum antibiotics as a first line of treatment. Such treatment strategies had to be balanced out against the need to make prescriptions affordable, as high medicine costs meant that patients generally only selected for purchase the drugs they could afford (not necessarily the most medically crucial ones) and ceased treatment as soon as symptoms resolved. Therapy management in the private sector was thus characterized by a vicious cycle of over prescription and under treatment.

Another problem encountered by health workers was the patients either did not take all the prescribed medicines or stopped taking their medicines as soon as symptoms eased. A health worker described his dilemma as follows:-

Women often do no complete the whole course of medicines; they may take just half the amount, or they may take it for one or two days and then stop. I only prescribe enough for one or two days because I know they wont' take any more. The other thing they do is to choose one or two medicines from the list - sometimes they take only the pain killers. Then, if the condition gets better they won't come back, and if it doesn't, they go to another doctor - this happens a lot.

While I was interviewing one CSW, she showed all her prescription and medicine. She had been treated for Non-Specific Urethras the day before and had been prescribed Norfloxacin for 5 days (which does not concur with syndromic management guidelines, according to which she should have been given a dose of Norfloxacin and 10 days of Doxycyclin). After just one day she claimed she was cured and she stopped the rest of medication. Next day she went back to her doctor to ask her money back for the remaining tablets.

During the course of study, six main factors were identified as influencing use of complete medicines. They were: anticipated speed of cure, cost, experience of side effects, a belief that medicines were inherently harmful, alcohol consumption and lack of knowledge about the importance of complete treatment.

Cost of medicine was a factor in early cessation of treatment and in adopting partial treatment regimes as described in the above quotation. Before purchasing medicines, it was common for patients to consult with the chemists and druggists in the medical shop to ascertain which medicines served which purpose at what cost. Unfortunately, this might lead to a patient purchasing a cheaper painkiller in preference to an expensive antibiotic, not realising that the antibiotic was the crucial drug in terms of cure. Medicines were usual purchased on a daily basis. Any tablets left over were saved for future self-treatment in case a similar problem recurred.

Cost was not the only factor affecting treatment compliance, as patients who had received all their medicines free were still highly erratic with compliance. Unpleasant side effects associated with certain medicines

contributed to early cessation of treatment. We found that patients were generally not prepared during a medical consultation to expect some adverse effects and thus viewed any symptoms with great alarm. A view that all allopathic medicines were powerful but harmful and should not be taken long term was prevalent. This belief, pharmaceutical action, was reinforced by the experience of side effects, though there was a general expectation that any tablets, including multi-vitamins would cause adverse effects. Medicines were to counteract this effect. Distress associated with side effects was usually expressed in the idiom of 'head spins' and 'weakness'. A woman told us that;

> Oh my God, again tablets - don't give me too many tablets. ....anyway I am weak and this will make me even weaker.

A woman showed her prescriptions and told us about her experience;

> *I do not need all these medicine for my simple headache. Look! It is more than by Khaja (breakfast). So I just took some.* (She had been given Cotrim (Cotrimoxazole), anti-histamine and multi-vitamins for her sinusitis, but she was taking only multi vitamins).

Complaints of side effects were particularly strong in the case of multiple therapy regimes. Expectations of side effects were raised if patients though the dose was high or if many tablets were given. Thus, patients would generally prefer one 500mg tablet to two 250mg tablets. Women had feeling that medicine in syrup form has fewer side effects than tablets and capsules. Similarly, injection is more 'powerful' than others.

We also encountered a belief (traceable to ayurvedic theory) that medicines act differently with different people according to their constitution. Thus the same medicines were thought not to 'suit' everyone. Assumptions about the specificity of allopathic medicines also led to the view that different medicines must be given for different conditions.

We found that alcohol use is common in returned women particularly in sex workers. Alcohol affected treatment compliance among the CSWs in three ways. First it could make treatment highly irregular as women forgot to take doses at the correct times. Second, there was a belief that that alcohol and allopathic medicines did not 'mix' and that it would be especially harmful to combine the two. However, beer (as opposed to spirits and home made liquor)

was not generally classified as 'alcohol'. Thus on being advised to refrain from alcohol, women would often ask if it was still alright to drink beer. Third, Alcohol consumption was a particular problem with conditions requiring Metronidazole (drugs which is commonly used for treating many gynaecological problems). Treatment of gynaecological problems/STIs among women who drank heavily was extremely erratic and usually only partial.

> *Radikha* is a CSW who had a long history of chronic PID (3 years). She described how she had recently lifted a heavy bucket causing her pain to worsen, and she also had fever. She went first to a public hospital and doctor prescribed medicines for 10 days. She took those medicines for four days and they helped a little but the pain was still there. Her friend advised her to attend another private clinic and she agreed. She went to private doctor and bought other medicine from there. Two days later she still had not started her course because she said she had been drunk the whole time and had been with customers. She then took three days worth of medicines over six days because she forgot to take them at the right time. Her pain was slightly improved and she was reluctant to continue with the course, but was counselled and given another two days medicines. She did not return for the rest until a week later saying again that she had had trouble in her house and had bought alcohol to lift her spirits. The pain had suddenly become worse again. She complained to us that the medicines had not helped and had made her very weak. She was planning to find a 'big' doctor who could 'catch the disease.'

This case study describes *Radikha's* response to an acute episode of pain. Examinations of her medical records showed that this was one of many such episodes in a long history of PID. There were many women and girls like *Radikha* in the rehabilitation centre and community for whom many constraints combined with cultural understanding of medications as harmful to produce a pattern of therapeutic management. The problems patients experienced with taking their medicines led to the development of chronic disease cycles where the patient alternated from acute exacerbation's (for which formal treatment was sought), to becoming asymptotic (in which case any medication was immediately stopped), to experiencing moderate symptoms (which were usually managed at home).

Home management for chronic symptoms cantered around pain killers and antispasmodics purchased directly from medical shops. Alternatively, if the problem was a recurrence of a previous disease, women sometimes dealt with it themselves by purchasing medicines from old prescriptions that had been

effective in the past. Even with acute exacerbation's where treatment was immediately sought, prescribed medicines were rarely taken for more than 5 days. Culturally specific understanding of body and the diseases seemed to play an important role in terms of treatment of choice and health seeking behaviour. Such understanding did affect these women's responses to prescribed treatment, in that they aimed to minimise the perceived harm and imbalance that these powerful medicines might cause.

7. Discussion and conclusions

We found that awareness on sexual health issues, particularly about STIs, and HIV/AIDS was poor among the returnees while they were in India but awareness level was relatively good after staying in a rehabilitation centre in Nepal. This is mainly due to counselling and training in rehabilitation centre (ABC Nepal, 1996) and extensive media campaigns in the whole nation (Aryal *et al,* 2002; Neupane and Nicholas, 2002; Mehta, 1998). The other reasons could be the age, time and development factors. It means that most of women and girls we interviewed were trafficked to India in the early 1990s and returned in mid 1990s, mostly in 1996. At the time of trafficking, there was not much condom promotion and other health education programme in India. Since HIV/AIDS became epidemic in India and Nepal, both governments, NGOs and INGOs have started their activities among sex workers and other risk groups. Which should have positive impact to improve the knowledge and reduce the high-risk behaviour.

The CSWs in Nepal seemed to be somewhat better off than in India. In Nepal they lived in their own houses in the villages or cities, moved freely across Nepal. In India, they lived in brothels and had no freedom of movement. Additionally, while the CSWs in Nepal kept most of the money received, those in India had to give it to the brothel owners. On health level, the CSWs in India were at a much greater risk than in Nepal. This finding is contradictory to previous finding by New Era (2001). I argue that sex workers (particularly trafficked from Nepal) in Indian brothel were at greater risk than sex workers in Nepal. There is enough evidence to make this argument. This does not mean that sex workers in Nepal were not at risk. The problems of condom use with

regular partner were reported in this study. This finding suggests that sex workers in Nepal were also at risk from their stable partners than from casual encounters with whom safer sexual practices can more easily be negotiated. Sex within a regular and long-term relationship takes on meanings and obligations that existed far beyond the fulfilment of physical ness alone. For this reason this study suggests that strategies aiming to encourage use within such relationships maybe unworkable, especial in cultural contexts where women have little power to discuss or jointly negotiate condom use (Mane and Maitra 1992).

The Nepali sex workers in Indian brothels are powerless to negotiate any terms of sex in order to protect themselves from HIV infection. They have virtually no say over whether or not to "service" a particular customer, how many customers to accept in a given day, condom use or the type of sex, much less payment. Young girls, some only thirteen or fourteen years old, may be particularly at risk. Not only are they often too intimidated even to attempt to negotiate the terms of sex, but preliminary medical research suggests that the younger the girl, the more susceptible she may be to HIV infection for physiological reasons.

Though further research on factors affecting condom use within different sexual relationships is required, our findings concerning the difficulties encountered by women in negotiating safer sex and the resultant need to target men as a priority have been documented in studies worldwide (Schoepf, 1991; Holland *et al*,1992; Mane and Maitra, 1992).

Previous studies have shown that certain aspects of gender relations in Asia and elsewhere may render women in general, and CSWs in particular, especially vulnerable to STIs and unwanted pregnancies (Holland *et al*, 992; Mane and Maitra, 1992; Schoepf, 1991). This study also reported that social and gender relations within different settings may affect women's ability to negotiate safer sex and seek health care on time.

Women in our sample pursued treatment for sexual health problems and ceaselessly visited various types of healthcare providers. These women belonged to an urban population and this may have influenced the health-

seeking behaviour pattern of invariably consulting chemist and druggist in medical shops first. However, after the initial contact, the type of healthcare provider subsequently consulted varied, and women also consulted providers from alternative health systems, such as ayurvadic and traditional healers. A distinction was evident between treatment sought for acute and chronic disorders, in that ayurvadic was sometimes used for long standing ailments such as menstrual irregularities, but generally only after a lack of success with allopathic.

Another issues emerged in this study was the stigmatisation and its effect on health seeking behaviour. Clearly, many factors underpin the forms of stigmatisation and discrimination described above. Many of these relate to the very real fear of HIV/AIDS that exists among both the general public and professionally qualified health care workers. The sources of these fears are complex and include lack of knowledge and understanding, as well as the manner in which AIDS has been reported in the national and local media (e.g. as being highly "contagious" when in fact it is not). Other causes of stigma and discrimination have their origins deep within Nepali culture and the manner in which "sexual wrongdoing" is popularly understood.

Others issues, particularly those within the health care setting appear to relate both to lack of knowledge about HIV/AIDS, its routes of transmission and means of protection, as well as to local beliefs about infection through closeness and proximity. Long-standing ideologies of gender that result in women being blamed for the transmission of sexually transmitted infections either directly as the supposed "vectors" of transmission or indirectly through failing to "satisfy" their husbands influence the ways in which families and communities react to the seropositivity of their members.

Although research into "health-seeking behaviour" entails a focus upon practices aimed at the restoration of health, applied studies have tended to focus on identifying culturally specific ideas about illness, in the assumption that these determine the nature of treatment sought for different complaints (Kendall et al., 1984; Scrimshaw and Hurtado, 1987; Bentley et al; 1990; Pelto et al., 1990; Nichter et al., 1994). In this way indigenous notions of health are

implicitly taken to be self-evident (given a bio medically oriented view of health as "absence of disease"), or are assumed to be unimportant with respect to treatment-seeking decisions. Our findings, however, indicate that indigenous understanding of health, on the hand, and socio-economic circumstances, on the other, constitute more salient determinants of sex workers' therapeutic strategies than their ethno medical beliefs about particular illness categories.

The pragmatic orientation, which was observed towards therapy among returned women and girls, was related to their conception of health. This conception, in addition to being considered in terms of balance, was also defined from a highly functional perspective related to the exigencies of everyday life, for which women needed to be strong and fit to keep going. As a result, therapeutic alternatives tended to be selected and evaluated largely in terms of their speed and effectiveness in restoring ability to carry out daily tasks (or at the very least not causing further weakness), rather than in relation to their perceived appropriateness for a particular health problem. These concerns can be illustrated with reference to women's worries about the potentially harmful effect of medications. When discussing medicines women never said, "this medicine makes me feel ill", but rather evaluated their effects in functional terms:

> Dr X's medicines almost killed me; I couldn't get up from my bed.
> This made me so weak; I couldn't do my work.
> I don't like taking medicines, I have so much work to do....

Thus, health-seeking strategies appear to be more closely related to general conceptions of the nature of health under particular material conditions than to ethno medical illness classifications or aetiologies. This suggests that the predominant focus on the latter in many applied studies of health-seeking behaviour (and particularly in those using "rapid" or "focused" methodological approaches) may be misleading. While documenting ethno medical "beliefs" and illness taxonomies may be extremely useful for certain purposes (such as improving communication between health workers and patients, or modifying health education messages to fit with local perceptions), understandings of health-seeking which seek to relate behaviour deterministically to underlying culturally embedded "beliefs" must be viewed with caution.

Affordability or cost was major determinants in the use of health services in general population in Nepal (Simkhada, 1999; Niraula and Morgan, 2000) and other countries (Thomas and Pechansky, 1984, Evans and Lambert, 1997; Bhatti and Fikree, 2002). Interestingly, anticipated cost or affordability was not major deciding factor in the choice of health care for these three groups, particularly among CSWs. Major deciding factors were privacy, satisfaction and lay rather than professional networks of referral to services. Another factor that affects access and utilisation is the hours that the care is available. Service hours in Nepal are determined by the provider and not by patients, the most convenient time for patients to obtain care may be very different from the time that is acceptable to providers.

Returned trafficked women preferred more private services than the public services. The quality of public services has often been neglected in developing countries. While some attention is given to technical qualities, the interpersonal components of the quality of the services are generally ignored or underestimated by planners (Haddad and Fournier, 1995). Satisfaction is an important element of the quality of health care, often determining willingness to comply with treatment and influencing the effectiveness of care. However, few specific assessments of patient satisfaction in the Nepal have been undertaken. Patient satisfaction, a component of quality of care, has been given high priority in developed countries. Fitzpatrick (1991) cited three reasons for the importance of patient satisfaction: it determines compliance with recommended treatment and influences patient choice of provider; it is a measure of patient involvement in decision about care; and it can be used to choose alternative methods of organising and providing health care.

The major problem for appropriate treatment of sexual health problems particularly sexually transmitted and gynaecological disease identified by this study was that of 'therapy management'. This includes non-compliance with dose scheduling during treatment regimes, early cessation of treatment once asymptotic and switching services in the middle of treatment. Such patterns of 'therapy behaviour' (associated with local understandings of allopathic drug action, the experience of unpleasant side effects and cost) have potentially serious implications for women both in terms of the risk of developing chronic

upper reproductive tract infections that exact a high price on quality of life, and of encouraging the development of drug resistance. Women in the study were generally unaware of the potential long term consequences of erratic use of medicines. The finding or a general lack of compliance with treatment lasting more than approximately 5 days also poses problems for syndrome based management of STIs which currently recommend medication regimes for a minimum of 10 days (unless a definitive clinical diagnosis can be reached).

The results showed that local understandings of disease and use of home remedies were generally not in themselves harmful, were consistent with syndrome approaches to disease management and did not constitute a serious delay to treatment seeking for acute illness. Thus it is suggested that women's perceptions of reproductive or sexual health disorders and existing indigenous knowledge could be used as a basis for developing culturally appropriate educational tools that encompass simple explanations of allopathic drug action and the need for proper treatment compliance.

A feature of much ethnographic research of this kind is that the restriction of date collection to one small locality severely limits any claims to representatives that can be made. As this was a small study examining an under-researched topic however, I consider it appropriate to have focussed on depth and detail in order to raise issues, which can be followed up in future larger scale research. As a result, the findings should be viewed as strictly suggestive and require substantiation in other contexts. All attempts were made to maximize validity of the results by means of triangulation (use of multiple methods with multiple informants) and by constantly checking the results with the respondents to clarify and areas of ambiguity. Although the results cannot be generalized without extreme caution, it is significant that striking similarities may be observed with the results of previous studies in South Asia with respect to treatment seeking behaviour (CINI, 1994) and therapy management (Nichter, 1989; Kanani, *et al,* 1991; Mull and Mull, 1994; Stewart *et al,* 1994; Bhatti and Fikree, 2002) in which general preferences for the private sector, 'shopping for a cure' and problems with treatment compliance have been documented. Women's understanding of the action of allopathic medicines was found to be an important determinant of treatment

patterns, but a number of questions, especially in relation to home management of acute and chronic problems, remain unanswered. Other findings, for example with respect to women's understandings and categorization of gynaecological disease, need validation in other settings.

CHAPTER SEVEN

CONCLUSIONS AND IMPLICATIONS ON POLICY AND FURTHER RESEARCH

1. Introduction

This final chapter summarises the main conclusions to be drawn from this research project and includes thoughts and ideas about my own learning from engaging in research, as well as considering the finding and their implications for policy and research. It is intended to cover the main points from my own personal perspective, which highlights the priorities as they appear to me at this point in time.

2. Conceptual clarification and approach

A great deal of trafficking prevention work is currently being undertaken in Nepal. The present study found that there is still a need for conceptual clarity to be developed on trafficking among some of the NGOs and by implication, among the donors who fund them. Interventions that fail to distinguish between trafficking and both sex work and migration and those that take a welfare approach may inadvertently compromise women's rights and may not address the reality of their lives (in particular, the need to migrate due to poverty or to escape intolerable home situations). In addition, they may also inadvertently fuel the social stigma against sex workers and those living with HIV, and may make reintegration of returned women more difficult than it already is. Lack of conceptual clarity affects all phases of a project, including monitoring and evaluation.

Conceptual clarity is needed in both policies and interventions on trafficking in particular, in its relation to migration and sex work. Adopting a human rights framework and basing interventions on sound research may help to clarify current trafficking discourses. A clearer international definition of trafficking in women is required in order to facilitate the prosecution of traffickers and to permit the extradition and

Conceptual clarity is an important element of a comprehensive and consistent response to trafficking

prosecution of traffickers in third countries. I would suggest that there is need for a stronger international legal instrument in order to combat trafficking in women and girls.

There is a need to move from a paradigm of rescue, repatriation, and rehabilitation to an approach that protects and promotes the human rights of women both in countries of origin and destination. Certainly, some women and girls are traumatised by their experience and may require care and support services. However, an analytical evaluation of the problem in several countries and an assessment of the lessons learned teach us that only "rehabilitation" is not what women need. Instead, they need support and sustainable incomes.

Anti-trafficking strategies must shift from paternalistic approaches to more holistic and participatory approaches.

Anti-trafficking strategies must shift from paternalistic approaches that seek to "protect" innocent women to more holistic and participatory approaches that seek to protect and promote the human rights of all women including their civil, political, economic and social rights. An emphasis on promoting human rights and promoting safe migration may help to overcome some of the ideological differences (particularly with respect to sex work) that currently divide the field. Women and girls need to migrate and migration can offer considerable development benefits to them and their families. However there is a need to equip women and girls to deal with vulnerabilities and risks that accompany migration. We need to understand the migration agenda of the poor and we need to work with women and girls to empower them in migration. Such an agenda for action would not subvert all trafficking harm but it would address many of the harms. Such a development would also require NGOs to listen to women and girls and develop pro-poor migration programmes that reflect the priorities of women and girls

Documentation and follow-up of "rescued" and "intercepted" trafficked women and girls, including those who do and who do not return home to their families, and those who are HIV positive is needed. Again, this would help develop a better understanding of vulnerability and is important to inform and refine care and support strategies.

Evidence from this research and from experience in other fields suggests that interventions that work from the bottom up, involve communities, build

capacities and aim to establish systems (e.g., women's groups) for providing support and taking action appear to hold greater promise for action and sustainability than top-down interventions that are characterized by one-time sensitisation programs. Likewise, interventions that are empowerment-oriented and that, through a process of dialogue, aim to facilitate informed decision making (e.g., on whether or not to migrate), are more likely to be relevant to community realities and to be accepted by target groups than those that are welfare-oriented and paternalistic in approach (telling people what is best for them). Interventions that aim to empower women and girls who have been trafficked, and that do so through an empathetic and dialogical process of counselling, and that offer a variety of future options (including non-traditional ones) appear to show the way forward for care and support (although implementation is acknowledged to be extremely difficult in the South Asian context). These interventions include supporting and encouraging trafficking survivors to be actively involved in gender rights programs and offering training and career options that raise self-esteem, build confidence and offer opportunities to break away from traditional gender stereotypes to enable a process of independent living.

Policy and legislative interventions must make clear distinctions between migration and trafficking. Simply controlling migration will not curb or prevent trafficking. The open-door agreement between Nepal and India should not be altered. Stricter border controls, such as instituting a passport system or more stringent border surveillance, will stop neither trafficking nor migration.

It is important to keep in mind that the causes of trafficking can not be reduced to poor economic conditions and ignorance only, but are related to a complex mixture of local and global structures concerning economic, political, socio-cultural and historical processes. In receiving countries, preventative measures often focus on the prevention of illegal immigration. Yet, as Battistella and Asis (1999) noted, this also requires coherent economic and political objectives, while as long as economic factors continue to attract migrants, policies aimed solely at combating or restricting irregular migration will fail.

As set out in its National Plan to Combat Trafficking, His Majesty's Government of Nepal (HMG/N) must fulfil its commitment to repeal all laws that discriminate against women. This may require the government to adopt specific measures for women that are consistent with the equality provisions in the Nepal Constitution. Consistent with its international commitments, HMG/N must ensure that anti-trafficking interventions do not subject trafficked persons to discriminatory treatment in law or practice because of gender, race, colour, sexual orientation, age, language, religion, age, cultural beliefs or practices, social origin, property, birth or other status, including their status as victims of trafficking or having worked in the sex industry. Some current laws and policies in Nepal do not actively follow the principle of non-discrimination and include punitive measures for women who work in the sex industry either consensually or non-consensually.

The definition and understanding of trafficking vary between key stakeholder, law and policy documents.

3. Causes and context of trafficking

Women and girls from all castes and many ethnicities are in this trade. However, there is certain age group of women that are trafficked most and there are certain areas, which have the highest prevalence rate. These demographic characteristics might serve as feedback to policy making bodies to adopt some sort of preventive measures. This study clearly illustrate that some trafficked girls come from difficult or dysfunctional family environments. Poverty, lack of employment opportunities, lack of education, and a lack of awareness among the general population and abuse in migration are usually seen as important causes for trafficking. Initiatives for the prevention of trafficking therefore usually focus on awareness-raising campaigns, skills training and education programmes and income-raising activities. Prevention initiatives aim at warning people about the risks of trafficking and inform them about the possibilities for regular migration. These programmes can have an important impact on target groups by raising awareness about trafficking. But information campaigns also have to reach out to target groups in rural areas where there is little access to the mass media and where the risk of trafficking is often especially high.

HMG/Nepal has focussed its anti-trafficking interventions in 19 "key districts" assuming that most women and girls are trafficked from these key districts. But my study found that women and girls were trafficked from 37 districts. Some districts (other than the key districts) have higher prevalence rate than the key districts. There are also several districts in Nepal, as this research has shown, which have not yet implemented anti-trafficking information campaigns.

This identified the fact that trafficking prevention takes place within the context of overall community economic and social development, especially in rural communities. This is a long-term process in which trafficking-specific indicators or outputs may be difficult to identify. In addition, NGOs may require further assistance to develop appropriate evaluation methodologies (some of which will require long-term follow-up) and carry out baseline and follow-up measurements of indicators.

4. Care and support for trafficked persons and preventive strategies

In the provision of care and support programmes there is a need for monitoring the number of girls who are "rescued" and the number of rescued girls who return home. There is a need for long-term follow-up of trafficking survivors as part of an overall evaluation to assess the appropriateness of current strategies and to develop better ones. In addition, evaluation of each component must be carried out, including individual and family counselling programs, family assessment strategies, skill training/income generation activities, follow-up strategies for girls who have returned home (to potentially difficult circumstances), and the appropriateness of current care and support for HIV positive girls, especially those in the AIDS hospice. It is not known how many trafficked persons return without NGO assistance and what type of reintegration strategies they employ. There is evidence that some women decide to settle in urban areas, setting up small businesses or, if they are sex workers, staying in the sex trade directly or indirectly as madams or brokers. Other anecdotal evidence suggests that women from communities where sex work is a common practice may find it easy to return home where they may marry and/or set up small businesses (Bhatt, 1996). Further research on the

coping and livelihood strategies employed by trafficked women would assist in development of more effective and meaningful reintegration strategies.

Many of the messages in the education materials reviewed are fear-based, highlighting the suffering due to sex work and HIV infection. Most of the messages are prescriptive and tell women and girls what is good for them. This has been shown to be ineffective and sometimes generates resistance from local populations or drives the problem underground. Other researchers such as Brandt (1988), Walkowitz (1980), and Asia foundation/Population Council (2001) have made the same conclusions. Furthermore, this approach does not provide any help or suggestions for women and girls in difficult circumstances. Information, Education, and Communication (IEC) messages should be based on an informed understanding of local migration processes or on community needs and priorities. They need to be realistic and relevant and should include concrete relevant advice on how to migrate safely. There is a compelling need for interventions that actually empower women and girls in migration rather than seeking to protect them. There is also a need to establish support systems to enable safe migration and to help women once they are in the cities.

An emphasis on women's empowerment, community development, conditions at the work place and safe migration appears to hold the most promise in terms of promoting the rights of women and girls and realistically addressing their needs. Of these, a focus on safe migration in particular seems to be of utmost significance. In this respect, organisations currently restrict themselves to warning women about the dangers of trafficking or giving limited advice on how to protect themselves (e.g., "note the address of the workplace"). This advice alone is unlikely to prevent trafficking. Interventions should consider developing other mechanisms to protect women who want and/or need to migrate. These programs need to be based both in rural areas (where most organisations are currently active), and in city work places since these appear increasingly to be used as trafficking transit points.

The experience of key informants (NGOs) and returned trafficked women and girls show that care and support cannot automatically be equated with

return to the family or community. This raises the questions of, where appropriate, how a return to the community can best be facilitated and, if inappropriate, what to do for girls who are unable or unwilling to return. The best approach for family reintegration is still unknown. More research and resources are required to determine the situation of returned girls and to determine the most effective strategies. This includes assessing the nature of support that NGOs or other agencies require to most effectively help women and girls in need. Current strategies are developed from a welfare orientation in which girls are given traditional skills, told what to do, and the only option presented to them is to return home or remain in residential care.

Care and support efforts are not well co-ordinated among the various actors at the governmental and NGO levels in Nepal.

Interception and repatriation efforts are not well co-ordinated among the various actors at the governmental and NGO levels. However, recent efforts by several NGOs in Nepal have led to the creation of national and regional anti-trafficking networks. These efforts are limited by the lack of resources and mutual co-operation.

Protection initiatives have focused on those who are within a potential trafficking situation as well as those who have come out of a trafficking situation. Most of the protection services, such as shelters, health care, counselling, education and training are focused on prostitution and are usually concentrated in urban areas. Insufficient services, lack of resources, capacities, and coordination and cooperation between the various services have limited the effectiveness of protection strategies. Furthermore, the marketability of certain skills or initiatives provided within vocational training and credit programmes, have not always been taken into account.

Initiatives focusing on the return and reintegration of trafficked persons are relatively new. Considering the larger estimates of numbers of trafficked persons, especially women and girls, and the lesser number of assisted returns, one may conclude that most somehow find their way back on their own. If trafficked women and their advocates are correct in their estimates, the number of known victims represents only the tip of the iceberg. Hardly any statistics are available on the extent of trafficking in women, partly because it is

an illegal activity and, hence, difficult to assess, and partly because those agencies which might compile statistics do not regard the practice as important enough to warrant collecting data. Trafficking in women receives considerable media publicity, not so much because of concern for the welfare of victims, but because journalists know that stories about sex and prostitution attract attention.

The legal and constitutional rights of socially and sexually stigmatised communities, including those who are HIV positive or engaged in sex work need to be protected. Protecting and ensuring their legal rights are important and essential steps in countering the social stigmatisation and marginalisation and creating viable ways to exit sex work. Withholding protection to stigmatised communities from constant harassment by law enforcers and exploiters in the sex industry will further dis-empower these women, their families and communities.

HMG/Nepal should move beyond an income generation approach for the prevention of trafficking. This approach is not an adequate substitute for people seeking better economic opportunities in the city or across borders. In addition, anti-trafficking programs should provide viable economic alternatives to women who have chosen to leave prostitution. These programmes must meet the needs of the individual woman as well as her family. State support, including legal rights that are available to all other families should be made available to mothers and their children, regardless of their work.

This research also suggests that the care and support of rescued girls is a difficult and long-term process complicated by high levels of stigma directed at trafficked girls. NGOs engaged in this work require technical and financial support to develop systematic techniques for family assessment, counselling, intervention, and follow-up. Particular help is required to develop appropriate plans for girls who cannot return home, particularly in the area of sustainable livelihood development. There is an urgent need to develop strategies for the reintegration of HIV positive returnees. In particular, one current strategy of segregating HIV positive "rescued" girls in a home in a remote district requires careful evaluation.

Though a great deal of trafficking-related work is being done, most interventions have not been systematically documented or evaluated and on-going monitoring of programs is absent, ad hoc, or is insufficiently rigorous. Hence, at this stage, it is not possible to make informed judgments of an intervention's relative efficacy or sustainability. There is an urgent need to support NGOs to develop appropriate monitoring and evaluation mechanisms. Some formative research may first be required to develop appropriate process and impact indicators. Thorough documentation and sharing of experiences would greatly help to identify lessons learned and to build up a better understanding of which approaches work/do not work and why. This may be particularly useful for care and support strategies.

Research on the livelihood and coping strategies of other sex workers and female migrants who have returned to Nepal is very crucial. This would help to inform care and support strategies. Furthermore, operational research to determine appropriate and effective strategies for both the prevention of trafficking and the care and support of trafficked persons is necessary. Experience indicates that research specifically on trafficking is best conducted by NGOs those have a strong field presence and that have built up trust in their target communities.

Working with children and young people through schools, teachers or child clubs appears to be an innovative anti-trafficking strategy. Peer support/influence is harnessed and the groups/clubs may act as neutral for a where children who are experiencing family problems can seek help. Involving trafficking survivors is another promising strategy. Their involvement may be useful in two ways. First, they can make anti-trafficking messages more realistic and relevant to particular target groups. Experience in other fields has shown that people are more likely to identify with peer-led education rather than that given by social workers. Second, their involvement can also play an important part in the rebuilding of their own self-esteem and confidence, and may act as an important capacity-building opportunity.

The problems of trafficking in women and girls cannot be solved by one country alone. It should be dealt with at regional and international level. In

many countries of South Asia, there is a lack of authentic data on the issue of trafficking. More studies must be undertaken to fill up this information gap. NGOs, activists, journalists, parliamentarians and different segments of the society, in both sending and receiving countries, must make efforts to organize themselves to deal with this issue. One's government must ratify as well as enforce international conventions on trafficking.

The media can play a very important role in sensitising this issue. Information related to the trafficking of women should be provided to the mass media, including, radio and television, on a regular basis. While most of the trafficked women and girls were non-literate, education given by print media like newspapers, magazines would be ineffective. Further more, there should be a programme of media activity in which reporting of trafficking and its consequences from both places of origin and operation are collected and disseminated to convince people from at high level decision making to the grassroots. Government and non-government organisations should work together with media. Information campaigns should alert the general public and officials coming into contact with migrant women about the nature of the crime of trafficking. At present, the police are almost solely responsible for identifying victims of trafficking. More effort should be made to encourage others, such as clients, doctors, lawyers, social workers and the women themselves to report trafficking. Victims are less likely to come forward whilst they fear an unsympathetic response from the police and social stigma.

All stakeholders agreed that a primary aim of care and support should be to reunite girls with their families and communities. All acknowledged, however, that this was difficult and that in certain circumstances it was neither possible nor desirable. This study noted that, given the stigma associated with sex work and with HIV in Nepal and the increasing publicity (often by the NGOs themselves) given to the link between working in India and having HIV, communities may refuse to accept girls back when their history is known. Families themselves may also be reluctant to take girls back, fearing social censure or ostracism from the wider community. In addition, families may (with some justification) worry that any loss of prestige would affect the marriage chances of other children. They may also fear retribution from the broker from

whom they may have received money. The girls themselves may worry about the extra burden they will place upon their parents, especially if they are HIV positive or if they are unlikely to marry subsequently, and be reluctant to return home.

The present situation in which these girls must face a lifetime in residential care is clearly unacceptable, though the NGOs are doing their best. Undeniably, it is extremely difficult for a young, poor, single woman to forge an independent life for herself in the South Asian context. However, NGOs in other countries have considerable experience of supporting women and children in such situations and may have important lessons to share. For example, these include providing useful (non-traditional) training, assisting with job hunting, supporting more independent living (in a hostel or group accommodation), and helping with arranging marriages. There is clearly a need to support NGOs in their work in this area and to formulate a strategy of long-term support for girls who do not return home.

A proper and thorough analysis of the trafficking situation is of essential importance to the development of effective strategies. Kelly and Le (1999) write that "the task of those agencies involved in trafficking issues is to accurately determine what actions are required to be the most effective to stop trafficking. To date no country has actually presented a model of intervention that has been totally effective in stopping trafficking completely. Part of this problem may be because no suitable framework for analysis has been developed on which to approach the formulation of coordinated interventions within a set system." They rightly state that the causes of trafficking, and therefore solutions to the problem, are multi-faceted and should be considered from various levels, including the societal, institutional, community and family levels.

5. Health seeking behaviour and appropriate health services for returned trafficked women and girls

While making any conclusions and recommendation, it is important to note that trafficked women and girls who have returned to Nepal from India but continue to undertake sex work may differ from those who are living in

rehabilitation centre and those who remain in India or resettle in their own communities. Health seeking behaviour cannot be understood in isolation from socio-cultural and other factors relevant to health and sex, including pressures to conform to some moral norm, legal repression of certain kinds of sexual activity, absence of sex education, and poor quality health services in general. In a transitional society where both traditional and modern methods of treatment are used, the choice between them is determined by socio-economic status and belief systems. Use and non-use of the health care facility is highly related to different variables.

Returned women and girls had very poor access to information regarding sexual health issues while they were in Indian brothels. Their awareness level, knowledge and negotiation skills on condom use were also poor. The Indian brothel owners and other concerned authorities were failed to summon the necessary political will and financial resources to inform and educate Nepali women and girls in brothels.

With respect to the utilization of health services, none of the interviewees in this study had utilized government hospital outpatient departments as a first choice of treatment. Their responses indicate a need to investigate quality of care in the public sector as a possible limiting factor on utilization. The popularity of the private medical sector and its widespread use in conjunction with other community-based services as identified in our study has implications for resource allocation and for the further development of sexual health services. A key issue concerns how private practitioners can be more effectively used to promote sexual health. Further study of treatment practices in the private sector and of doctor-patient interactions in targeted communities is recommended with a view to the development of interventions that utilize these popular health resources.

The findings of this study indicate a number of possible directions both for improving services and for helping returned trafficked women and girls sex workers to adopt alternative therapeutic strategies in order to attain the goals of more effective

Privacy, prestige, the lay referral system, a demand for high quality treatment and perceived efficacy of the service all combine with economic considerations to influence choice of service.

treatment of STIs and prevention of HIV infection. However, the study also raises questions about the appropriateness of applied research into health-seeking behaviour, which tends to privilege cultural beliefs over considerations of political economy and disease over health. There is an obvious reason for this predominant emphasis; most such research is, by its very nature, devised in response to difficulties (anticipated or actual) in successfully implementing biomedical interventions, the clinical orientation of which is presumed to be appropriate. Accordingly, in associated social research the study of patient and provider characteristics and local "culture" is privileged over broader social and political economic influences on health. This means data concerning health-seeking behaviour are inescapably located within a biomedical framework, such that findings may be interpreted in relation to predefined conceptions concerning the nature of "health" and the purpose of therapy. As an alternative, I would suggest that a more fruitful starting point for studies of health seeking would be to explore local definitions might affect health seeking behaviour, services utilisation and therapeutic strategies. In addition, a consideration of the interactions between cultural understanding of health and ill health and the particular socio-economic environments in which they are located is required, in order to give due weight to the influence of material conditions upon both strategies for seeking treatment and interpretations of their effects.

In relation to these recommendations, it is worth reiterating the research finding that "health" was not one of the returned trafficked women' explicit priorities. This seems to be a common finding among the economically and socially marginalized groups in other setting (Cornwall, 1984; Graham, 1984; Calnan, 1987). The usual response of planning agencies to a lack of perceived interest in health among a target group is either to seek to "create" a need by fostering awareness of medical treatments, or to address the community's other perceived needs first, as a way of engendering trust and subsequently improving receptiveness to the health intervention. However, the functionally oriented health strategies evident among sex workers in this study suggest that a community's perceived needs and priorities (which may appear to be unrelated to health) are not separable from, but rather are constitutive of, their health-related actions. The very term "sexual health" implies that interventions

directed towards this end should aim to improve health rather than merely to reduce levels of STIs/HIV. With respect to returned trafficked women and sex workers, applied research and interventions that do not directly address the socio-economic context of women's lives may succeed in reducing levels of STIs, but they may have a questionable impact on improving women's health in the longer term.

The very nature of STIs and some of the legal aspects of treating STIs in minors may give the impression of eroding the principle of confidentiality. Confidential matters need to be handled in an environment of privacy. STI services should be seen to provide both privacy and confidentiality. This is especially important for young women. This study clearly indicates that while distance and cost are major obstacles in the decision to seek care, the relationships are not simple. There is evidence that sex workers often consider the quality of care particularly, privacy and confidentiality more important than cost. These three factors, distance, cost and quality alone do not give a full understanding of decision-making process. Their salience as obstacles is ultimately defined by illness-related factors, such as severity. Differential use of health services is also shaped by such variables as gender and socio-economic status. Women and girls who make a timely decision to seek care can still experience delay, because the accessibility of health services is an acute problem in Nepal.

Stigmatisation of those seeking advice about STIs, lack of privacy and perceived lack of confidentiality were the main reasons for not utilisation the health care facilities by sex workers.

Many health problems are further compounded as sex workers find difficulties in reaching friendly services where they could discuss questions related to their actual problem without being worried that confidentiality would not be respected. As a result, their reliance on quacks (Untrained practitioners) for health matters further increased their vulnerability where health was concerned in many ways.

Very often when planners and policy makers think about any intervention programme with sex workers they put a lot of stress on the control and prevention of HIV/AIDS. But what they really need first and foremost is access

to quality health care with sensitive counselling and referral to the support system. Too often, this group lacks these facilities, rendering them up to a life full of danger. Additionally, policy makers very easily label them as bad people. Until this categorisation is done away with, any intervention they design for them will have little impact.

Integration of STI services into broader reproductive health services could enhance their acceptability and effectiveness. Form the above literature it is clear that an ideal health care service for sex workers could have a holistic approach and combine STI and infectious disease screening and treatment, contraceptive services, other general health care and health promotion. In addition, STI control in these settings must compete for resources with other important and less stigmatised health problems. Although funding for STI control has increased as a result of HIV/AIDS control programs, resources are still inadequate and health infrastructures remain weak. Given the urgency of the task at hand, more innovative approaches must be developed and implemented.

Given the limited opportunities for further increasing condom use by targeting women alone, research into health-related perceptions and behaviour of men is thus urgently required for the purpose of developing appropriately targeted interventions/health education. Key questions concern how different groups of men see their roles, obligations, responsibilities and relative risks within different social contexts; how these relate to sexual health practices, especially condom use with different partners; and how these findings can be translated into interventions/messages that are meaningful to different men in differing contexts. In the absence even of baseline information concerning these issues, it is recommended that future research into these issues initially utilize exploratory qualitative methodologies with different social groups from which key areas of importance can be identified, and later operationalised into terms suitable for larger scale use in surveys or interventions.

More information is required on the economics and composition of health care spending in relation to income, expenditure and patterns of treatment seeking and therapy management. The extent to which income actually affects

differential use of services and purchasing of drugs needs to be clarified. The finding that some women were delaying necessary treatment for serious gynaecological problems for which costly surgical or diagnostic procedures had been advised indicates that an important area, about which little is presently known, concerns ability to afford major medical interventions and the impact this has on therapy management.

All services should be provided with an understanding of the specific needs of different sex workers, and the impact of their working conditions on health problems. For example, if a sex worker has pelvic inflammatory disease, routine advice about abstaining from sex for two weeks is unlikely to be feasible, and therefore other options, such as encouraging non-penetrative sex, and an earlier follow-up visit, may be discussed.

The acceptability of services is likely to be greatest when care is integrated into routine health services

STI services in the public sector should be integrated into existing health care structures such as outpatient departments, first-level health care facilities, maternal and child health clinics and family planning clinics. Attention should be paid to ensuring coverage for women, men and young people.

Personal risk may be appreciated by patients and the need for treatment accepted, but without appropriate services patients may not seek treatment. It is important for the STI programme to embark on a campaign of:

- Improving attitudes of health care workers towards returned trafficked women, sex workers and patients with STIs;
- Improving the clinical services and the provision of drugs;
- Making health centres accessible and acceptable for patients;
- Integrating STI services into other health disciplines to minimize stigmatisation. An integrated service that caters for the needs of sex workers along with other population groups will help to de stigmatise STIs.

Stigma originates in societal values and can be increased by institutional systems. STI services for commercial sex workers, for instance, may stigmatise the very people they are meant to serve.

Negative responses in the health care setting (or the belief that there will be negative responses) lead people to conceal their HIV status in treatment facilities for fear of being denied care. Individuals who are sick may also delay seeking treatment until the last moment, harming their own health in the process.

Negative responses in the health care setting can lead people to conceal their HIV status

Because of the social stigma associated with HIV/AIDS and in the absence of legislation and procedures stipulating how people living with HIV/AIDS should be treated at work, many prefer to keep their serostatus secret. This contributes to the invisibility of the epidemic and makes life more difficult for those individuals affected. Occasionally, however, HIV/AIDS-related stigma may trigger more positive responses such as the altruistic actions of those who carve roles for themselves as educators, counsellors and HIV/AIDS activists. Through their work, such individuals may develop a collective identity and mobilize group support that results in a greater awareness of the epidemic and more positive responses towards those affected.

6. Further research on health seeking behaviour

Further research examining the socio-economic dynamics of condom use is required to clarify the key factors affecting usage. Such research is recommended for the purpose of developing appropriate socio-economic interventions that enable women to exercise greater control over their bodies and lives. Local women's groups such as that in the present study constitute potential bodies with which social and economic interventions can be developed, and deserve support as they act as empowering agencies in themselves.

In order for appropriate and acceptable treatment regimes to be developed it is suggested that further investigation of medication usage be undertaken, focused on the following questions: (i) in view of women's humoral understandings of the body, how is the action of allopathic medicine

construed? And at what point do side effects arising from treatment lead to its cessation? (ii) What information (if any) do women receive from health workers about drug action and expected side effects? (And would receiving such information if an understandable way make a difference to treatment compliance? (iii) What are the main factors that influence self-treatment versus resort to an allopathic practitioner? (iv) To what extent does self-treatment mask symptoms and delay health care seeking when used to manage chronic complaints characteristic of PID? (v) Is it possible to develop teaching materials that advise on safe self-treatment measures and management of side effects?

It is clear from this finding that the systematic framework, which is currently available, is not sufficient or appropriate to assess the health seeking behaviour. There is need for well-defined, broad framework to study the health seeking behaviour of particular risk group.

References

Aamodt, A.M. (1989) Ethnography and Epistemology: Generating Nursing Knowledge. In: Morse, J.M. (eds.) *Qualitative Nursing Research: A Contemporary Dialogue*, pp27–40, Aspen Publishers, Inc. Rockville, Maryland.

ABC Nepal (1996) *Red light Traffic: The Trade in Nepali Girls.* ABC Nepal, Kathmandu.

ABC Nepal (1998) *Life in Hell: The True Stories of Girls Rescued from Indian Brothels.* ABC Nepal, Kathmandu.

Acharya, M. and Bennett, L. (1981) *The Rural Women of Nepal: An Aggregate Analysis and Summary of 8 Village Studies.* CEDA, Tribhuvan University: Kathmandu, Nepal.

Acharya, U. (1998) *Trafficking in Children and the Exploitation in Prostitution and Other Intolerable Forms of Child Labour in Nepal: Nepal Country Report* (unpublished), prepared for ILO-IPEC. Kathmandu, Nepal.

ADB (2002) *Combating trafficking of women and children in South Asia.* Summary of Regional Synthesis Paper, Asian Development Bank, Agriteam Canada Consulting LTD.

Adhikari, K. (1996) *Bambaima Dehavyapar: Ek Sarvekshan* (Flesh trade in Bombay: A Survey) in Rajbhandari, Vinayak et.al.(eds.). *Cheliko Vyatha* Kathmandu: Women Rehabilitation Centre, Vol.1 (1), pp16-19.

Adler, P. A. and Adler, P. (1994) Observational techniques. In: Denzin, N., and Lincoln, Y., (eds) *Handbook of Qualitative Research*, Thousand Oaks, CA: Sage Publications, pp 377-392.

Agar, M. (1980) *The Professional Stranger: An Informal Introduction to Ethnography.* Academic Press: New York.

Agar, M. (1981) *The professional stranger: An Informal Ethnography.* Academic Press: New York.

Agar, M. (1986) *Speaking of Ethnography.* Sage University Paper Series on Qualitative Research Methods. Vol. 2. Beverly Hills, CA: Sage Publications.

AIDS Action (1998) *People on the Move,* Edition on HIV and Migration, Issue 40, July-September.

Allan, G. and Skinner, C. (eds) (1991) *Handbook for Research Students in Social Sciences*, London: The Falmer Press.

Alperin, S. and Needle, R. (1991) Social network analysis: An approach for understanding IV drug users. In: National Institute on Drug Abuse. *Community-Based AIDS prevention: Studies of Intravenous Drug Users*

and Their Sexual Partners. DHHS Publication. No. (ADM) 91-1752 *pp 217-224.* Supt. of Documents, Washington, DC.

Altink, S. (1995) *Stolen Lives*, Harrington Press: New York.

Anderson, G. (1998) *Fundamental of educational research.* London: The Falmer Press.

Anderson, G. and Arsenault, N. (1999) *Fundamental of Educational Research.* London: The Falmer Press.

Anderson, J.M. (1991) The phenomenological perspective. In: Morse JM (ed) *Dialogue Qualitative Nursing Research. A Contemporary Dialogue*, pp 25–37. Sage, London.

Anti-Slavery Organization (2001a) *Trafficking of Children in West Africa: Focus on Mali and Cote d'Ivoire,* May 2001 page 2 [http://www.antislavery.org/archive/other/trafficking-children-wafrica.htm]. (Accessed 23/03/2002)

Anti-Slavery Organization (2001b) *Synopsis of a Report on the Trafficking of Children between Benin and Gabon*, May 2001 page 1 [http://www.antislavery.org/archive/other/trafficking-benin-synopsis.htm]. (Accessed 23/03/2002)

Arayal, A., Nichols, D. and Shrestha, B. (2002) *Nepal adolescents and young adults survey: Background characteristics or urban respondents*, NAY report series, Family Health International, Kathmandu, Nepal.

Asia Foundation/Population Council (2000) *Trafficking in Nepal: Intervention model; A comparative analysis of anti-trafficking intervention approach in Nepal*, The Asia Foundation Kathmandu Nepal and Population Council, New Delhi India.

Asia Foundation/Population Council (2001) *Prevention of Trafficking and the care and support of trafficked persons: In the context of an emerging HIV/AIDS epidemic in Nepal.* The Asia Foundation and Horizon Project Population Council. Creative Press, Kathmandu Nepal.

ASMITA (1998) *Efforts to Prevent Trafficking in Women and Girls.* Women's Publishing House and Media Resource Organization, Kathmandu Nepal.

Atkinson, P. (1990) *The Ethnographic Imagination: Textual Constructions of Reality.* Routledge, London.

Azize-Vargas, Y. (1996) *Regional Report on Trafficking of Women in Latin America and the Caribbean.* International Research Project, sponsored by GAATW and the Foundation for Women (the Netherlands).

Baker, C. (1997) Cultural Relativism and Cultural Diversity: Implications for Nursing Practice. *Advances in Nursing Science*, vol. 20(1), pp3–11.

Battistella, G. and Asis, M. B. (1999). *The Crisis and Migration in Asia.* Quezon City, Philippines, Scalabrini Migration Centre

Becker, H. and Burgess, R.G. (1984) *In the Field: an Introduction to Field Research.* London: Routledge.

Bedi, M. (1990*) Concept and Causes of Prostitution in CSWB. Prostitute and their Children* (New Delhi: Central Social welfare Board), pp38-49.

Benner, P. (1985) Quality of life: A phenomenological perspective on explanation, prediction, and understanding in nursing science. *Advances in Nursing Science,* vol. 8 (1), pp1-14.

Bentley, M., Gittelsohn, J., Nag, M., Pelto, P. and Russ, J. (1990) Use of Qualitative research methodologies for women's reproductive health in India. *Proceeding of the International Conference on Rapid Assessment Methodologies for Planning and Evaluation for Health Related Programmes.* PAHO, Washington DC.

Bernard, H. (1988) *Research Methods in Cultural Anthropology.* Newbury Park, CA: Sage.

Bhatt, P. (1996) Melemchi: a case study in community Mobilisation, In *Red light Traffic: The Trade in Nepali Girls,* ABC Nepal (eds.) pp 56-64, ABC Nepal, Kathmandu.

Bhatt, P., Gurubacharya, V. L. and Vadies, G. (1993) A unique community of family-orientated prostitutes in Nepal uninfected by HIV-1, *International Journal of STD and AIDS,* Vol. 4, pp280-283.

Bhatta, A. (1990) Cheliko Vyapar sambandhi Kes Adhyayan (Case Study of illegal trade girls) in Ghimire,Durga (eds.) *Cheliko Abaidh: Yeska Paksha(Illegal trade of girls: Its various aspects),* pp 39-48, ABC Nepal Kathmandu.

Bhatti, L.I. and Fikree, F.F. (2002) Health-seeking behaviour of Karachi women with reproductive tract infections. *Social Science and Medicine,* Vol. 54 (1), pp 105-117

Bishop, R. and Robinson, L. S. (1998) *Night Market: Sexual Cultures and the Thai Economic Miracle.* London, Routledge.

Blanchet, T. (1996) *Lost Innocence, Stolen Childhoods.* Dhaka University Press.

Blustain, H. S. (1976) Levels of Medicine in a Central Nepali Village. *Contributions to Nepalese Studies,* Vol. 3, pp83-105.

Bodgan, R. and Taylor, S.J. (1975) *Introduction to Qualitative Research Methods: A Phenomenological Approach to the Social Sciences.* New York: Wiley.

Booth, R., Koester, S., Reichardt, C. and Brewster, T. (1993) Qualitative and quantitative methods to assess behavioural change among injection drug users. In: Fisher, D., and Needle, R. (eds.) *AIDS and Community-Based Drug Intervention Programs: Evaluation and Outreach;* pp161-183. *New* York: The Haworth Press.

Brandt, A. (1988) AIDS: From Social History to Social Policy. In Fee, E. and Fox D. (eds.) *AIDS: the Burdens of History*, pp.147-172, Berkeley: University of California Press.

Brooks, C. (1994) Using ethnography in the evaluation of drug prevention and intervention programs. *International Journal of Addiction;* 29(6), pp791-801.

Brown, L. (2000) *Sex Slaves: The Trafficking of Women in Asia*. London: Virago.

Bruce, J. and Dwyer, D. (1989) *A Home Divided: Women and Income in the Third World.* Stanford University Press.

Bryman, A. (1988) *Quantity and Quality in Social Research*. London: Unwin Hyman.

Burrell, G. and Morgan, G. (1979) *Sociological paradigms and organisational analysis*. London: Heinemann Educational Books Ltd.

Calnan, M. (eds.)(1987) *Health and Illness: The Lay Perspective*. Tavistock, London.

Carlson, R., and Siegal, H. (1991) The crack life: An ethnographic overview of crack use and sexual behaviour among African Americans in a Midwest metropolitan city. *Journal of Psychoactive Drugs;* 23, pp11-20.

Carlson, R., Siegal, H. and Falck, R. (1994) Ethnography, epidemiology and public policy: Needle use practices and HIV risk reduction among injecting drug users in the Midwest. In: Feldman, D., ed. *Global AIDS Policy.* Westport, CT: Bergin and Garvey, pp185-214.

CATW (1997) Asia Pacific and Philippine Women's Groups, 4th International Congress on AIDS in the Asia Pacific 29 October 1997, Coalition Against Sexual Exploitation of Women.

CATW (1999) Declaration of Rights for Women in Conditions of Sex Trafficking and Prostitution", *re/productions*, No.2, April. Coalition Against Sexual Exploitation of Women.

CBS (1987) *Statistical Year Book*. Central Bureau of Statistics: Kathmandu, Nepal.

CBS (1989) *Statistical Year Book*. Central Bureau of Statistics: Kathmandu, Nepal.

CBS (1991) *Population Census*. Central Bureau of Statistics: Kathmandu, Nepal.

CBS (1997a) *Nepal Living Standards Survey Report 1996 (Volumes I and II)*. Central Bureau of Statistics: Kathmandu, Nepal.

CBS (1997b) *Statistical Year Book*. Central Bureau of Statistics: Kathmandu, Nepal.

CBS (2001) *Population Census*. Central Bureau of Statistics: Kathmandu, Nepal.

CeLRRD (2000) *Condemned to Exploitation: Impact of Corruption in Criminal Justice System on Women*. Centre for Legal Research and Resource Development, Kathmandu, Nepal.

Child In Need Institute (CINI) (1994) *Gynaecological Morbidities among Women in West Bengal*. CINI, West Bengal.

Chivariak, K. (1999) Starting to work with sex workers in Cambodia: The need for context. *Research For Sex Work*, vol. 2, pp 5-6 August 1999, Vrije Universiteit, The Netherlands.

Clatts, M. (1991) Ethnography and AIDS intervention in New York City: The use of life history as a research strategy. In: National Institute on Drug Abuse. *Community-Based AIDS Prevention: Studies of Intravenous Drug Users and Their Sexual Partners,* pp 225-233, DHHS Pub. No. (ADM) 91-1752. Washington, DC: Supt. of Docs. US. Govt.

Cohen, L. and Manion, L. (1994) *Research Methods in Education*. London: Routledge.

Cohen, M. and Omery, A. (1994) Schools of phenomenology: Implications for research. In Morse J. (eds), *Critical issues in qualitative research methods,* pp136-156. Newbury Park, CA: Sage.

Constas, M. A. (1992) Qualitative analysis as a public event: The documentation of category development procedures. *American Educational Research Journal,* vol.29 (2), pp 253-266.

Coomaraswamy, R. (2000) *Report on Trafficking by the Special Rapporteur on Violence Against Women, Its Causes and Consequence*, submitted in accordance with Commission on Human Rights resolution 1997/44, E/CN.4/2000/68, 56th Session of the Commission on Human Rights.

Cornwall, J. (1984) *Hard Earned Lives: Accounts of Health and Illness from East London*. Tavistock, London.

Crabbé, F., Tchupo, J.P., and Mvondo, J.L., *et al.* (1993) Evaluation of a social marketing program for the treatment of urethritis in men in Cameroon. In: Abstract book from the Xth international meeting of the International Society for STD Research. Helsinki, Finland: *International Society for STD Research*, Abstract 158.

Dahal, G. P. (1999) An Insight on the Recommendations of the ICPD Program of Action: Emerging Challenges to Implement Reproductive Health Policy in Nepal, *FPAN Journal of Reproductive Health,* pp132-44.

Dallabetta, G., Laga, M., and lamptey, P. eds (1996) *Controlled of Sexually Transmitted Diseases*. AIDSCAP/FSH, Virginia USA.

Davis, K. (1937) The sociology of prostitution, *American Sociological Review;* 2, pp 744-55.

Debabrata, R. (1997) *The Lost Childhood: a survey of child prostitution in Delhi.* National Commission of Women, New Delhi.

Denscombe, M. (1998) *The Good Research Guide: For Small Scale Social Research Projects.* Milton Keynes: Open University Press.

Denzin, N. (1970) *The Research Act.* Chicago: Aldine.

Denzin, N. (1978) *The research act: A theoretical introduction to sociological methods.* New York, McGraw-Hill.

Denzin, N. and Lincoln, Y. (1994) Introduction: Entering the field of qualitative research. In N. Denzin & Y. Lincoln (eds.) *Handbook of qualitative research,* pp, 1-17. Thousand Oaks, CA: Sage.

Dixit, S (Undated) The impact of HIVAIDS in Nepal in Annamanthodo, Priscilla (ed.). Undated. *Red Light Traffic: The Trade in Nepali Girls;* pp 49-55. ABC Nepal, Kathmandu.

Dixit, S. (1991) *Nepal: a challenge of HIVAIDS.* A project Report: United Nations Development Project-UNDP, Kathmandu, Nepal.

Doezema, J. (1998) Forced to Choose: Beyond the Voluntary Vs. Forced Prostitution Dichotomies. In Kemapadoo, K. and J. Doezema (eds) *Global Sex Workers: Rights, Resistance and Redefinition.* London: Routledge, pp 34-51.

Doezema, J. (1999) *Loose Women or Lost Women? The Re-Emergence of the Myth of "White Slavery"* in contemporary discourses of "trafficking in women". Presented at the ISA Convention, Washington, D.C. February pp17- 21.

Europap/Tempep (1999) *Hustling for Health: Developing services for sex workers in Europe.* European Network for HIV/STD Prevention in Prostitution (Europap/Tampep) London

Evans, C. and Lambert, H (1997) Health-seeking strategies and sexual health among female sex workers in urban India: Implications for research and service provision, *Social Science and Medicine,* Vol. 44(12), pp.1791-1803.

Fernand-Laurent, J. (1983) *Report of the Special Reaporteur on Suppression of the Traffic in Persons and the Exploitation of the Prostitution of others.* Geneva, United Nations.

Fetterman, D.M. (1989) Ethnography Step by Step. *Applied Social Research Methods Series,* Volume 17. Sage Publications, London.

Fitzpatrick, R. (1991). Survey of patient satisfaction-Important on general considerations. *British Medical Journal* 302: 887-9

Fogarty, M. (1982) Just a job, *Social Work Today,* Vol.14 (10), pp 9-12.

Fontana, A. and Frey, J. (1994) Interviewing: The art of science. In: Denzin, N., and Lincoln, Y. (eds). *Handbook of Qualitative Research,* pp 361-376. Thousand Oaks, CA: Sage Publications.

Frederick, J. (1998) Deconstructing Gita, *Himal,* Vol. 11 (10), pp 12-23.

Frederick, J., and Kelly, T. (eds.) (2000) *Fallen Angels: The Sex Workers of South Asia,* New Delhi; Lustre Press, Roli Books.

Friedmann, J. (1996) Rethinking Poverty: Empowerment and Citizen Rights. *International Social Science Journal.* No. 148 (June).

Fritz, R. (1990) Computer analysis of qualitative data. In: Lambert, E., (eds). *The Collection and Interpretation of Data from Hidden Populations.* National Institute on Drug Abuse Research Monograph 98. DHHS Pub. No. (ADM) 90-1678. Washington, DC: Supt. of Docs, U.S. Govt, pp59-79.

Furber, A.S., Newell, J.N., Lubben, M.M., (2002) A systematic review of current knowledge of HIV epidemiology and of sexual behaviour in Nepal, *Tropical Medicine and International Health*, vol.7(2), pp140-148.

GAATW (2001) *Human Rights and Trafficking in Persons: A Handbook.* GAATW, Bangkok, Thailand.

Gautam, M. and Shrestha, B. (1994) *Health Sector Review.* Report prepared for the Ministry of Health/World Health Organization. Kathmandu.

Geer, B. (1957*) Participant Observation and Interviewing: A comparison,* Human Organisation, vol. 16 (3), pp 28-35.

Geertz, C. (1973) *The Interpretation of Cultures.* New York: Basic Books

Geertz, C. (1988) *Works and Lives.* Stanford University Press, Standford, CA.

Ghimire, D. (1998) *Chelibetiko Abaidh Vyapar*(Illegal trade of girls) in Ghimire,D.(ed.). Chelibetiko Abaidh Vyapar: Yasaka Vivid Paksha(Illegal trade of girls : Its various Aspects), pp1-16. ABC Nepal, Kathmandu.

Ghimire, D. (Undated) Girls trafficking in Nepal: a situation analysis in Annamanthodo Priscilla (ed.) Undated. *Red Light Traffic: The trade in Nepali girls,* pp 4-8. ABC Nepal, Kathmandu.

Gilbert, K. (1992) Women and family Law in Modern Nepal: Statutory Rights and Social Implications. *International Law and politics*, Vol. 24:729.

Glaser, B. and Strauss, A. (1967) *The Discovery of Grounded Theory: Strategies for Qualitative Research.* Chicago: Aldine.

Goetz, J.P. and LeCompte, M.D. (1984) *Ethnography and qualitative design in educational research.* Orlando Academic Press Inc.

Gorter, A., Sandiford, P., Segura, Z. and Villabella, C. (1999) Noucher programme for female sex workers in Nicaragua. *Research For Sex Work*, vol. 2, pp 11-13, August 1999, Vrije Universiteit, The Netherlands.

Graham, H. (1984) *Women, Health and the Family*. Harvester/Wheatsheat, Brighton.

Gregory, T.B. (1990) Discussion on ethics. In: Guba EG (ed), *The Paradigm Dialogue,* pp165–166. Sage Publications, USA.

Guba, E. G. & Lincoln, Y.S. (1988) Naturalistic and rationalistic enquiry, pp81-85. In J. Keeves (ed.) (1988) *Educational research, methodology, and measurement: An international handbook*. Oxford: Pergamon Press.

Guba, E.G. (1990) The Alternative Paradigm Dialog. In: Guba EG (ed) *The Paradigm Dialogue*, pp17–27. Saga Publications, USA.

Guest, P. (2000) Population Mobility in Asia and the Implications for HIV/AIDS. In *Population Mobility in Asia: Implications for HIV/AIDS Action Programmes.* United Nations Development Programme, South East Asia HIV and Development Project.

Gurubacharya,V. (Undated) HIVAIDS-Everybodys' concern in Annamanthodo. Priscilla (ed.) Undated. Red Lights Traffic: The trade in Nepali Girls, pp42-48. ABC Nepal, Kathmandu.

Gushulak, B. D. and MacPherson, D.W. (2000) Health issues associated with the smuggling and trafficking of migrants. *Journal of Immigrant Health*, Vol. 2(2), pp67-78.

Haddad, S. and Fournier, P. (1995) Quality, cost and utilisation of health services in developing countries. A longitudinal study in Zaire. *Social Science and Medicine*, vol. 40(6), pp743-753.

Hameed, S. S. *et al.* (1997) *The velvet blouse: sexual exploitation of children.* National Commission for Women, New Delhi, India.

Hammersley, M. (1983) *The Ethnography of Schooling: Methodological Issues*, London, Allen and Unwin.

Hammersley, M. (1992) *What's Wrong With Ethnography?* London, Routledge.

Hammersley, M. and Atkinson, P. (1983) *Ethnography: Principles in Practice.* Tavistock Publications, London.

Herdt, G. (eds) (1997) *Sexual Cultures and Migration in the Era of AIDS: Anthropological and Demographic Perspectives,* Oxford: Clarendon Press.

Hitchcock, G. and Hughes, D. (1989) *Research and the Teacher: A Qualitative Introduction to School-based Research.* London: Routledge.

HMG/JICA (1995) *Report of baseline Survey in Newakot District.* HMG/JICA Primary Health Care project.

HMG/MOH/WHO (1990) *Evaluating the Strategies for Health for All by the year 2000.* Common Framework, Second Evaluation. Policy, Planning, and Supervision Division.

HMG/NPC/UNICEF (1995) *Nepal Multiple Indicator Surveillance*. Phase II: Primary Education, April-June.

Holland, J., Ramazanoglu, C., Scott, S., Sharpe, S. and Thomson, R. (1992) Risk, Power and the Possibility of Pleasure: Young Women and Safer Sex. *AIDS CARE* Vol 4 No 3.

Holstein, J.A. and Gubrium, J.F. (1994) Phenomenology, ethnometodology and interpretive practice. In: Denzin N & Lincoln Y (eds) *Handbook of Qualitative Research.* Thousand Oaks, Calif age.

Hook, E.W., Richey, C.M., Leone, P., Bolan, G., et al. (1997) Delayed presentation to clinics for sexually transmitted diseases by symptomatic patients. *Sexually Transmitted Diseases,* vol.27, pp 443-448.

Hotchkiss, D.R., Rous, J.J., Karmacharya, K. and Sangrula, P. (1998) Household health expenditures in Nepal: implications for health care financing reform. *Health Policy and Planning*, vol.13 (4), pp371-383.

House, E.R. (1990) An Ethics of Qualitative Field Study. In: Guba EG (ed) *The Paradigm Dialogu,* pp 158–164. Sage Publications, USA.

Human Rights Watch (1995) *Rape for Profit: Trafficking of Nepali Girls and Women to Indian Brothels.* Human Rights Watch, New York, USA.

Human Rights Watch (2000) *Owed Justice: Thai Women Trafficked into Debt Bondage in Japan.* Human Rights Watch.

Huntington, D. (2002) *Anti-Trafficking Program in South Asia: Appropriate Activities, Indicators and Evaluation Methodologies*; Summary report of a Technical Consultative Meeting. Population Council, New Delhi.

ILO (1998) *Trafficking in Children for Labour Exploitation in the Mekong Sub-region: a Framework for Action.* Discussed at sub-regional consultation, Bangkok, 22-24 July 1998.

ILO/IPEC (1998)*Trafficking in Children for Labour Exploitation, including Sexual Exploitation in South Asia*: Synthesis Paper (unpublished). Nepal, South Asian Sub-Regional Consultation.

IOM (1998) *Information Campaign Against Trafficking in Women from Ukraine: Research Report*, International Organization for Migration, July, pp16.

IOM (2000) Combating Trafficking in South Asia: A Review of Policy and Programme Responses, International Organization for Migration February 2000 pp 6.

Jana, S. (1994) *Three year stint at Sonagachi: an exposition*, All India Institute of Hygiene and Public Health, Department of Epidemiology, Calcutta, India.

Jeness, V. (1990) From sex as sin to sex as work: COYOTE and the reorganisation of prostitution as a social problem, *Social Problem*, vol. 37(3), pp 403-26.

Johnston, H. and Khan, S. (eds) (1998) *Trafficking in Persons in South Asia,* Shastri Indo-Canadian Institute, New Delhi.

Justice, J. (1986) *Policies, Plans and People: Culture and Health Development in Nepal.* Berkeley: University of California.

Kabeer, N. (1995) *Reversed Realities: Gender Hierarchies in Development Thought.* Verso, London.

Kanani, S., Latha, K. and Shah, M. (1991) *Application of ethnographic research to understanding perceptions of women and health practitioners regarding specific health disorders in India.* Paper presented at conference on Women's Health-The Action Agenda for the 90s, Virginia.

Kelaher, M., Ross, M.W., Rohrsheim, R., Drury, M., Clarkson, A. (1994) Dominant situational determinants of sexual risk behaviour in gay men. *AIDS*, vol.8, pp101-05.

Kelly, P.F. and Le, B. D.(1999) *Children and women trafficking in Vietnam: what we know from literature, interviews, and analyses.* Ha Noi.

Kempadoo, K. and Doezema, J. (eds) (1998) *Global Sex Workers: Rights, Resistance and Redefinition.* London: Routledge.

Kendall, C. *et al.* (1984) Ethnomedicine and oral rehydration therapy: a study of ethnomedical investigation and programme planning. *Social Science and Medicine*, vol. 19 (3), pp253-260.

Kennedy, M. M. (1979) Generalizing from single case studies. *Evaluation Quarterly*, vol.3 (4), pp661-66.

Kent, G. (1992) Little foreign bodies: International dimensions of child prostitution. In Freenman, M. and Veeran, P. (eds.) *The ideologies of children's right.* Netherlands, Kluwer Academic Publishers.

Khanal, H. (1999) Adolescent Reproductive Health in Nepal, *FPAN Journal of Reproductive Health, V*ol. 1, pp45-53.

Khonde, N. and Kols, A. (1999) Integrating services within existing Ministry of Health institutions: CIDA-AIDS Project. *Research For Sex Work*, vol. 2, pp 16-17, August 1999, Vrije Universiteit, The Netherlands.

Kilmarx, P.H. *et al.* (1998) Seroconversion in a prospective study of female sex workers in northern Thailand: continued high incidence among brothel-based women. *AIDS,* vol. l12, pp1889-1898.

Koirala, G. P. and Thapa, G. B. (1997) *Food Security Challenges: Where Does Nepal Stand?* Kathmandu: WINROCK International.

Kunwar, B. (1996) *Prevention of Child Trafficking in Nepal.* An unpublished article. Collection of Asmita Library Kathmandu:WINCOM)

Laga, M. (1994) Epidemiology and control of sexually transmitted diseases in developing countries. *Sexually Transmitted Diseases,* 21(suppl 2), pp45-50.

Lee-Wright, P. (1990) *Child Slaves.* London, Earthscan Publications.

Leininger, M.M. (1985) *Qualitative Research Methods in Nursing.* Grune & Stratton Inc., New York.

Leininger, M.M. (1991) *Culture Care Diversity and Universality: A Theory of Nursing.* National League for Nursing Press, New York.

Leininger, M.M. (1995) *Transcultural Nursing. Concepts, Theories, Research and Practices.* McGraw Hill Inc., College Custom Series, USA.

Leininger, M.M. (1997) Overview and Reflection of the Theory of Culture Care and the Ethnonursing Method. *Journal of Transcultural Nursing,* vol.8(2), pp32–52.

LHRA (1997) Wife, domestic servant, slave !!! *Child Workers in Asia* 13, pp16-19, Lawyers for Human Rights and Legal Aid, Karachi, Pakistan.

Lim, L.L. (1998) *The Sex Sector: The Economic and Social Bases of Prostitution in Southeast Asia,* Geneva: International Labour Organisation.

Lincoln, Y.S. and Guba, E.G. (1994) Competing Paradigms in Qualitative Research. In Denzin K.N. and Lincoln (Eds.). *Handbook of Qualitative Research,* pp105-117. London: SAGE Publications.

Lincoln, Y.S., and Guba, E.G. (1985) *Naturalistic Inquiry.* Beverly Hills, CA: Sage.

Lipson, J.G. (1989) The Use of Self in Ethnographic Research. In: Morse JM (ed) *Qualitative Nursing Research: A Contemporary Dialogue,* pp61–75. Aspen Publishers, Inc.Rockville, Maryland.

Lipson, J.G. (1994) Ethical Issues in Ethnography. In: Morse J (ed) *Critical Issues in Qualitative Research Methods,* pp333–356. Sage Publications, London

Lofland, J., and Lofland, L.H. (1995) Analysing Social Settings: A Guide to Qualitative Observation and Analysis, 3rd Ed. Belmont, CA: Wadsworth.

Luborosky, M. & Rubinstein, R. L. (1995) Sampling in qualitative research: rational, issues and methods. *Research on Aging,* Vol.17(1), p.89-114.

Mackenzie, A.E. (1994) Evaluating ethnography: considerations for analysis. *Journal of Advanced Nursing* vol.19, pp 774–781.

Mahrer, A. R. (1988) Discovery-oriented psychotherapy research. *American Psychologist*, vol.43(9), pp694-702.

Maki, F. T. and Park, G. (2000) *Trafficking in Women and Children: The U.S. and International Response*. Congressional Research Service Report pp98-649.

Mane, P. and Maitra, S. (1992). *AIDS Prevention: The Social-Cultural Context of India*. Bombay: TISS.

Marcus, G. and Fisher, M. (1986) *Anthropology as Cultural Critique*. University of Chicago Press, Chicago.

Marshall, C. & Rossman, G.B. (1995) *Designing qualitative research*. London: Sage.

Mbuya, C., Nyamuryekunge, K., Laukamm-Josten, U., *et al.* (1995) *STD services for women in truck stops in Tanzania: an evaluation of acceptable approaches*. Abstract presented during the 3rd USAID HIV/AIDS prevention conference. Washington, DC: U.S. Agency for International Development, August pp7-9.

McGirk, T. (1997) Nepal's Lost Daughters: India's soiled goods, *Nepal/India News*, 27 January.

McKinlay, J. (1972) Some approaches and problems in the study of the use of services: an overview. *Journal of Health and Social Behaviour*, vol.13, pp 115-52.

Mehta, S. (1998) *Responsible sexual and reproductive health behaviour among adolescents,* UNFPA.

Melville, N.S. (1987) Iron Deficiency Anaemia among Village Women of the Middle Hills of Nepal, MOH Kathmandu Nepal.

Mertens, T.E., Ward, H. and Thomas, C. (1997) Health seeking behaviour and control of sexually transmitted disease, *Health policy and planning*, vol. 12(1), pp19-28.

Mitchell, J.C. (1983) Case and situation analysis, *Sociological review,* Vol. 31, pp 187-211.

MOH (1987) *Nepal Fertility and Family Planning Survey Report 1986*. Kathmandu: Nepal Family Planning and Maternal Child Health Project, Ministry of Health.

MOH (1991) *Nepal Family Health Survey 1991 Data File.* Kathmandu, Family Health Division, Ministry of Health.

MOH (1992) *Nepal Family Health Survey 1991*. Kathmandu: Family Health Division, Ministry of Health.

MOH (1993) *Nepal Fertility, Family Planning and Health Survey*. Kathmandu: Family Planning and Maternal Child Health Division.

MOH (1995) *Health Information Bulletin*. Ministry of Health.

MOH (1996a) *Nepal Family Health Survey 1996 Data File*. Family Health Division, Ministry of Health.

MOH (1996b) *Nepal: National Safe Motherhood Programme*. Kathmandu: Family Health Division, Ministry of Health.

MOH (1997) *Second Long-Term Health Plan (1997-2017)*. Kathmandu: Ministry of Health.

MOH (1999) *Annual Report*, Department of Health Service, Ministry of Health Kathmandu Nepal

MOH (2000) *Annual Report*, Department of Health Services, Ministry of Health, Kathmandu Nepal.

MOH (2001) Nepal Demographic and Health Survey. Final Report, Family Health Division, Department of Health Services, Ministry of Health, Kathmandu, Nepal.

Montgomery, R. (1999) There aren't even any written materials in the clinic to read. *Research For Sex Work*, vol. 2, pp 3-4, August 1999, Vrije Universiteit, The Netherlands.

Moses, S., Ngugi, E.N., Bradley, J.E., *et al.* (1994) Health care-seeking behaviour related to the transmission of sexually transmitted disease in Kenya. *American Journal of Public Health*, vol. 84, pp1947-1951.

Mull, D. and Mull, J. (1994) Insights from community based research on child pneumonia in Pakistan. *Medical Anthropology,* vol.15(4), pp335-353.

Muntabhorn, V. (1992) *Sale of Children*. Report submitted by the United Nations Special Rapporteur on the Sale of Children. New York, United Nations E/CN.4/1992/55.

Nag, M. (1994) Sexual behaviour and AIDS in India: state of the art. *Indian Journal of Social Work,* vol.55, pp 503-46.

Neupane, S., Nichols, D. (2002) HIV/AIDS and other sexually transmitted infections in Nepal: Knowledge and beliefs among urban youth, *NAY report series* No. 14, Family Health International, Kathmandu, Nepal

New Era (1986) *Fertility and Mortality Rate in Nepal*. New Era, Kathmandu Nepal.

New Era (1994) Xerophthalmia Prevalence Survey in Five Districts of the far and Mid-Western Regions of Nepal. New Era, Kathmandu Nepal.

New Era (2001) *Behavioural Surveillance Survey (BSS) in the Highway Route of Nepal: Third Round.* FHI/AIDSCAP/Nepal, New Era Kathmandu Nepal.

Newar, N. (1998) My sister next? *Himal* vol. 11 (10) October, pp 24-29, Kathmandu, Nepal.

Newman, L., Zierler, S., and Cheung, D. (1991) Epidemiological and ethnographic methods for research in high-risk behaviour: Integrated approaches to acceptability and intervention. In: Wasserheit, J.; Aral, S.; Holmes, K.; and Hitchcock, P., eds. *Research Issues in Human Behaviour and Sexually Transmitted Diseases in the AIDS Era.* Washington, DC: American Society for Microbiology, pp 258-266.

Nichter, M. (1989) *Anthropology and International Health: South Asian Case Studies*. Kluwer, Dordrecht.

Nichter, M., Pelto, G.and Steinhoff, M. (1994) *Medical Anthropology*. Special Issue: Acute Respiratory Infection, vol.14(4), pp319-450.

Nilsson-Shönnesson, L., Clement, U. (1995) Sexual attitudinal conflict and sexual behaviour changes among homosexual HIV-positive men. *J Psychol Hum Sex*, vol. 7, pp41-58.

Niraula, B.B. and Morgan, S.P. (2000) Gender inequality in two Nepali settings . In Garcia, Brigida (ed.) *Women, Poverty and Demographic Change*. Oxford: Oxford U. Press.

Nowak, A (1999) Political transformation in Poland: The rise in sex work, *Research For Sex Work*, vol. 2, pp 9-11, August 1999, Vrije Universiteit, The Netherlands.

NPC/UNICEF (1996) *Health and Nutrition: NMIS First Cycle Report*, Kathmandu Nepal.

NPC/UNICEF (1997a) *Diarrhoea, Water and Sanitation*: NMIS Third Cycle Report. Kathmandu.

NPC/UNICEF (1997b) *Early Childhood, Feeding, Nutrition and Development*: NMIS Fourth Cycle Report. Kathmandu.

O'Grady, R. (1994) *The Child and the Tourist*. Bangkok, ECPAT.

O'Dea, P. (1993) *Gender Exploitation and Violence: The Market in Women, Girls and Sex in Nepal: An Overview of the Situation and a Review of the Literature.* Kathmandu: UNICEF.

Panday, D.R. (1995) Foreign Aid and Liberalisation. *Economic News and Views.* 1:3 (October).

Pandey, C. (1980) Population Growth and Health Development. In *Population of Nepal Country Monograph Series:* No. 6, pp104-21, Bangkok: ESCAP, United Nations.

Pant, R. D. And Acharya, S. (eds.) (1988) *Population and Development in Nepal*, Kathmandu: National Commission on Population.

Patton, M.Q (1990) *Qualitative Evaluation and Research Methods*. London: SAGE Publications.

Pelto, P. and Pelto, G. (1973) Ethnography: The fieldwork enterprise. In: Honigmann, J., ed. *Handbook of Social and Cultural Anthropology.* Chicago: Rand McNally, pp 241-288.

Pelto, P. and Pelto, G. (1978) *Anthropological Research. The Structure and Inquiry*. Cambridge University Press, Cambridge.

Pelto, P., Bentley, M. and Pelto, G. (1990) Applied anthropological research methods: diarrhoea studies as an example. In *Anthropology and Primary Health Care*, Eds. Coeil, J. and Mull, D. pp253-277. Westview, Boulder.

Phongpaichichit, P., Piriyarangsan, S. and Treerat, N. (1998) *Guns, Girls, Gambling, Ganja: Thailand's Illegal Economy and Public Policy*. Chiang Mali, Silkworm Book.

Platt, J. (1988) What Can Case Studies Do? *Studies in Qualitative Methodology*, Vol.1, pp 1-23.

Polit, D. and Hungler, B. (1978) *Nursing Research: Principles and Methods*. Philadelphia: J.B. Lippincott

Pool, R. (1994) *Dialogue and Interpretation of Illness: conversations in a Cameroon village*. Berg, Exeter, United Kingdom.

Poudel, P. and Carryer, J. (2000) Girl-trafficking, HIV/AIDS, and the positional of women in Nepal, *Gender and Development*, vol. 8 pp74-79

Poudyal, M. (1996) Report of the South Asian Workshop on Trafficking in Women and children. Formulating strategies of resistence. A report to Nepali co-workers after participating the seminar organized by UBINING. Bangladesh.

Pradhan, G. (1990) *Chelibetiko Dehavyapar. Yatarko Thatha Chunautiharu* (Trade of girls: Facts and challenges) in Ghimire D. (ed.). Chelibetiko abaidh Vyapar: Yaska Vivid Paksha(illegal trade of Nepali Girls : Its various Aspects), ABC Nepal, Kathmandu.

Pradhan, G. (1996) *Back Home from the Brothels: A Case Study of the Victims of Commercial Sexual Exploitation and Trafficking Across Nepal-India Border.* Kathmandu: CWIN.

Pradhan, G. (undated) The road to Bombay- forgotten women in Annamanthodo. Priscilla (ed.) undated. *Redlight traffics* : The trade in Neplai Girls, ABC Nepal, Kathmandu.

Pradhan, G.(1992) Road to Bombay, *Voice of the child workers* No.15-16. December, CWIN Kathmandu, Nepal.

Pratt, T. (2001) Sex Slavery Racket a Growing Concern in Latin America, *Christian Science Monitor*, 11 January.

Prior, L. (1997) Following in Foucault's Footsteps: Text and Context in Qualitative Research, in Silverman, D.(ed) *Qualitative Research: Theory, Method and practice,* London, Sage Publication.

Punch, M. (1994) Politics and ethics in qualitative research. In: Denzin, N., and Lincoln, Y. (eds.) *Handbook of Qualitative Research.* Thousand Oaks, CA: Sage Publications, pp 83-97.

Rajbhandari, R. (ed.) (1997) *Present Status of Nepali Prostitute in Bombay.* WOREC, Kathmandu, Nepal.

Rajbhandari, R. and Rajbhandari, B. (1997) *Girl Trafficking: Hidden Grief in the Himalayas,* WOREC, Kathmandu, Nepal.

Ramanathan, U. (1996) Women, Law and Institutionalisation: A Manifestation of State Power, in *Indian Journal of Gender Studies, 3.2.*

Rana-Deuba, A. (1997) *A situational analysis of Violence against Women and Girls in Nepal,* SAATHI and Asia Foundation, Kathmandu, Nepal.

Reissland, N. and Burghart, R. (1989) Active Patients: The Integration of Modern and Traditional Obstetric Practices in Nepal. *Social Science and Medicine,* Vol. 29, pp 43-52.

Rhebergen, D. et al (1999) Some reflections on street sex workers and STD/HIV/AIDS services in Surabaya, Indonesia. *Research For Sex Work*, vol. 2, pp 20-22, August 1999, Vrije Universiteit, The Netherlands.

RIDA (1991) *The Status of Girl Child in Nepal: a Survey Report.* Prepared for HMG/MDL and UNICEF Nepal.

Robertson, M.H.B. and Boyle, J.S. (1984) Ethnography: Contributions to nursing research. *Journal of Advanced Nursing,* vol. 9 pp43–49.

Ross, M.W. and Ferreira-Pinto, J.B. (2000) Toward a public health of situations: the re-conceptualisation of risk. Cadernos Saúde Pública (English abstract)16 pp109-21.

Rozario, Sr. and Rita, M. (1988) Status of Women Series: *Trafficking of Women and Children in India* (Sexual Exploitation and Sale). New Delhi, India.

Salunke, S.R., Shaukat, M., Hira, S.K and Jagtap, M.R. (1998) HIV/AIDS in India: A Country Responds to a Challenge. *AIDS, 12* (suppl B), S27-S31.

Sanghera, J. (1999) Trafficking of women and children in south Asia: Taking stock and moving ahead. *A review of anti-trafficking initiatives in Nepal, Bangladesh and India.* UNICEF and Save The Children Alliance.

Schoepf, B. (1991). Women, AIDS and economic crisis in Central Africa. *Canadian Journal of African Studies*, 22, 625-644.

Scrimshaw, S. and Hurtado, E. (1987) *Rapid Assessment Procedure for Nutrition and Primary Health Care:Anthropological Approaches to*

Improving Programme Effectiveness. UCLA Latin America Centre, Berkeley.

Seddon, D. (1998). HIV/AIDS in Nepal; the coming crisis, *Bulletin of Concerned Asian Scholars*, vol. 30, pp35-45.

Seddon, S., Jagganayth, J. and Gurung, G. (1999) *Foreign Labour Migration and the Remittance Economy of Nepal.* (unpublished) report prepared for DFID Nepal Country Office.

Serrano, Y., Faruque, S. et al (1993) Assessment of street outreach for HIV prevention: Selected sites, 1991-1993. *MMWR,* 42:873, pp879-880.

Shah, A. J. (1987) *Access of Low Income Families to Social Services, A Study in Selected Areas of Kathmandu.* Kathmandu: CEDA, Tribhuvan University.

Shrestha, R. M. and Lediard, M. (1990) *Faith Healers: A Force for Change.* Kathmandu: UNFPA/UNICEF.

Shtrestha,p. and Panta,P. (1995) *Economically active population* in CBS. Population Monograph of Nepal(Kathmandu: Central Bureau of statistics). pp205-238.

Shtrishakti (1995) *Women Development Democracy*: A study of the Socio-Economic Changes in the Status of Women in Nepal (1981-1993). Kathmandu Nepal.

Siegal, H. (1990) Intravenous drug abuse and the HIV epidemic in two midwestem cities: A preliminary report. *J Drug Issues, vol.*20(2), pp281-290.

Silverman, D. (1993) *Interpreting Qualitative* Data. Sage, London.

Simkhada, P. (1999) *Factors affecting the Non-utilisation of Public health Services for Primary Health care in Kathmandu, Nepal.* M.Sc. Thesis submitted to Brunel University, London.

Sinha, I. and Sleightholme, C. (1996) *Guilty Without Trial: Women in the Sex Trade in Calcutta* New Brunswick, New Jersey: Rutgers University Press;

Sitton, T., Mehaffy, G.; and Davis, O. (1983) *Oral History: A Guide for Teachers (and Others).* Austin: University of Texas Press.

Skrobanek, S. (1997) *Traffic in Women: Human Realities of the International Sex Trade,* London: Zed Books.

Smart, C. (1984) Researching Prostitution: some problems for feminist research, *Humanity and Society*, vol.8, pp 407-13.

Spradley, J.P. (1979) *The Ethnographic Interview.* Holt, Rinehard & Winston, New York.

Spradley, J.P. (1980) *Participant Observation.* Holt, Rinehart & Winston, New York.

Stewart, K. *et al.* (1994) Acute respiratory infections(ARI) in Bangladesh: perceptions and practices. *Medical Anthropology,* vol. 15(4), pp377-395.

Stone, L. (1976) Concepts of Illness and Curing in a Central Nepal village. *Contributions to Nepalese Studies*, Vol. 3, pp55-80.

Strauss, A. and Corbin, J. (1990) *Basics of qualitative research: Grounded theory procedures and techniques.* Newbury Park, CA: Sage.

Taft, R. (1988) Ethnographic research methods.pp.59-63. In J. Keeves (Ed.) (1988). *Educational research, methodology, and measurement: An international handbook.* Oxford, Pergamon Press.

Taylor, A. (1991) *Prostitution: What's Love Got To Do With It?* London, Optima McDonald and Co.

Taylor, S. J. and Bogdan, R. (1984) *Introduction to qualitative research methods: The search for meanings.* New York: John Wiley & Sons

Thapa, P. (1990) *Keti bechbikhan: Lukeko Aparadh*(Trade of girls: A hidden Crime) in Ghimire, Durga(ed.). Chelibetiko Abaidh Vyapar: Yasaka vivid Paksha (Illegal trade of girls: Its various aspects) pp.21-25, ABC Nepal, Kathmandu.

Thomas, J. (1993) *Doing Critical Ethnography. Qualitative Research Methods Series 17*, Sage Publications, Inc. California.

Thomas, J.W. and Penchansky, R. (1984) Relating satisfaction with access to utilisation of services. *Medical care,* vol. 22(6), pp553-568.

Thorne, S. (1997) The Art (and Science) of Critiquing Qualitative Research. In: Morse JM (ed) *Completing a Qualitative Project: Details and Dialogue,* pp117–133. Sage Publications, Inc., California.

Tinker, I. (ed.) (1990) *Persistent Inequalities: Women and World Development.* Oxford University Press, New York

Trebucq, A., Louis, J.P., Tchupo, J.P., Migliani, R., Smith, J. and Delaporte, E. (1994) Treatment regimens of STD patients in Cameroon: a need for intervention. *Sexually Transmitted Diseases*, vol. 21, pp124-126.

U.S. Department of State (2001) *Victims of Trafficking and Violence Protection Act 2000: Trafficking in Persons Report*, July 2001.

UNAIDS (2000a) *Report on the global HIV/AIDS epidemic,* UNAIDS, Geneva, Switzerland

UNAIDS (2000b) *Female sex worker and HIV prevention projects*: lessons learnt from Papua New Guinea, and India and Bangladesh. UNAIDS case study November 2000.

UNDP (1998a) *Nepal Human Development Report 1998*. UNDP, Kathmandu Nepal.

UNDP (1998b) *Development Co-operation Report 1998*. UNDP, Kathmandu Nepal.

UNDP (1998c) *Human Development Report 1998*. New York: Oxford University Press.

UNDP (1999a) *Beyond Trafficking: A Joint Initiative in the Millennium Against Trafficking in Women and Girls*. Kathmandu, Nepal.

UNDP (1999b) *Human Development Report 1999*. New York: Oxford University Press.

UNDP (2000) *Population Mobility in Asia: Implications for HIV/AIDS Action Programs.* Thailand: UNDP South-East Asia HIV and Development Project.

UNFPA (1996) *Reproductive tract infections including STDs and AIDS/HIV in Nepal*, UNFPA, Kathmandu, Nepal

UNFPA (1999) *The state of World Population 1999: 6 billion; A time of choice*. UNFPA.

UNFPA (2000) *State of the World's Population*. UN Fund for Population Activities September 2000 page 5.

UNICEF (1992a) *Children and Women in Nepal: A Situation Analysis*. Kathmandu.

UNICEF (1992b) *The State of the World's Children*. New York: Oxford University Press.

UNICEF (1996a) *Children and Women of Nepal: A Situation Analysis*. Kathmandu Nepal.

UNICEF (1996b) Country Report on Indicators for the Goals for 1996. New York, UNICEF.

UNICEF (1997) *Foreign Assistance and Human Development Priorities in Nepal*. Kathmandu.

UNICEF (1998) *National Plan of Action against trafficking in children and other commercial sexual exploitation,* An unpublished report: UNICEF Nepal.

Uprety, K. and Simkhada, P. (1992) *The Role of Traditional Healers and Herbals Medicine on Primary Health Care in Nepal*. A paper presented on International Seminar on Traditional Medicine: A Challenge of Twenty First Century, Calcutta, India.

USAID (1999) *Strategic Framework for the Asia Regional Anti-Trafficking Initiative*, Washington, D.C.

USAID (2001) *Trafficking in Persons: USAID's Responses*, United States Agency for International Development, Office of Women Development.

Van Maanen, J. (1995) An End of Innocence. Ethnography of Ethnography. In: Van Maanen J (ed) *Representation in Ethnography*, 1–35. Sage Publications Inc. Thousand Oaks, California

Wadhwa, S. (1998) For sale childhood, *Outlook,* 1998.

Wake, C. J. (1976) Health Services and Some Cultural Factors in Eastern Nepal. *Contributions to Nepalese Studies*, Vol. 3, pp 113-126.

Walkowitz, J. (1980). *Prostitution and Victorian Society: Women, Class and the State.* London: Cambridge University Press.

Weller, S. and Romney, A. (1988) *Systematic Data Collection: Sage University Paper Series on Qualitative Research Methods*. Vol. 10. Newbury Park, CA: Sage Publications.

Weppner, R. (1977) Street ethnography: Problems and prospects. In: Weppner, R., (eds.) *Street Ethnography: Selected Studies of Crime and Drug Use in Natural Settings,* pp 21-51. Beverly Hills, CA: Sage Publications.

Werner, O. and Schoepfle, G.M. (1986) *Systematic Fieldwork*, 2 vols. Sage, Newsbury Park, CA

WHO (1995) *Safer Motherhood*, World Health Organization, Geneva.

WHO (1999) *World Health Report 1999*. World Health Organisation, Geneva.

WHO (2001) *STI/HIV: Sex Work in Asia*. World Health Organisation, Regional Office for Western Pacific.

Widgren, J. (1994) *Multinational Cooperation to Combat Trafficking in Migrants and the Role of International Organizations*, IOM Seminar on International Responses to Trafficking in Migrants and Safeguarding Migrant Rights, Geneva. October 26-28.

Wiebel, W. (1990) Identifying and gaining access to hidden populations. In: Lambert, E., ed. *The Collection and Interpretation of Data from Hidden Populations.* National Institute on Drug Abuse Research Monograph 98, pp. 4-11, DHHS Pub. No. (ADM) 90-1678. Washington, DC: Supt. of Docs.

Wijers, M. and Lap-Chew, L. (1997) *Trafficking in Women, Forced Labour and Slavery-like Practices in Marriage, Domestic Labour and Prostitution.* Foundation Against Trafficking in Women (STV), The Netherlands, and Global Alliance Against Traffic in Women (GAATW), Bangkok, Thailand.

Williams, M., and Johnson, J. (1993) Social network structures: An ethnographic analysis of intravenous drug use in Houston, Texas. In: Fisher, D., and Needle, R. (eds). *AIDS and Community-Based Drug Intervention Programs: Evaluation and Outreach.* New York: The Haworth Press, 1993. pp 65-90.

Wolff, K. H & Pant, R. P. (1975) *Social science research and thesis writing.* Kathmandu: Buddha Academic Enterprises.

Wolffers, I. (1999) Appropriate health services for sex workers. *Research For Sex Work,* vol. 2, pp 1-3, August 1999, Vrije Universiteit, The Netherlands.

WOREC/CEDPA (1999) *Advocacy Against Trafficking in Women Training Manual,* prepared by WOREC and CEDPA, Kathmandu, Nepal.

World Bank (1989) *Nepal: Policies for Improving Growth and Alleviating Poverty.* A World Bank Country Study, Washington, D.C.

World Bank (2000) *Thailand's Response to AIDS: Building on Success, Confronting the Future* Thailand.

World Bank (2002) *World development report 2002. Building institutions for markets.* Washington, DC: Oxford University Press.

Yin, R. K. (1994) *Case Study research Design and Methods.* London: SAGE Publications.

APPENDIX 1

SOCIO-POLITICAL OVERVIEW OF NEPAL

1. Nepal – Initial Overview

1.1. Geography

Nepal is a sovereign, independent, democratic, constitutional monarchy, and a non-aligned Hindu Kingdom. It lies on the lap of the highest mountain of the Himalayas, the highest peak of which is known throughout the world as 'Mount Everest" (*Sagarmatha*). It is a landlocked country, the nearest seaport being Calcutta in India, which is 1,120 kms away from Kathmandu, the capital of the country. Situated in South Asia, Nepal is bordered by the Tibetan Region of China in the north and by India in the east, west and south. It is roughly rectangular in shape with a total land area of 147,181 square kilometres, stretching 885 kilometres from east to west and between 145 kilometres to 241 kilometres from north to south (Pandya, 1995).

Topographically, the country can be divided into three distinct regions from north to south: the mountains, the hills, and the flat plains known as the Terai. Lying at an altitude ranging from 4,877 to 8,848 metres above sea level, the mountainous area includes the renowned Himalaya, the world's youngest mountain chain, with eight of the world's ten highest mountain peaks, including Everest. The hilly region lies in the middle part of the country, with altitudes varying between 610 metres and 4,877 metres above sea level. The Kathmandu Valley, where the country's capital is situated, and many other scenic valleys, basins and pockets are in this region. The Terai, which is an extension of the Gangetic plains of India, forms a low flatland along the southern border. It comprises most of the fertile and forest areas of the country. Due to its diverse topography, almost all the climatic zones of the earth are found in Nepal from tropical to sub-arctic. The mean annual temperature is about 15 degrees celsius; rainfall varies between 250 millimetres and 4000 millimetres, with about 80 percent of the precipitation occurring during the monsoon season, which typically lasts from June until September.

1.2. Natural Resources

Water is the most important natural resource of the country. There are about 6,000 rivers and rivulets, which add up to 45,000 kilometres in length. The total drainage area of all the rivers amounts to about 191,000 square kilometres of which 74 percent lies in Nepal. The total average run-off is estimated at about 170 billion cubic meters and the hydroelectric power potential is estimated at 83,000 megawatts, of which about 50 percent could be economically harnessed. However, less than 0.5 percent of this economically viable potential has so far been exploited. Almost every known forest type, with the exception of the equatorial tropical rain forest, is found in Nepal. This diversity supports more than 175 species of mammals, 850 species of birds and almost 10 thousand species of plants.

The threat of deforestation is another challenge for Nepal's fragile ecosystems. According to the National Forest Inventory (NFI), published in 1998, forests presently cover 4.25 million hectares (29 percent) of total land area, with shrub lands occupying some 1.56 million hectares (10.6 percent). In a previous survey conducted in 1978/79 by a Land Use Resource Mapping Project, total forest cover was 38 percent. This change has taken place both in the Terai and in the Hills, with the average annual deforestation rate in the former standing at about 1.3 percent during the past 20 years (1978/79-1990/96). In the hills, forests have been reduced to shrub land at an annual rate of 1.7 percent, although forest and shrub area taken together has remained almost constant (UNDP, 1998b).

1.3. Population

The population of Nepal is over 23.4 million (UNFPA, 1999), with women outnumbering men slightly. The population density stands at an estimated 144 persons per square kilometre. The share of the urban population is around 10 percent and is growing at around 7 percent annually (CBS, 1991). The three towns of Kathmandu Valley, namely Kathmandu, Patan and Bhaktapur, account for almost 40 percent of the entire urban population in the country. Other relatively large towns are Pokhara, Dhankuta and Tansen in the hills and Biratnagar, Birgunj, Janakpur, Hetauda, Nepalgunj, Mahendranagar, Dhangadhi, Bhairahawa and Butwal in the Terai.

Nepal's population is relatively young, with 46 percent under the age of 16. Nepal is ethnically as diverse as it is geographically. It is home to several races and tribes, languages and religions. There are some 75 different ethnic groups speaking about 50 different languages (CBS, 1991). Most agree that the original inhabitants were Tibetan-Mongoloid from the north migrating south and Indo-Aryans from the south migrating north. The majority of the Nepali people are Hindus, followed by Buddhists. Other religions represented are Islam, Christianity and Animism. The 1990 Constitution recognises the Nepali language in the Devanagari script as the official language of the kingdom of Nepal, and accords all languages spoken as the mother tongue in the various parts of the country the status of national languages.

1.4. History and Politics

The beginning of the country's modern history dates back to the second half of the eighteenth century when Prithivi Narayan Shah, the King of Gorkha, began the unification of various small hill kingdoms including the Kathmandu Valley. The territorial expansion continued under his successors, although much of the newly annexed territory was lost in the Anglo-Nepal war of 1814-16. In 1846, Jung Bahadur Rana assumed supreme power and started a hereditary rule of Rana Prime Ministers. This ended in 1951 when an armed revolt led by the Nepali Congress Party, with the moral support of King Tribhuwan, paved the way for a joint government of the Nepali Congress and the Ranas. The period 1951-1959 was marked by a rapid succession of governments and political instability. An election was held under a parliamentary constitution in 1959, which brought the Nepali Congress Party to power. Its leader, B. P. Koirala, who commanded a two-thirds majority in the parliament, was in his seventeenth month of premiership when King Mahendra, father of the present King Gyanandra, dissolved the first popularly elected government of the country and replaced the new regime by the partyless Panchayat system. This system lasted for thirty years, until April 1990, when a pro-democracy movement, led jointly by the then banned political parties - the Nepali Congress and the United Left Front (a loose coalition of seven communist factions) - brought an end to the thirty-year ban on political organisations. Following the success of the democracy movement,

an interim government was formed, headed by the Nepali Congress Chairman K. P. Bhattarai. This government, as mandated, accomplished two major tasks: i) it prepared and promulgated a new Constitution incorporating elements of constitutional monarchy, multiparty democracy and fundamental freedoms, and ii) it held the first multi-party elections in thirty years.

The new Constitution that came into effect in November 1990 established a two-tiered legislature, the National Council (Upper House) consisting of 60 members and the House of Representatives (Lower House) consisting of 205 members. Members of the House of Representatives are elected every five years through national elections. The National Council consists of members selected by the Lower House, the King, and an Electoral College consisting of members from local level committees. The King, as Head of State, appoints the majority leader of the House of Representatives as the Prime Minister, who leads the affairs of the country with the help of council of ministers that s/he forms.

Administratively, the country is divided into five development regions, fourteen zones and seventy-five districts. The districts are the main units of local governance, with the structure comprising the Village Development Committees (VDCs) with a Chairperson and Vice-Chairperson and members consisting of representatives elected from various wards, and the District Development Committees (DDCs) elected indirectly by them. The urban areas elect their own Mayors who lead municipalities that have similar structures. Efforts directed at greater decentralisation have primarily sought to strengthen the government machinery at the district level. The Regulations of the Local Self-Governance Act of 1999 have now been signed into effect, making it possible for elected local bodies to raise revenue, enter into collaborative ventures with the private sector, adjudicate and, generally, effect development in a decentralized, sectoral fashion.

Nepal completed a decade of democratic exercise in 2000. The five years prior to the 1999 elections saw several coalition governments formed, none of which lasted longer than 18 months. As a consequence, key development-related decisions were delayed and implementation was either

rushed or uncertain. The May 1999 general elections to parliament, the third in the decade of the 1990s, brought to power a majority government, of the Nepali Congress Party.

The most serious internal political problem faced by Nepal's governments since the restoration of parliamentary democracy in 1990 has been the armed Maoist insurgency. Although the present number of armed Maoist insurgents may be less than ten thousand, they did succeed in disrupting life both in rural and urban parts of the country with acts of violence. Thus far, their acts of violence have been directed only at Nepalese citizens, although some INGO development projects have also been vandalized. There were no incidents involving foreigners reported, although the government has cautioned foreign missions to be alert. Furthermore, any efforts to resolve the problem by any government in power during the past five years failed.

In the evening on June 1, 2001, a very tragic incident occurred that may have a profound impact on the already fragile political situation in Nepal. A routine weekly dinner party of the royal clan in the palace turned suddenly into a bloody carnage that left the King, his Queen, two of his children, his brother, three sisters, a brother-in-law and a son-in-law dead or dying. Although there were many versions of the shooting circulating in Kathmandu by informants who requested to remain anonymous, hardly any presented the true facts. It has also not been confirmed just how many people attended the dinner party, only that fourteen people were either killed or seriously injured in the shooting including Prince Dipendra, who allegedly committed suicide. The new King formed a three-member probe panel that included the leader of the main opposition in parliament to investigate the palace shooting and present its full report within three days. Probe panel prepared the report but the report also seems to have generated some doubts about the validity of the findings.

On November 2001, the Maoists unleashed well-coordinated mayhem in more than twenty districts that has claimed hundreds of lives. Consequently, the government declared a state of emergency on November 26, 2001. The King also approved mobilization of the army and promulgated an ordinance

declaring the cadres of CPN (Maoist) as terrorists. First state emergency finished after 6 month and second phase emergency started again.

In a surprise move, on October 4, the King dismissed the Deuba government and assumed all executive powers in accordance with Article 127 of the constitution and appointed a new government headed by Lokendra B. Chand, a politicians from the Panchayat era and one of leaders of NDP party. With the general elections to be held at some not too distant future date, everyone is aware that elections cannot be held unless the Maoist insurgency has been resolved. The Maoist leadership again stated that they are ready to engage in a dialogue. The government is also under pressure from all quarters to immediately seek solution to the insurgency, although it has been rather slow in establishing a contact with the insurgents. There is still no indication of any direct contact with Maoists, nor has any planned agenda for talks been made public. The PM stated that the government intends to form a "cell" that would conduct the negotiations with the Maoists. The government even seems to be receptive to the Maoist precondition of holding elections into a constituent assembly.

Although the Chang government has been in office for two months now (until end of December 2002), any peace negotiations with the Maoist rebels remain an elusive goal. It seems that the press statement issued by the Maoist leadership that they are ready to resume the talks is not being recognized by the government as a genuine peace offer. According to a statement made by the Home Minister, the government would respond to a peace offer made directly to the government. Subsequently, Prachanda, the senior most Maoist leader, sent a signed fax to the media repeating their offer to resume the peace talks. He also stated that his party formed a high level negotiating team. The response from the government side was they first want to verify the authenticity of the statement. In spite of the urgency to deal with the insurgency, the government's actions toward this end are proceeding at a snail's pace. As a minimum condition, they want a roundtable discussions involving the King, the government and all political parties. Other conditions are the formation of an all-party government and elections into a constituent assembly. Prachanda

also pledged to refrain from attacks on development infrastructures and killings of political activists.

On October 31 2002, the army issued statistical data on the casualties since the start of the insurgency almost seven years ago. So far, the insurgency has claimed the lives of 6,011 Maoist rebels, 873 civilian policemen, 773 civilians, 97 armed policemen and 219 army personnel, since its inception in February 1996, according to figures made available by the Home Ministry and the Royal Nepal Army. Of the total of 7,073 people killed since February 1996, 4,366 were killed since the declaration of the emergency in November 2001.

1.5. Culture and Religion

Nepal is a unique country, rich in heritage. Although a small and poor country, it is noted for its glorious history and diverse ethnic communities. Despite various races, castes and creeds a religious harmony has existed among the people of the Nepal, constituting a solid national unity base. If we look into Nepal's 'proud history' we note that the *Gopalas* were the first rulers and they brought forth the light of '*Lingam*' of the famous Hindu temple *Pashupatinath*. They were followed by the *Kirats* and the *Lichhavis*. During the *Lichhavis* dynasty both Hinduism and Buddhism flourished in the country under the benign patronage of the kings. For the common people *Sanskrit* became the language and there was an advent of deity worshipping by the people. After the *Lichhavis* till the rise of *Mallas* there were multifarious activities on the social, cultural and religious fronts. It was because of the competitive spirit of the *Malla* rulers of the Kathmandu Valley that innumerable temples, *stupas* and monasteries along with the palace and squares were erected.

Religion has played a very promising role in shaping the destiny of the Nepalese. Hindu is the major religion of Nepal. The King should be of Hindu origin. *Pashupatinath* is worshipped as the national Go and 86.5 percent of the total population of Nepal are Hindu followers. There are many famous temples spread all around the country such as *Guheswari, hidrayani, Mahakal, Shankata, Dakshinkali, Bbadrakali, Barahi* of the goddess *Devi*; and

Jalabinayak, Asohkbinayak, Suryabinayak the temples of the god *Ganesh*. At *Lumbini* a temple is sited at the place where the god Gautam Buddha was born, and has considerable religious significance among the Buddhist community. *Ashok* Monument, Temple of *Maya Devi*, and its gardens are significant from the religious and tourism point of view.

Muslims are 3.5 percent of the total population of the country and most of them are concentrated in the mid and western *Terai* districts, like Bara, Parsa, Banke etc. A few of than are also settled in Sunsari and Morang Districts. There are two Musjids in Kathmandu and 1.7 percent of the total population follow Christian religion.

Nepal is appropriately called the 'Land of Festivals' because not even a week passes without festivals taking place in some part of the kingdom. Whether of local or national character, most of them are associated with one or the other divinities, sacred either to Hindu or Buddhist theology or mythology. The people of Nepal deem the festivals as their rich heritage and celebrate them in the spirit of solemnity and gaiety.

1.6. Ethnic Groups and Languages

Many ethnic groups inhabit the different parts of the country. Broadly these groups can be classified into two major classes (i) Tibeto-Nepalese race (ii) Indo-Nepalese race. Tibeto-Nepalese Race can be further classified into Tibetan Group and Ancient Nepalese Group. The Tibetan group consists Bhotes, Sherpas and Thakalli. But the ancient Nepalese groups consist of Newars, Tamangs, Magars, Gurungs and Sunuwars, Rais, Limbus, Budhas, Rukhas, and Tharus who are classified in the same group. The Tibetan groups live in the high mountain part of the country. Some of them have migrated into Middle Mountain and city centres for economic reasons. The ancient Nepalese groups live all around the country. Newars are mostly found in the city centres and villages of the mid mountains. Tamangs are found in eastern and central mid mountain. Magars are found in *Chure* and mid-mountains of western and mid western development regions of the country. Similarly Tharus are found in mid-western, western and eastern Terai.

Indo-Nepalese racial groups can be classified into two groups: Nepalese Group and Indian Group. Nepalese Groups consist of Brahamins, Chetries, Khas and Thakuries, as well as Terains, Gharhwals and Kumaus. Within the Indo-Nepalese race Brahamins and Kshetrias are found all over the country. But their largest number is found in mid-mountains of the country. Terrains are mostly found in Terain Kumaus and Gharwals are found mostly in the far west of Nepal (CBS, 1991).

Many different languages are spoken in Nepal with various ethnic tribes having various languages. But Nepali is the main language spoken and written all over the country. Regarding other languages, according to the 1991 census, Maithili is spoken by 11.8% of the Nepalese people as their mother tongue. 7.5% of the Nepalese people speak Bhojpuri; and Tamang Language is spoken by 4.9% of the Nepalese people. Tharu language is spoken by only 1%, and Newari is spoken by 3.7% of the Nepalese people who are scattered in all the zones. 2.3% of the people speak Magar language. Likewise, 2.4% of the total population of Nepal speak Rai and Kirati language and Limbu language is also spoken by the majority people of the eastern hill and mountain region of Nepal. According to the linguistic composition there is vast diversity. Most of the literature and cultural books and local technical books are written in Nepali. It is spoken by 50.3% of the people as their mother tongue.

1.7. Economy

Despite of the immense amount of development grants and loans that have been pumped into the country, the kingdom of Nepal is still one of the poorest in the world. The GNP is only some $220 per capita (World Bank, 2002) and more then 70% people live below the poverty line. Nepal is an agricultural economy, with 94% of the population engaged in agriculture (UNDP, 1998a). Only about 10% live in urban areas (UNDP, 1998a). The average level of income is one of the lowest in the world. Incomes are unevenly distributed across the regional and social groups and urban income is more than double that in the rural areas. The average rate of growth of per capita income in the 1990s has been 2.9 percent per year (lower than in other

SE Asian economies), attributable entirely to relatively rapid growth in the non-agricultural sectors (UNDP,1998a). The agricultural sector recorded a negative growth rate in per capita term. Income growth, thus, was narrowly based, had a low employment intensity and helped to intensify a pattern of uneven income distribution across sectors, regions and households. Low rate of income growth, skewed income distribution, and deteriorating terms of trade of the agricultural sector *vis-à-vis* other sectors have intensified poverty.

The low level of *household income* has resulted in a high ratio of consumption to the level of income. In addition, the consumption income ratio has been increasing (from 84 percent in the late 1970s to 90 percent in the 1990s). Nonetheless, household income is often inadequate to meet even basic needs. Food expenditure alone accounts for 62 percent of household income in the rural areas and approximately 50 percent in the urban areas. Clothing expenditures, particularly in urban areas, consume a significant proportion of household income. Expenditures on education, health and other necessities, therefore, are far from adequate.

Access to credit is highly limited. The informal financial market, with diverse and exorbitant rates of interest, is the sole source of credit for four-fifths of the rural borrower households. Despite a large expansion of financial institutions and products due to the establishment of joint-venture banks, the financial system remains decidedly lopsided in favour of urban centres and larger borrowers. The recent expansion of credit-based NGOs has been able to mitigate this shortcoming only to a small extent. Women, because few of them own and control assets, have minimal access to credit. Traditional, collateral-based lending and the increasing trend toward commercial banking is depriving the small, marginal and landless households of institutional borrowing opportunities. Government-owned/controlled banks have almost stopped opening new branches. The centralisation of economic opportunities in urban centres is further inducing flow of resources from the rural areas to the urban centres.

The number of absolutely poor persons has nearly doubled in the past 20 years, approaching the 9 million, 45 percent of the total population in 1996

(UNDP, 1998a). The growing incidence of poverty is the outcome of an economic process which is both growing very slowly and being distributed unevenly. Highly limited access to productive resources, high level of underemployment and/or unemployment, low wage rates and indebtedness of the poorer strata, among others, are exacerbating poverty.

The incidence of poverty varies across various caste/ethnic groups, place of residence, occupation, sector of employment, education, source of income, family size, etc. The relative incidence of poverty in the rural areas is 2.6 times higher than in the urban areas. The illiterate are much more prone to be poor than the literate. Households with agricultural workers are more prone to poverty. In particular, agriculture wage workers are likely to be poor. Households exclusively or largely dependent on agriculture income are closer to poverty than those who rely on other sources of income.

Despite an initial and small-scale spurt of economic growth following the adoption of liberal economic policy, poverty has been worsening due to deterioration in real wage rates, withdrawal of subsidies, retrenchment of civil servants, wage freeze, deregulation of administered prices and upward revision in the prices of the goods and services generated by public enterprises.

1.8. Human Development

The Human Development Report 1999, published by UNDP, places Nepal at the 144th position among 174 countries in its Human Development Index (HDI). A composite measure of life expectancy, literacy and income required for a decent living standard, Nepal's HDI stands at 0.378, against a maximum attainable value of 1. As reflected in Nepal's Human Development Report for 1998, the level of human development attainment varies widely across regions: human development in Kathmandu is, for example, four times that of Mugu, the most deprived district (UNDP, 1999b).

There are, however, other indicators of human development that are encouraging. With an increasing number of citizens and civic groups active in diverse fields, the intensity of popular participation has increased substantially

after the restoration of democracy in 1990. Civil society continues to flourish in a supportive environment characterized by a free press, increased connectivity to NGO networks, and greater access to government and donor resources. In addition, the periodic national and local elections have routinely marked a high turn out of voters, demonstrating confidence in the democratic process.

In Nepal, the delivery of basic social services as a way to eradicate absolute poverty will remain the priority for the foreseeable future. In particular, regional imbalances in development priorities and assistance by government and donor alike call attention to the need to prioritise and balance policies and investment efforts in favour of poverty reduction in remote districts. There is a strong case to be made for forging a partnership between government, donors, and local communities because of the special concern with equity and the relatively high marginal cost of achieving full coverage for the most vulnerable and unreachable groups of more distant districts.

1.9. Educational Status

The literacy rate has been increasing very slowly in Nepal. The current national literacy ratio is 40 percent. But women, many castes, ethnic and regional groups and the poor have a much lower literacy ratio. For some groups the ratio is as low as 10 percent. Only about 72 percent of the 2.7 million 6-10-year-old children are enrolled in school (1995 figures). Two-thirds of those not enrolled in primary schools at this age group were girls. Gross enrolment in primary schools, however, nearly doubled from 1.75 million in 1984 to 3.26 million in 1995. Physical access to primary schools has improved greatly in the last decade (UNDP, 1998a). Rates of repetition and drop-out are very high even at the primary level. Only 10 percent of all the children enrolled in grade one complete primary school (i.e., grade five) without repeating any grade. Low enrolment and high failure and drop-out rates are generally attributed to household work burden of children, irregularity of school operation, income poverty, physical distance to schools, caste and ethnic discrimination, neglect of mother-tongue in schools, presence of under-age students and low perceived relevance of education among parents. Although the primary education is free for all there are other hidden cost on it.

Non-formal education programmes have contributed significantly to the promotion of literacy. Some non-formal programmes focussed on out-of-school children enable such children to join school at upper primary grades. Non-formal programmes focussed on adults are reported to have imparted literacy skills to 0.93 million persons between 1992 and 1997. While access to lower secondary (grades 6-8) and secondary (grades 9-10) levels are expanding, the net (appropriate-age) enrolment rates at these levels are low at 26 percent and 16 percent, respectively. In addition, gender discrimination in enrolment at these levels is high: for every 10 girls enrolled, the number of boys enrolled is 16 at the lower secondary level and 18 at the secondary level. There is little gender variation in repetition and drop-out rates; however, higher secondary education (grades 11-12) is a recent innovation. Access to vocational schooling remains highly limited. Access to tertiary, i.e., post-school, education is limited as well. In 1991, only 0.83 percent of the total population had acquired a Bachelor's degree. Among all the college graduates, only 18 percent were women (UNDP, 1998a).

Despite announced policies, public school education is not totally free. Almost all schools charge one-time, non-tuition annual fees. Access to free textbook is limited to girl students at the primary level and to the small body of (all) primary school children in the designated "remote areas". A significant, although not an overwhelming, proportion of parents is discouraged from sending their children to schools because they are unable to pay these costs. Much improvement needs to be made in the overall quality of public investments in education. On the other hand, while the total educational expenditure and state support to education have increased gradually in the last half-decade (from an average of 2 percent of GDP and 10 percent of the annual public expenditure during 1975-1990 to an average of 2.6 percent and 13.2 percent, respectively, during 1992-1997), such levels of expenditure are far from adequate.

During the last 15 years or so, private, commercially organised educational institutions have made rapid gains due to the above-mentioned deficiencies of the public school system, rise of income and decrease in the level of fertility among urban households and the anticipation that return from

educational investments might be higher than those from productive physical assets. While the quality of commercially organised schools, in general, is noted to be better than that in publicly organised schools, the highly expensive nature of such schools means that private education cannot be a substitute for public education for the vast majority of the households. (Private primary schooling, for example, is 13 times as expensive as public primary schooling.)

2. Health Status and Health Services in Nepal

2.1. Life expectancy

In 2000, the average life expectancy at birth in the country, estimated at 57 years, was very low (WHO, 2001). This fundamental deprivation involved in the capability of surviving is attributable to limited access to health facilities and services, very low level and quality of nutrition and acute problems of sanitation. It is also attributable to the low effectiveness of health-related institutional structures. Efforts have also been unsuccessful at enhancing local stockholding in the promotion of health. At a more systemic level, high deprivation in relation to survival is linked to low rates of literacy and education, high underemployment, low income and widespread poverty and exclusion from political and social participation, particularly of women, members of the low caste groups and residents of the mountain region.

Women in Nepal, on the average, have a life span, which is *shorter* by about two years compared to men. This pattern, in addition, has remained stable at least for the last 45 years. In contrast to such a pattern, globally, women live considerably longer than men. Lower life expectancy among women in Nepal is a stark indicator of the human developmental deprivations women encounter here during their lives. Such a deprivation is intimately related to higher childhood mortality rate (compared to male children), a very high maternal mortality rate and educational, economic, political and cultural exclusion. Life expectancy also differs significantly by place of residence. Residents of the mountain region, on the average, die 7 years earlier than the residents of the Tarai. Similarly, life expectancy among the rural residents is lower by nearly 10 years compared to that in the urban areas (UNDP, 1998a).

2.2. Morbidity

Available information indicates that morbidity levels are high. However, information on causes of morbidity is sparse. Gautam and Shrestha (1994) argue that most health problems can be attributed to insufficient food intake, early marriage and early-age child bearing, poor housing, lack of access to safe drinking water, insufficient sanitary facilities, outdoor and indoor air pollution, abuse of alcohol, tobacco and drugs, natural disasters, insufficient provision of health services, and socio-economic deprivation. These conditions give rise to distinct patterns of morbidity, which, in turn, have definite consequences in terms of mortality.

Early and universal marriage has traditionally been common in Nepalese culture, although the practice of delayed marriage appears to be on the increase. In 1961 nearly 75 percent of young women aged 15-19 years were married; this figure declined to just under 50 percent by 1991, and most recent figures from the 1996 Nepal Family Health Survey (NFHS) show 44 percent of 15-19 year old women to be married (Mehta, 1998; Khanal, 1999). Among young women who are married, early onset of childbearing is common. Most recent figures from NFHS indicate that, by the age of 19, 31 percent of women have one child and a further 12 percent two or more.

Data on morbidity compiled from cases reported in public health institutions (sub-health posts, health posts, and primary health centres and district, regional and central hospitals) are far from complete. Nonetheless, they provide a simpler, even if tentative and less than definitive, indication of the scale and the leading causes of morbidity.

2.3. Disability

Data on disabled persons are sparse. The disability rates reported are contentious as well. A disability rate of 10 percent (of the total population) is often regarded as the global "norm". But it should be taken as a sharp indicator of governmental apathy towards the disabled that the censuses fail to report even the total number of disabled persons in the country and, instead, provide information on disability only when reporting the "economic activity"

rate. That is, disability, in the censuses, acquires salience only on account of the economic inactivity it presumably signifies. The censuses, as such, report disability rates only for those 10 years age and older. In addition, disability is apparently highly under-enumerated. The censuses of 1971, 1981 and 1991, put the proportion of the physically and mentally disabled population aged 10 years and over at 1.1 percent, 1.5 percent and 1.3 percent, respectively. On the other hand, various organisations struggling for the rights of the disabled have put forward much higher estimates of disability, sometimes well above the global "norm" (UNDP, 1998a).

A survey on disability among children up to six years of age, which utilised parental reports on the disability of their children (NPC/UNICEF, 1997b), found that 2 percent of the children had hearing difficulty. The survey also found that 0.7 percent had difficulty seeing at night. 2 percent up to 3 years of age suffered from physical disability and another 0.2 percent suffered from mental disabilities.

While there are sufficient grounds to believe that the censuses significantly under-enumerate the disabled, it is probably unfair to define disability solely on medical grounds. Disability (and, more generally, health and illness as such) and, more importantly, disability-led deprivation are culturally - and economically and politically - constructed as well. In particular, the fact that the scale of self-employment in the country is high (and the scale of wage employment low) leads to a considerable muting of the extent of deprivation due to partial disability.

2.4. Maternal Mortality

Maternal mortality is one of the key indicators of the status of reproductive health care service delivery and utilisation, and also of women's overall status in the society. The maternal mortality *rate* in the country, at 850 per 100,000 women aged 15-49 years, however, is one of the highest in the world (WHO, 1999). This estimate suggests that 27 percent of all deaths of women aged 15-49 years are attributable to childbirth complications. The maternal mortality *ratio*, which, on the other hand, indicates the extent of obstetric risks associated with live births, is estimated to be 539 per 100,000

live births (for the same period). The level of maternal mortality in the country, thus, is one of the highest in the world, proximately linked, among others, to the low level of access to antenatal, delivery and postnatal care. Over 90 percent of births in the country take place at home and without professional assistance.

Although recent data are unavailable, it can be assumed from previous data that the nutritional status of most rural Nepali women of childbearing age is extremely low. While in some communities, pregnant women are known to consume special food such as chicken, especially if their families are relatively wealthy, in general women are not acknowledged to have special dietary needs during pregnancy. Studies have shown a widespread lack of sufficient protein, vitamin A, iron and iodine in the diets of rural women (New Era, 1994).

Micro-level studies have shown that rural Nepali women work an average of 14 to 16 hours per day, and there are indications that women's workload remains relatively the same during pregnancy (HMG/JICA, 1995). Women often do not achieve the expected weight gain during pregnancy, due to continued workload and primarily to lack of calories and protein, and proper recovery of the mother and healthy development of the foetus are not always ensured. Lack of iodine in the mother's diet can lead to still births, mental retardation, hearing impairment and cretinism in the child, and is a major contribution to childhood disability in Nepal.

Nutritional anaemia is one of the major contributors to the high maternal mortality rate in Nepal. It is well documented in studies carried out in other countries that nutritional anaemia is associated with severe health risks for the infant, including intrauterine growth retardation, stillbirth, premature birth and low birth weight. For cultural and economic reasons, many Nepali women eat little meat and green leafy vegetables, which makes it difficult to obtain iron through diet alone. Iron deficiency anaemia is a widespread and neglected problem among women and children in Nepal. Although nutritional anaemia is common, especially among pregnant women, there are no national-level studies, which give a definitive picture of the problem. According to the Joint Nutrition Support Programme survey of 1986, prevalence rates of anaemia

ranged from 71 percent in Sindhupalchowk District (in the hills) to 95 percent in Nawalparasi District (in the Terai) among mothers of children six to 36 months (JNSP, 1986 cited from UNICEF, 1996a). A study conducted in 1987 reported that the prevalence of anaemia is about 68 percent among non-pregnant women in the middle hills (Melville, 1987).

The high maternal and infant mortality rates of Nepal are a product of the low availability and utilisation of health services, the poor health a nutritional status of expecting mothers, inadequate birthing practices and early, closely spaced and repeated pregnancies. Women's poor nourishment and frequent pregnancies result in physical depletion, birth complications and delivery of low birth weight babies with low chances of survival.

2.5. Infant Health and Infant Mortality

The infant mortality rate is widely and legitimately regarded as a key indicator of the level of public health achievements as well as general socio-economic development. More importantly, however, it is a fundamental indicator of human deprivation in as much as it signifies, to a large extent, an avoidable end of human life itself. Nation-wide data on infant mortality is inconsistent, due to inadequacy of reporting and the absence of a formal system of birth and death registration. In particular, census data generally show a significantly higher rate of mortality among the female infants than among the male.

Infant mortality rate in the country, at 98 per 1,000 live births, is very high (WHO, 1999). Nearly one child in every ten dies before reaching the age of one. Contrary to expectations, however, male infant mortality rate is slightly higher than the female rate. The NPC/UNICEF (1996) findings, which report that there is no gender difference among children 6-36 months of age in relation to nutrition, also lend credence to these infant mortality figures.

Infant mortality, however, varies substantially by region. Infants in the rural areas are exposed 1.6 times more to risk of death compared to infants in the urban areas.

Similarly, infants in the mountain region are two times as likely to die as infants in other ecosystem regions. Furthermore, infants in the mid-western and far western regions have a very high mortality rate compared to others. On the other hand, many more infants now enjoy an opportunity to survive than in the past (UNDP, 1998a). Urban IMRs are consistently lower than rural figures because women in urban communities generally have better access to health facilities, greater awareness and use of perinatal health services, and more income with which to utilise those services.

The Nepal Family Planning, Fertility and Health Survey has shown the effect of socio-economic variables, including education, hygiene, environmental sanitation and place of residence on infant mortality (MOH, 1993). Educational level of mother, correlated with other factors of low socio-economic status especially health awareness and women's workload, is a significant indicator of potential infant health. The difference in average IMR between mothers having no education and having some education is about three-fold (39 compared to 103). Combining socio-economic variables, it is seen that children living in mountain areas, with mothers aged less than 20 years and having no education, stand the highest chance of dying before they reach their first birthday.

The poor nutritional status of pregnant women results in a high incidence of low birth weight (LBW) deliveries, infants who are more susceptible to illness, particularly acute respiratory infections (ARI). The average incidence of low birth weight deliveries is less than 10 percent in most developed countries. Data in Nepal on low birth weight are based on small samples and are variable. The main causes of death during the perinatal and neonatal periods are congenital abnormalities, prematurity, birth injuries, neonatal tetanus and low birth weight. The Nepali child still benefits from the almost universal practice of breastfeeding. The 1995 NMIS reports that approximately 90 percent of Nepali women are still breastfeeding at 18 months and at least half of the women in Nepal continue to breastfeed to the child's third year (HMG/ NPC/UNICEF, 1995). The mean duration is about 30 months (HMG/ NPC/UNICEF, 1995).

2.6. Family planning, fertility and contraception

The Family Planning Association of Nepal, a non-governmental organisation, introduced the family planning programme for the first time in 1959 when family planning services and information on contraception became available in Kathmandu. Public sector intervention in family planning were introduced in 1968 (Pant and Acharya, 1988) with the formation of a Family Planning and Maternal Child Health Board. Its implementing body, the Family Planning and Maternal Child Health Project, was instituted under this board. The Family Health Division, which is the eventual successor of the project, carries out various family health services in all districts of the country. Private and NGO sector initiatives have also played a key role in assuring access to family planning. Despite these efforts, and despite the professed desire of most mothers to limit the number of children, Total fertility rate (TFR) remained constant at around six during 1961-1986 (CBS, 1987; MOH, 1987). That figure declined marginally to 5.8 in 1991 (MOH, 1992, 1996a) and more rapidly, to 4.5, in 1996 (MOH, 1996a).

Access to knowledge on contraceptive methods, modes of procurement and use has increased sharply within the last two decades, however. The percentage of currently married women aware of at least one method of family planning as well as its accessibility increased from 6 percent in 1976 to 33 in 1986 and 56 percent in 1996.

2.7. Reproductive health and safe mother-hood

The reproductive process, however, remains a serious health hazard for women in Nepal. As already noted, the maternal mortality ratio is extremely high. Such a ratio can be linked to a number of social and health-related features. Approximately 44 percent of all women are married by age 19 and 42 percent of all married women give birth to a child by that late teen age. Approximately two-thirds of all pregnant women are anaemic. An overwhelming proportion of women does not have access to professional health facilities and services during childbirth. While this is undoubtedly beneficial for the child, many mothers remain deprived from adequate nutritional and other support during this period. Data for 1991 and 1996 show

that the extent of deprivation among mothers has increased with respect to the incidence of early childbirth and anaemia. More mothers, however, been able to access immunisation against tetanus and to receive semi-professional support during childbirth.

Access to professional or semi-professional antenatal care has improved a great deal between 1991 and 2001 (MOH, 2001). Increase in such access has been pronounced for women in the Tarai. While far more women in the urban areas enjoy such access than women in the rural areas, the trend shows that such care is increasingly available in the rural areas as well. Yet, nine out of 10 deliveries occur at home. Even in the urban areas, the majority of women give birth at home. Most births continue to be assisted by friends and relatives. Indeed, 11 percent of all births are totally unassisted and present great risk for both the mother and the child. Only 13 percent of all mothers have access to professional post-natal care. Another 24 percent access post-natal care from traditional birth attendants with varying levels of skills (MOH, 1996a).

Recently, a more organised safe-motherhood programme has been initiated in the public sector. In its first phase, it is being implemented in 10 districts. The programme, among others, seeks to strengthen community-based maternal health services and the referral system, to standardise maternity care practices and to upgrade the quality of maternity care in institutions. The main foci of the Safe Motherhood Programme are to improve the quality of maternal care services, including family planning services, at all levels of the health care delivery system and in the community, and to provide women with knowledge about maternal health and nutrition, including hygienic birthing practices, perinatal maternal nutrition, and breastfeeding. Accompanying the programme, a number of legislative and regulative activities have taken place.

2.8. Immunisation

Neonatal tetanus, pertusis, measles, acute respiratory tract infection, polio, tuberculosis and diarrhoea are the major killers of children in most of the developing world. They are also the major causes of morbidity and disability.

In Nepal, the expanded programme for immunisation, which has been internationally organised as a major initiative against these diseases, was started in 1977. At its initial stage, it covered only three districts with one antigen. In addition, the coverage of immunisation until 1985 was limited to a small proportion of eligible children, often only those who lived in district headquarters or close to health institutions (UNICEF, 1992a). By 1989, however, it was implemented, with six antigens, in all districts. By 1990, according to the data generated by the government, more than 90 percent of the children below one year of age were immunised against tuberculosis. The coverage rate for DPT3 and OPV3 was 78 percent while, for measles, it was 67 percent. Evidence from MOH (1996a), however, indicates that the high immunisation rates reported may have been inflated.

Relatively independent data sources, accordingly, report a much lower immunisation rate for the more recent years. The 1995 NMIS (NPC/UNICEF, 1996) study indicates that BCG coverage for children under 12 months was only 72 percent. Access to DPT and OPV was limited to 50 percent of the children. Only 47 percent of all eligible children had access to immunisation against measles. Furthermore, another set of 1996 data (CBS, 1997a) shows that only 36 percent of all children under five years were fully immunised. Children in the rural areas and the mountain region are particularly deprived from immunisation (MOH 1996a). For 1995, the WHO ranked Nepal as one of the 12 countries, which accounted for 80 percent of the global estimated neonatal deaths from tetanus. In addition, the WHO has classified 21 of the 75 districts as high-risk areas.

The rates reported on immunisation inflated their impact in another extremely worrisome way as well. The efficacy rates of vaccines under field conditions are generally found to be very low. Illustratively, the protection that measles vaccine provides has been estimated at only 22 percent (NPC/UNICEF 1996). That is, only one out of five children vaccinated against measles is likely to be fully protected against it. Failure to maintain the cold chain, which is extremely important in keeping the vaccine potent, is the main reason underlying such a low efficacy rate.

Access to immunisation against TT, among women aged 15-49 years, also remains very poor. In 1996, only 19 percent of the women in this reproductive age category had access to more than one dose of the TT vaccine (MOH, 1996a).

Vital activities to ensure safe motherhood also fall within the purview of other sectors. These include, among others, hygiene and sanitation awareness, parenting education, control of micronutrient deficiencies, and reduction of women's workload (refer to the chapters Protection and Care, Preparation for Life, and Family and Environmental Conditions). Antenatal health care has traditionally not been practised in Nepal. Pregnancy is usually diagnosed symptomatically by the woman herself. Nepali women are shy about discussing pregnancy and it becomes known to outsiders only when there are visible signs. Due to cultural modesty, women are reluctant to seek antenatal care, especially from male health workers (Simkhada, 1999).

2.10. Access to food and nutrition

Nutritional status is determined by various factors operating at various levels. At the individual and household level, availability of food items, their processing, timing of intake and intra-household food distribution regimes can impact on nutritional status. Access to productive resources (principally agricultural land), work and employment and income can also crucially impact on household nutritional status. Mechanisms of redistribution and general prosperity among the kin and in the community can also affect nutritional status significantly. At the macro level, nutritional status remains crucially linked to overall food production, marketing (including import and export) and non-market support to food security provided by the state. Low man/agricultural land ratio, skewed land and income distribution, widespread poverty rapid population growth, poor performance of the agricultural sector and the overall employment market and irresponsive political structures have all contributed to making Nepal a food-insecure region - notwithstanding the fact that agriculture is the mainstay of its economy. Thus, food security, which is defined as a state of affairs where "all people at all times have access to safe and nutritious food to maintain a healthy and active life" (FAO, cited in

Koirala and Thapa 1997), remains a distant dream for the majority of the people.

Available statistics for 1995 indicate that 55 of the 75 districts have a food deficit. As a result, the export of food grains (particularly rice and maize), which was the major source of foreign exchange earnings for the country until 1979, dwindled by the mid-'80s. The country now imports a significant quantity of food grains. The scale of food imports, in addition, has been increasing. The food and live animals import/export ratio, which was 1.46 for 1986/87, increased to 2.75 in 1995/96 (CBS, 1997b).

The recommended minimum caloric requirement for an adult in the country is 2,250 kilocalories per person per day. Adult caloric requirements, however, vary by a number of conditions. Among such conditions, only a rough regional classification has been made in the country. According to this classification, 2,140 kilocalories person/day is recommended for adults in the Tarai while the corresponding recommendation for the Hills and the Mountains is 2,340 kilocalories. In addition, for both men and women, 2,250 kilocalories are recommended. Refined and fully reliable data on actual food intake and their calorific values, however, are not available. Information on the distribution of food and nutrition across regional, socio-economic, gender and age groups is not available either.

2.11. Access to safe Water and Sanitation

The status of public health, in addition to the level of access to nutrition and health/medical facilities and services, crucially depends upon the level of access to safe drinking water and sanitary facilities. Despite continuing improvements, however, the level of such access in the country is very low.

Water, particularly safe drinking water, is a scarce good in many parts of the country. Most settlements and households do not have access to piped water. In such instances, fetching water from a distant source daily consumes considerable time and energy - particularly of girls and women, who generally perform this task. The onerous nature of this task implies that households make do with as little water as possible. This is particularly true of the hill and

mountain regions. The level of per capita consumption of water, therefore, is very low. The highly limited use of water, on the other hand, is one of the principal causes of a low level of sanitation.

Furthermore, in areas in which water is more accessible and/or is piped to the settlement or to the house, the safety of the water for human consumption is problematic. This is particularly true in the urban areas, and health workers and the mass media regularly counsel residents to drink only boiled water. In urban areas, *E. coli* counts in drinking water are reported to be high and increasing. In addition, it has also been reported that contamination of drinking water, including in the rural areas, occurs because of unsanitary storage and utilisation mechanisms.

Access to latrines, however, is extremely low in the rural areas. It is also the single most potent source of environmental pollution. The very high prevalence rate of diarrhoea and dysentery and other water-borne diseases owes principally to the low level of access to latrines. Access to sanitary latrines unlike access to drinking water, increased only marginally during 1991-1996. The MOH data on latrines are fully corroborated by the 1996 NPC/UNICEF (1997a) data.

Limited housing space because of large family size and broad-based poverty, also leads to a variety of pollutions. Indoor smoke pollution and diseases associated with such pollution are endemic, particularly in the northern areas with a cold climate where the wood-based hearth is also utilised as a living room and the kitchen heat is utilised to heat the home. Communicable diseases find a receptive condition in such settings. The very high incidence of skin diseases there, noted earlier, can be linked to such housing conditions. The high incidence of tuberculosis, measles, etc. can be similarly linked as well.

APPENDIX 2

LEGAL STATUS OF WOMEN IN NEPAL

1. The Constitutional Rights (1990)

Between 1990-91 Nepal's political structure underwent a fundamental change. The *Panchayat* one party system of government with an absolute monarchy as the head of the state gave way to a constitutional monarchy with a bicameral parliament, an executive cabinet responsible to the parliament, and an independent judiciary. The Constitution guarantees fundamental rights to all citizens without discrimination on the basis of ethnicity, caste, religion or sex. It also in theory guarantees equal treatment before the law without discrimination on the basis of caste, sex and religion and equal pay to men and women for similar work. Provision is made for equal rights to all citizens to earn, enjoy, sell and transact wealth within the law. The Directive Principles include a policy statement for making special arrangements for women in education, health facilities and employment. The Constitution specifies those political parties contesting elections to the Lower House must have at least 5 percent women candidates. The Upper House of 60 members must have at least 5 percent women.

With minor exceptions, laws in Nepal gemerally allow only males to permanently inherit property. Although widows do inherit the property of their husbands and enjoy the right to dispose of it with some restrictions, the property passes automatically to male lineage holders after the widow's death. A daughter gets an equal share with the son in ancestral property if she remains unmarried. The husband is free to dispose of up to 56 percent of the joint family property at any time.

Article, 17 (2) of the Constitution of Nepal (l990) clearly guarantees the right of all citizens to acquire, enjoy, dispose of, and deal in any manner with their property. However, existing laws fundamentally discriminate against the interests of women. For example:

- It is not mandatory for the father to provide food and clothing to his daughter, but only to his son and wife.
- The son and his wife, but not the daughters are entitled to a share of the father's property if he does not provide food and clothing.

- A married daughter does not have the right to inheritance as long as the son or son's son is alive.
- Under the Land Reform Act 2021 (BS), tenancy rights are transferable to the wife or sons of the tenant after his death, but not to the tenant's daughter or widowed daughter-in-law.
- Article 9(2) of the Constitution identifies a child as a citizen through the identification of the father only.
- A woman requires her father's or husband's written permission to apply for a passport.

It is interesting to note that the principal legal terms used to define women are related to marriage and to sexual relations, which are synonymous under Nepali law. Women are characterized as "kanya" (virgin), "bihe nagareko" (never married), "bihe gareko" (married), "liyaeko" (brought as wife but not formally married), "bahira rakheko" (kept secretly outside the home), "chora hune" or "chora nahune" (with or without sons), and "vldhva" (widow). By using these terms, the legal code assumes that every woman who is not incapacitated will at some stage be married and that the principal source of rights to property for a woman is found in her status as wife and mother (Gilbert, 1992).

There are only two categories of property over which a woman may have independent control. "Daijo", or dowry, consists of property given to a woman on the occasion of her marriage by her relatives, friends and neighbours. This property is not included in the ancestral property to be shared with the husband's family. "Pewa" is any property that a woman owns as a direct, legal gift from her husband, father or brothers, or property she has earned herself In terms of household decision-making, however, women may not have actual control over this property.

Women's limited property rights constrain their roles as caregivers. They are prevented from having autonomy in alternative income generation, as they cannot provide collateral for loans and have restricted access to capital for investment.

There are notable exceptions in some of Nepal's ethnic communities, whose traditional practices at times o contrary to the modern, conservative

legal system. Many ethnic communities of Tibeto-Burman origin, such as the Newar, Gurung, Tamang, Sherpa, Limbu and Rai, have more egalitarian practices regarding women's property rights. In the Sherpa family system, for instance, separate and equal property shares are provided to both sons and daughters. Among the Tamang, daughters also inherit family property. The Newar at one time enjoyed a system of ensuring property rights to daughters, although this has been lapsing in favor of the male-oriented modern legal system.

However, two basic discriminatory features of the Nepalese tradition, gender discrimination in citizenship and inheritance rights are retained by the new structures. The Constitution guarantee equal rights to all citizens but the Citizenship Chapter of the Constitution and subsequent Acts discriminate against women in not recognising maternal decent for natural citizenship rights, an in unequal treatment of foreign spouses of male and female citizens. Equal property rights areguaranteed to earn, enjoy and transact wealth within the laws, which are discriminatory against women.

2. The Inheritance System and Women's Command over Resources

Lack of control over family resources is in part a product of women's inability to acquire independent resource bases with which they can exercise autonomy and independence. This inability stems from the lack of legal rights, especially property rights, allowed women in Nepal.

According to the National Code, as amended in 1975, a woman shares equal rights of inheritance with her husband and her sons in her husband's property. She is also an equal co-partner (one who may claim a share) in the ancestral property, if her husband is not alive, provided she is at least 30 years old and/or has been married for at least 15 years. She is entitled to equal inheritance rights with her brothers in her parental household only if she is unmarried at the time of partition of the property. The property she gets in the marital household is conditional on her remaining faithful to the husband and his clan even if he is dead. She looses all rights to his property on marriage to another person or divorce. She has no claims on even maintenance after five years of divorce. A woman inheriting property in her parental household must

return this property to her brothers or their direct male descendants if she decides to get married afterwards. A woman has absolute rights only over Stridhan. Stridhan is property which originates in the woman's own earnings, gifts from her parental household, her husband, his household or from any other sources. Her access to sources of income are, also limited by the "family law", according to which the husband has the right to decide the place of settlement, and the wife has to have her husband's permission to work outside the home. Also, a woman can make legal contracts only in connection with her *Stridhan*. These provisions severely limit economic and political options for women. Attempts at integrating women in development programmes and projects often fail because of these social and economic constraints.

A constant struggle is being waged by women activists at various levels in the last the 5 to 6 years for reforms in inheritance laws so that daughters also may inherit in parental property. A new Bill introducing some changes in the inheritance rights making women's access to property a little more has been approved by the Parliament. The New law removed the age limits for women to inherit property both in the natal and afinial households, to ensure property rights of divorced women while she is not remarried, to make girls eligible for adoption, and to strengthen preventive measures against polygamy, child marriages and rape. However, a woman's right to inheritance will remain conditional on her marital status. On marriage a daughter will still forfeit all her rights to inheritance in the natal household.

3. Women's personal rights

Changing attitudes and practices, be they regarding hygiene, care of diarrhoea or the education of girl children, are not simply a product of communicating information. Changing personal and often tradition-bound behaviours requires a process of psychological transformation, a "willingness-to-change" which in Nepali women is constrained by low self-esteem and lack of assertiveness. Repeatedly, it has been noted that providing women with literacy, peer support, opportunities for self-expression and avenues of autonomous action leads to the development of self-confidence, and this in

turn leads to increased inclination to receive new ideas and to implement them in the home.

Prevailing practices in Nepali society, both cultural and legal, militate against women's psychological "empowerment". Essential life decisions, such as marriage, divorce and fertility, are denied even when granted to women by law. Women generally have little choice in selecting marriage partners, or in choosing when or whether to get married. These decisions are made for them by their parents.

As soon as a girl reaches adolescence, in many communities the family will start looking for a groom. In most communities, the marriage of the daughter is arranged by the age of 16 and, in some communities, below this. Marriage is often feared by girls, and the trauma of marriage is constantly referred to during a girl's childhood. According to the 1991 census, the mean age at marriage for males at that time was 21.4 years and for females was 18.1 years. The mean age at marriage for females was 18.9 years in the hills, 18.6 years in the mountains, and 17 years in the Terai. If marriage trends are examined by district, the highest mean age at marriage (23 years) was found in Mustang, a northern, primarily Bhotia, area, and the lowest (15.1 years) in Kapilvastu, Bara, and Parsa Districts, in the strongly Hindu Terai (CBS, 1991).

There is a more marked preference for later marriages today compared to the 1980s. Another study estimates the current average age at marriage to be 20 years for women and 22 years for men (Shrti Shakti 1995). The study found that the mean age at marriage in rural areas was 19.3 years for women and 21.8 years for men, while in urban areas, both men and women tend to delay their marriage, to 20.2 years for women and 23.9 years for men.

Most Nepali women have little control over how soon they bear children and how many children they will have. These decisions (in the absence of access to birth control) are often made by the woman's husband and mother-in-law after her marriage. An adolescent could have borne her first child by the age of 14 or 15, facing many years of reproductive life, combined with the physical burden that many pregnancies can place on a poorly nourished and overworked individual. With the birth of her first child, a girl is fully accepted as an "adult", although for many years she still may be subject to the authority of

her mother-in-law and her husband's family. According to a 1986 study, 40 percent of women had given birth to one child between the ages of 15 and 19 (New Era, 1986).

A woman has the right to divorce. The divorced woman is granted the right to claim up to five years of maintenance from the former husband. However, a separated or divorced woman has the right to keep her children only until they are five years of age.

4. Laws Against Violence

Another problem women face is the widespread violence against them, in both domestic and community level. This violence may range from a lighter "eve teasing" to export for prostitution in the public arena and from mental torture to violent beating and rapes within the domestic arena.

The laws against violence are focused on physical violence and trafficking only. Law against trafficking in women and children are described in a following chapter. Violence against women in domestic, social and work arena is hardly touched by current laws. The only redress available to women victims of domestic violence is her share of property in the afinial household. Mental cruelty is completely ignored. Enforcement of laws is lax and legal and judicial structures are normally inaccessible to women. The punitive provisions of the law on rape are not up to international standards. For example, rape of girls below 14 years of age is punishable by imprisonment ranging between 6 to 10 years, while those of women above 14 the imprisonment may range between 3 to 5 years. Additionally, a rape victim is entitled to half of the property of the culprit.

The new Bill discussed above has also provisions to strengthen punitive measures against rape. According to these provisions the rape victims are to be classified in three categories instead of two, namely those below 10 years of age, those between 10 to 16 years and those 16 years and above. According to the new provisions victimisers of girls below 10 will face imprisonment ranging between 10 to 20 years. Rapists victimising girls between 10 to 16 will be punishable by imprisonment of 7 to 14 years.

Punishment for rape of women above 16 has been increased to imprisonment of five to 10 years.

5. The Labour Laws

The Constitution of Nepal (1990) guarantees equal pay for men and women workers in similar jobs. Working conditions in general are governed by Labour Act and the Trade Union Act, both promulgated in 1992, replacing the old acts, which placed restrictions on freedom of association. The Labour Act, which replaced the 1959 Act, incorporates provisions of job security, minimum wages, clean and healthy working environment, security, and welfare measures, code of conduct and penalties, consultative and co-operative management and labour courts for dispute settlement. The Trade Union Act is primarily geared to maintaining industrial peace while at the same time protecting the constitutional rights of the workers to organise for collective bargaining and redress of their legitimate demands according to ILO standards. This Act has no gender specific provisions. The Labour Act together with the Labour Regulations (1993) formulated under the Act have following provisions specifically relevant to women.

- 52 days of paid pregnancy leave up to two pregnancies, replaceable in case of death of either of the previous children.
- Create child care facilities equipped with necessary toys and staffed with trained caretaker for babies and children of the women workers, in cases where the factories employ more than 50 women, and necessary breast feeding time for women with breast feeding babies.
- Separate toilet facilities for women and men in factories employing more than 50 women.
- Working hours have been fixed at 48 hours per week or 8 hours per day including half hour lunch break. Only 5 hours of continuous work is allowed. Overtime work is allowed only for four hours per day, which must be paid at 1.5 times the regular rate.
- Women and underage children may not be generally employed outside 6 A.M. to 6 P.M. except in cases of special agreements between the management and the Workers, and in hotel, travel, tourism and related

business. In such cases women must be provided with necessary security.

- Individuals may not generally be required to carry loads larger than their own body weight, except in cases of adult male workers carrying pre-packaged loads. Allowable load for girls of 16-18 years of age is 20 kg. Boys in the similar age group may carry 25 kg. Adult men and women may carry 55 kg and 45 kg respectively.

Women are entitled to equal pay for similar jobs as stated earlier, but are discriminated in practice because they are concentrated in lower paying jobs and get hired mostly at piece rates. It is telling that even government fixed wage rates is lower for tea estate workers, where women are concentrated.

6. Migration Law

Several laws and Orders in Nepal restrict women's options for legal international migration:

- The Foreign Employment Act was enacted in 1985 in response to the increasing numbers of Nepalese who were migrating from the country in search of employment abroad. It requires licensure of foreign employment agencies and specifies which countries can recruit Nepali workers.
- In 1998, Section 12 of the Foreign Employment Act was amended to prohibit the provision of foreign employment to women and minors without the permission of the government and their guardians.
- A Foreign Employment Order issued by the Ministry of Labour further limits the overseas travel of women under 35 years of age, unless they are accompanied by a relative or can show proof of consent from a guardian.
- The Passport Order requires women to show permission letters from their fathers or husbands, even for travel to India. This was issued despite the Open Border Agreement of 1950 that effectively allows citizens of India and Nepal to travel freely between the two countries without displaying passports or visas. The order is not legally stipulated but is widely implemented by immigration authorities, especially in the case of young women, single women or women from disadvantaged social groups.

7. Interface between HIV/AIDS policy National Plan of Action for trafficking

The National Policy on AIDS and STD Control and the Strategic Plan for HIV and AIDS in Nepal, 1997-2001, have been issued by the National Centre for AIDS and STD Control of the HMG/N Ministry of Health, Department of Health Services. These documents are based on a pro-rights framework, while at the same time addressing those factors that render persons more vulnerable to HIV/AIDS. Likewise, the Ministry of Women, Children and Social Welfare has issued National Plan of Action for Trafficking. Many of the features of the anti-trafficking laws and policies are in direct conflict with the HIV/AIDS policy in Nepal. This is most striking in the areas of prostitution, migration, and care and support.

7.1. Prostitution

The HIV/AIDS Strategic Plan recognises that that the HIV epidemic has raised a number of human rights concerns. Those most relevant to trafficking are the issues of workplace discrimination and the legal regulation of prostitution. Although the Strategic Plan makes no specific recommendations for legal reform, it does provide that legal reform be based on non-discrimination in order to produce an "enabling environment." At no point does it call for limitation or criminalization of prostitution as a strategy for controlling HIV.

7.2. Migration:

The HIV/AIDS Strategic Plan explicitly recognises that the population in Nepal is "highly mobile," and that both domestic and international mobility opens up sexual and other networks, thereby creating conditions for the spread of HIV. It recognises that *"movement of young people to towns has its origin in the poverty and harshness of rural living,"* and calls for interventions to effectively address the spread of HIV without compromising the right to freedom of movement and the right to seek a better standard of living. The Strategic Plan bases its interventions on the stated premise that improvement of living conditions (including education and primary health care) may reduce

internal and external mobility, without making suggestions for the implementation of laws to limit migration.

7.3. Care and Support

The HIV/AIDS Strategic Plan highlights the need to ensure the continuity of employment of HIV-infected persons, to ensure that persons living with HIV/AIDS receive medical treatment and access to services without discrimination, and that counselling is provided to positive persons as well as to their families. Similarly, the National Plan on trafficking calls for counselling of the victim, her family and community of origin, legal assistance, use of victims as peer educators, and the establishment of a *"system for ongoing mobilisation and advocating for victim, family, and community, ongoing health and counselling programs, and privacy protection."*

However, the National Plan of Action for trafficking also calls for identifying and rescuing sex workers, setting up monitoring systems to *"keep records of the progress of the victims,"* and the establishment of *"transit homes,"* without specific statements to protect against potential rights violations in the implementation of such recommendations.

APPENDIX 3

THE ROLE OF NGOS

1. The rehabilitation, care and support of trafficked women

During the past decade, both the scale of trafficking in Nepal and public awareness about the problem has increased. Various international donor agencies have supported anti-trafficking s, which have become a high priority issue for many donors. However, there has been very little documentation, monitoring, or evaluation of the effectiveness, feasibility or sustainability of current intervention approaches. As I mentioned in a previous chapter, existing interventions have been reviewed many times as part of broad-brush anti-trafficking strategy development activities, but their individual components have rarely been examined in-depth.

This sub section analyses the different approaches adopted by NGOs, particularly by rehabilitation centres to address the problem of trafficking in women and girls in Nepal. Intervention approaches were assessed according to the conceptual framework outlined in the previous chapter, with attention to issues of coverage, feasibility, sustainability, and effectiveness. Intervention approaches were assessed both in terms of content (e.g. what kind of anti-trafficking messages or advice were they giving out?) and in terms of process (e.g. how was a particular approach implemented?). Activities and efforts to prosecute and convict traffickers were not considered focused on in these approaches, unless they impacted directly on efforts to rescue individuals. For this analysis purpose, interventions are classified into three main categories: pre-trafficking, during trafficking and post-trafficking interventions. These three level interventions are carried out mainly by following activities.

2. Awareness raising activities

Activities that raise awareness, give advice, and provide social mobilization operate with an underlying assumption that information and education leads to desired behaviour change. Six NGOs made instructional and educational (IEC) materials available for review and two NGOs were observed. Based on observation and those materials different issues were identified.

In line with the common definition of trafficking, all IEC materials available for review equated trafficking with sex work. Many contain gruesome descriptions of suffering due to sex work. However, materials from one NGO attempt to address this by actively promoting tolerance and acceptance of returned trafficked sex workers. Most IEC materials encourage girls to stay in their villages, while providing little information on safe migration. NGOs report that some families are afraid to allow their migrant daughters to return to their villages for fear that they may be prevented from leaving again, be arrested as potential traffickers, or face stigma as sex workers. The message in many IEC materials is that trafficking is due to a girl's extravagant wish for a modern life and more money. They urge girls

"Not to be so modern, work hard, be patient and stay at home."

These messages are not relevant to the realities of women's lives at the village level. They assume that home and village life is a good place to be, but that is not always the case. Some NGO informants noted the conflict between women's empowerment messages and educational activities that encourage women to dream and have aspirations, and anti-trafficking messages that encourage the opposite. Only three NGOs gave advice for women on what to do if approached by someone to leave their homes for work or marriage. The advice included suggestions such as:

Before marriage, inquire about the family, address, and work of the boy. Before deciding about marriage or taking a job, discuss this with others.

Guardians should accompany girls to their jobs and be careful of strangers - men and women.

Before starting work, inquire about the full address of the work place and the employer.

While such advice takes the first step of acknowledging that women and girls migrate, it may not be enough to safeguard them. In cases where women are trafficked by those known to them, they may trust them and not perceive a risk at all. In addition, it is known how often family and community members are involved in trafficking. Most IEC materials portray traffickers only as strangers. Accompanying girls to a workplace, or taking down the address of

the workplace, may not in itself prevent onward trafficking from the work site (which, according to the NGOs, is a growing trend in Nepal).

3. Capacity building and improvement of livelihood activities

Some form of income generation, micro-credit, or vocational training is a feature of most community-based and targeted interventions. Common activities include animal husbandry, credit for buying goats/chickens, developing vegetable gardens, setting up teashops, bee keeping, sewing /tailoring, credit to buy sewing machines and other technical help.

The underlying assumption of such activities is that improved economic opportunities in the rural areas will prevent women and girls from needing to migrate and from being trafficked in the process. They can therefore be more accurately described as a migration or community development strategy with indirect or incidental effects on trafficking. There are a few cases who were successful in improving their livelihood with a small business.

> *Pema* was sent back to Nepal after one year when she was rescued during a police raid. She did a tailoring course at a rehabilitation shelter and returned to her parents' place. She was provided a sewing machine by the NGO and now earns money as a tailor.

One NGO actively attempts to intercept girls and women at border points between Nepal and India. In collaboration with the police, trafficking survivors are posted at border stations to intercept women and girls crossing in suspicious circumstances. If any doubt about their circumstances remains after questioning by the police, they are held in a transit home until a guardian is contacted or, if they do not wish to return home, they are referred to a Kathmandu shelter run by the same NGO.

In this intervention programme, trafficking is suspected in cases where the suspected victim gives hesitant or conflicting answers to questioning. This strategy has not been systematically evaluated for accuracy and, indeed, there have been reported instances of women and girls who have been prevented from crossing the border of Nepal despite their vehement protestations that they are travelling of their own free will.

In addition, attempts to intercept trafficked persons at the border cannot cover all border points. The current programme covers only four of the 26 Indo-Nepal border posts and it seems likely that traffickers would simply shift their operations to the border crossings that are not monitored.

All NGOs agreed that a primary aim of care and support should be to reunite girls with their families and communities. All acknowledged, however, that this was difficult and that in certain circumstances it was neither possible nor desirable. NGOs noted that, given the stigma associated with sex work and with HIV in Nepal and the increasing publicity given to the link between working in India and having HIV, communities may refuse to accept girls back when their history is known. Families themselves may also be reluctant to take girls back, fearing social censure or ostracism from the wider community. In addition, families may (with some justification) worry that any loss of prestige would affect the marriage chances of other children. They may also fear retribution from the broker from whom they may have received money. The girls themselves may worry about the extra burden they will place upon their parents, especially if they are HIV positive or if they are unlikely to marry subsequently, and be reluctant to return home. *Neela* escaped with the help of her regular costumer and rehabilitated by an NGO in Kathmandu.

> *After a lot more counselling I decided that I would not marry my boyfriend in Bombay. I wrote him a letter saying how sorry I was that our dream would not take place. I said how I hoped that he was not infected with HIV as I did not want to spoil his life. I want him to be happy and prosperous. I want to go back to my parents' house.*

4. Care and support activities

In 1996, 124 Nepali sex workers were returned to Nepal from India in a widely publicized brothel rescue. Several NGOs took on the responsibility of their care and many have continued to work in care and support activities since. Of the interviewed NGOs working in the area of care and support, only one works exclusively in trafficking. The others include care and support activities along with other organizational foci. Interventions target trafficking survivors, their families, their communities, and health workers.

As in prevention activities, care and support interventions can be classified according to their approach. Some NGOs adopt a welfare approach in which girls and families are given prescriptive advice about future options and a return to the status quo is advocated. Others aim to empower trafficked survivors and engage in a dialogue with women and girls about their futures. All NGOs agreed that a primary aim of care and support should be to reunite girls with their families and communities. All acknowledged, however, that this was difficult and that in certain circumstances it was neither possible nor desirable.

The case studies and realities of many trafficked girls, which I described in previous sections clearly illustrate that some trafficked girls come from difficult or dysfunctional family environments. In these situations, the family may not be interested in taking the girl back or she herself may not want to go back. The concerned NGOs may first have to assess whether or not it would be in a girl's best interests for her to return home in order. Once a girl has been delivered into their care, most NGOs undertake a process of initial medical checks and counselling. Some enrol girls into vocational training programmes with the aim of ultimately providing them with skills that they can use in their villages. At some point in this process, attempts are made to contact families. Depending upon available resources, some NGOs visit the family and community (sometimes repeatedly). Others just write to them and invite them to come to Kathmandu. If families come to the shelter and if both parties are ready and willing, the girl may be sent home with them. Most NGOs provide seed money for setting up a small business.

Counselling is seen as essential by all NGOs. They noted that it was common for girls to initially be extremely depressed and to display disruptive or inappropriate behaviour. Research team observed 4 counselling session in two NGOs. Only one NGO had a trained counsellor available, however. Others did their best, but one organization appeared to use directive approaches (suggesting to women and girls what was thought to be good for them) as opposed to an interactive process enabling them to work through their experiences and reach decisions about their futures.

Family counselling is provided to families who visit the shelter. However, this is also generally directive in approach, encouraging the families to take the girl back and fostering acceptance of her. Although NGOs acknowledged that it is not always desirable to send a girl back to the family situation, there was little apparent emphasis on working with families to discuss why a girl may have run away or migrated in the first place, what the problem might be, and how one could possibly resolve this. Hence, in spite of theoretically recognizing the problems that some girls had at home, some NGOs appeared ambivalent about the extent to which they accepted, in practice, that families could be unsafe and unhappy places for the girls in their care. For example, the same NGO that published the twelve case studies of trafficked girls (in which some very unhappy circumstances were detailed), nevertheless maintained that family reunions invariably represented a "happy ending" for the girls:

> *"They had every right to return to their home . . . it was the duty of everyone to welcome them and give them sympathy and love . . . The response of the parents and family members to the girls was very positive . . . The majority of the parents wanted to take their daughters home as soon as possible . . The parents were so glad"* (ABC Nepal 1998:4).

Overall, NGOs do not follow a systematic process for follow-up after the girls and women return home. This is in part due to a lack of resources and work force, as girls come from different regions across the country. However, some NGOs conduct community follow-up visits on an ad hoc basis, especially when there is a high degree of community censure.

Most girls are provided with skills training before returning home, usually in traditional skills such as sewing, knitting, and animal husbandry. Some women who are brought back to Nepal and sent to rehabilitation centres are neither positive about it, nor do they stick with rehabilitation measures for long. Some of them went right back into prostitution. Of 42 interviewed in my study, six were working as commercial sex workers. Out of those six commercial sex workers, four had been to rehabilitation centres before for month or years. "*Bipana*", for instance, was brought back from Delhi in 1998 and 'rehabilitated' for a year. Now she is again a commercial sex worker in the capital.

"With some counselling and skill training like knitting, we can't get around anywhere. If I knew that this is what I would get for leaving the brothel, I wouldn't have come back", Bipana said.

The failure of rehabilitation efforts for many of these women are making officials concerned. One activist asserts that though rehabilitation centres do bring the girls back, they fail in giving the women viable alternatives for a normal life.

"Those women, who have earlier earned a lump sum of money in Bombay and Delhi, will definitely not be ready for knitting and stitching the whole day,".

Some activists and returned girls and women had different views. Some girls were very happy with rehabilitation activities.

The centre was very supportive and seemed to understand how I was feeling. They gave me lots of counselling, care and affection. I felt no discrimination against me while I was there.

Another girl said,

Love and care I received from this centre, will be the most happy memory in my life, if I would have got few sympathetic words at home, I would not have to undergo the trauma......

The rescuer is greater than my parents. I can not find any words to thank this centre...

Women and girls who cannot or do not want to return home have very few options. The only option at present seems to be living long term in a residential home. Some of the girls who were returned in 1996 are, five years later, still in homes in Kathmandu and elsewhere. Here they contribute towards their keep through undertaking traditional handicrafts or farming. Some have been employed by the NGOs as wardens in the homes and some are employed at the borders to help intercept trafficked girls. However, there does not appear to be any long-term strategy worked out for their futures. This again, is related to a lack of capacity and resources among the NGOs who are caring for them. Some girls were only teenagers when they returned to Nepal.

The present situation in which these girls must face a lifetime in residential care is clearly unacceptable, though the NGOs are doing their best. Undeniably, it is extremely difficult for a young, poor, single woman to forge an independent life for herself in the South Asian context.

5. Advocacy and networking activities

At present, three networks in Nepal potentially concern themselves with trafficking. Two of these, the Alliance Against Trafficking in Women and Children in Nepal (AATWIN), and the National Network Against Girl Trafficking (NNAGT), are focused only on trafficking, whereas a third, Children at Risk (CAR), is focused on 'children at risk', but includes trafficking in its activities. Three networks, NNAGT, AATWIN, and ATSEC, appear to be split by ideological and political differences. These differences reflect those between the two global anti-trafficking alliances, the Coalition Against Trafficking in Women (CATW), and the Global Alliance Against Trafficking in Women (GAATW) as I described in earlier chapter. NNAGT and ATSEC equate trafficking with sex work and migration and take a welfare approach, including advocating tighter legal restrictions on women's travel. In contrast, AATWIN de-links trafficking from sex work, migration and HIV and is beginning to develop a safe migration emphasis. Both networks are engaged in awareness and advocacy activities with the same target groups (e.g., parliamentarians or the police), resulting in conflicting messages and inconsistent advice.

6. Problems for rehabilitation, care and support

Several programmes address the needs of trafficked persons by providing services that take place either during rescue, rehabilitation or reintegration. Rescue related activities are extremely problematic in their implementation due to the difficulties in evaluating ambiguous migrant categories, coupled with the use of fraud and deception by the trafficker. As a result, programmes that attempt to seize trafficking victims at the border invariably restrict women's rights or encourage corruption.

Rescuing victims at the end point of the trafficked movement reduces the risk of stopping legitimate migration. Rehabilitation-related activities are, by comparison, easier to implement.

Rehabilitation shelters in Kathmandu, centres such as Maiti Nepal or CWIN, regularly receive parents who are aware of the probability that their disappeared daughter has been trafficked for prostitution. Cases are filed and

photos given, but typically this is all that can be done. A social worker told us that;

> *Many parents do not report their daughter as missing - either due to fear or shame or tacit compliance. Often reports are filed by friends or neighbours.*

Intervening to protect a girl from a dysfunctional family setting is more problematic. A first step is for programmes is to acknowledge that all families do not necessarily provide a protective environment against trafficking, and that relatives of the trafficked child may in fact be responsible for selling the child into servitude. This recognition carries implications for programmes that strive to rehabilitate victims of trafficking and then reintegrate individuals back into their communities.

APPENDIX - 4

Guide for In-depth Interview
विस्तृत अन्तवार्ता प्रश्नावली (बेचिएकी महिलाहरुसित)

A. Family Background
पारिवारिक पृष्ठभूमी

I would like to begin by asking you about your family background at the time you began working in the brothels or you were trafficked.
तपाईंसंग म यस पेशामा लाग्दाको समयको तपाईको पारिवारीक पृष्ठभूमी जान्न चाहन्छु ।

1. Can you tell me where is your natal family home? What are the predominant castes/ethnicity in that village/community?
   के तपाईको माईती घर भएको ठाउं बताईदिन सक्नुहुन्छ ? त्यहां तपाईको थर वा जात के थियो?

2. How many family members were in your family? (Probe: father, mother, step mother, number of sibling).
   तपाईको घरमा कति जना सदस्यहरु हुनु हुन्थ्यो? (बा, आमा, सौतेनी आमा, जम्मा केटाकेटीहरु आदि बारे विस्तृत जानकारी लिने)

3. Can you tell me about your father's education? What was his occupation?
   तपाईको बुबाले कति पढ्नु भएको थियो ? वहाको पेशा के थियो?

4. Now tell me about your mother's education. What was her occupation?
   मलाई तपाईको आमाको शिक्षा पनि बताईदिन सक्नु हुन्छ? वहाको पेशा चाहि के थियो नि?

5. Did you get the chance to go to school? What was your major responsibility (job/work) before you trafficked? (probe: education, occupation)
   के तपाईले स्कूल जाने मौका पाउनु भयो? तपाई यस पेशामा लाग्नु अघि तपाईको मुख्य जिम्मेबारीहरु (काम) के के थिए? (शिक्षा, पेशाको बारेमा थप जानकारी लिने) ।

6. What was the main source of income in your family? (probe: Agriculture, business, service, causal labour, number of working adults)
   तपाईको परिवारको मुख्य आम्दानीको श्रोत के थियो ? (कृषी, व्यापार, जागिर, ज्यामी (श्रम), र काम गर्ने जम्मा जनाको बारेमा विस्तृत जानकारी लिने)।

7. Was your family income enough to adequately feed the whole family all the time? (probe: food sufficiency)
   के तपाईको पारिवारिक आम्दानीले तपाईको परिवारलाई राम्रोसित खान लाउन पुग्थ्यो?

8. How do you compare your family income with the surrounding community at that time?

त्यस बेला तपाईको पारिवारीक आम्दानी त्यस गाउंघरका अन्य समुदायको दाजोमा कस्तो थियो?

9. Was your family indebted when you left home? what was severity of the debt? (Probe: Family could pay dept with out affecting family welfare. Payment of dept moderately affected welfare Payment of debt severely affected welfare)
त्पाईले घर छोड्दा तपाईको परिवारलाई कुनै प्रकारको ऋण थियो ? यदि थियो भने कति थियो । (विस्तृत जानकारी लिने)

Note: If respondent was married before trafficking, please repeat same type of questions (Q1-9) by asking her about marital family background)
नोटः यदि उत्तरदाताले यस पेशामा लाग्नु भन्दा अघि बिबाह गर्नु भएको भए,विवाह भएको घरको बारेमा पनि १ देखी ९ नम्बरसम्मको प्रश्नहरुको उत्तर यहि प्रकारले झैं विस्तृत जानकारी लिने) ।

B. Process of trafficking:
बेच बिखनमा लैजादाको अवस्था

I would now like to ask you about how you came to be involved in sex work or how you reached into Indian brothels.
म तपाई कसरी बेचिन पुग्नु भयो वा भारतको कोठीमा कसरी पुग्नु भयो भन्ने बारेमा केहि सोध्न चाहन्छु।

10. Could you describe how you came out from your home first? (Probe who brought you, Did you came alone or with somebody else, Did you know that person before, Did you have consent from your parents,)
तपाई घरबाट बाहिर कसरी आई पुग्नु भयो (निकाल्यो)? (कसले ल्यायो, कसरी ल्यायो, एक्लै वा अन्य महिलाहरुसितै, त्यो व्याक्तीसित पुर्व परीचय थियो वा थिएन, त्यसरी आउन परिवारका सदस्यहरुको मन्जुरी थियो वा थिएन आदिबारे विस्तृत जानकारी लिने) ।

11. At what age did this happen?
त्यसबेला तपाई कति वर्षको हुनुहुन्थ्यो?

12. Where did you go first? (probe: Where and to whom did you stay, means of transportation, route, journey time)
सबभन्दा पहिले तपाई कहां पुग्नु भयो? (कहां र कसरी बस्नु भयो, सबारी साधन, बाटो (द्धार), यात्रा समय आदिको बारेमा विस्तृत जानकारी लिने)।

13. Did you know what was happening, or where you were going? (Probe: Did you know how many money broker bribed from the brothels?)
के हुदैछ, कहां लादैछ भन्ने तपाईलाई जानकारी थियो? कोठीमा दलालले तपाईलाई बेच्दा कति पैशा मागेको थियो आदिको बारेमा जानकारी लिने)।

C. Life in Brothels:
कोठीको जीन्दगी

Your life and activities in the brothels is another important issues in this research. I would like to ask you more about daily life in the brothel.
तपाईले कोठीमा भोग्नु भएको जीन्दगी पनि यस अध्ययनको महत्वपूर्ण पक्ष हो । म तपाईको **Lüwê** को दैनिक जीवन र कृयाकलापबारे विस्तृत जानकारी लिन चाहन्छु ।

14. Could you please tell me about your early days in brothels? (Probe: expose to pornographic picture, injecting hormone, mental and physical touchier, motivation) b) Were you ever punished- what for? What happen?
कोठीको शुरुका दिनहरु कसरी बिते? (उत्तेजक फोटाहरु, सुई, मानसिक र शारिरीक यातना, आदि)। के तपाईलाई कहिल्यै सजाय दिईएको थियो? यदि हो भने के को लागि?

15. Now tell me more details about daily life in the brothel, what were your duties in a typical day? (Probe: duty hours, holidays, rest, food, physical condition of brothel)
कृपया कोठीमा वितेका दिनहरुका बारेमा व्याख्या गरि दिनुहोस् । विशेष दिनहरुमा तपाईको विशेष जिम्मेवारी के थियो? (काम गर्ने घण्टा, बिदा, आराम, खाना, कोठीको भौतिक अवस्था आदि बारे विस्तृत जानकारी लिने ।)

16. How much freedom were you allowed in the brothel? Did you have contact with anyone outside the brothels? (Probe: go to shop, to hospital , go out alone etc)
तपाईलाई कोठीमा कत्तिको स्वतन्त्रता थियो? कोठी बाहिर पनि कसैसित सम्पर्क थियो? (किनमेल गर्न जान, अस्पताल जान, बाहिर एक्लै घुम्न जान आदि)।

17. Did you communicate with other girls in brothel? (Probe: Did you discuss sex, risks or diseases?
के तपाईको कोठीमा अन्य महिलाहरुसित सम्पर्क र गफगाफ हुन्थ्यो? (जस्तै: यौन सम्पर्क, चुनौती तथा रोगहरु) ।

18. Can you estimate how many clients you served daily? Who were the common clients? (Probe: max, min per day, businessman, police. students etc)
तपाईले एक दिनमा सरदर कति जनासित यौन सम्पर्क राख्न पर्थ्यो? कस्ता खालका मानिसहरु बारम्बार आउंथे? (सरदर, थोरै, धेरै, व्यापारी, पुलिस, विद्यार्थी आदि)।

19. Were you paid by the client or by your boss? How much money were you allowed to keep per month? Did you ever get any gifts or tips from clients? (Probe: average income , total income, expenses, support for family)
यौन सम्पर्क गर्न आउने मान्छेले तपाईको मालिकलाई पैसा कहां तिर्थ्यो? तपाईलाई मासिक कति दिन्थ्यो? यौन सम्पर्क राख्न आउनेले अन्य उपहार तथा भिन्नै पैसा दिन्थ्यो कि? (मासिक आम्दानी, जम्मा आम्दानी, खर्च, पारीवारिक सहयोग आदिको बारेमा विस्तृत जानकारी लिने)।

20. a) Can you estimate what proportion of clients used a condom? Who decided to use?
कति जति ग्राहकले कण्डम लगाउथे? कण्डम लगाउन कसले भन्थ्यो?

b) if a client refused to use a condom, could you convince to use one- what would happen?(probe: negotiation process, outcome, power relationship)
यदि ग्राहकले कण्डम लगाउन अस्वीकार गरेमा तपाईले सम्झाउनु हुन्थ्यो? त्यसपछि के हुन्थ्यो?
(छलफलको प्रकृया, उपलब्धी, शक्ती र सम्बन्ध आदिको बारेमा विस्तृत जानकारी लिने)।

21. Did the brothel owner encourage/discourage condom use? Did they (owner) give girls any information about condom? Did they supply condom? (Probe: condom provider, price of condom, condom availability)
कोठी मालिकले ग्राहकलाई कण्डम लगाउन उत्साहित वा निरत्साहित के गर्थ्यो? मालिकले केटीहरुलाई कण्डमको प्रयोगको बारेमा जानकारी दिन्थ्यो? के उनीहरुले कण्डम आपूर्ती गर्थे? (कण्डम उपलब्ध गराउने व्यात्ती, मुल्य, उपलब्धता आदिको बारेमा विस्तृत जानकारी लिने)।

D. Health Condition

स्वास्थ्य अवस्था

I would now like to ask you about your health while you were in the brothels and your contact with health services.
अब म तपाई **Lüwê**मा हुदाको स्वास्थ्य अवस्था र स्वास्थ्य सेवामा सुविधा लिन जादाको अवस्थाबारे विस्तृत जानकारी लिन जानकारी लिन चाहन्छु ।

22. a) What were the common health problems of girls in brothels?
Lüwêका केटीहरुको मुख्य स्वास्थ्य समश्याहरु के के थिए?

b) Did you ever become sick while in brothels? (probe: communicable diseases, STIs etc.)
Lüwêमा हुदाखेरी तपाई कहिल्यै बिरामी पर्नु भयो? कस्तो खालको रोग लागेको थियो? सरुवा, यौन रोग आदि ।

If yes, did you ever get any treatment? Where did you get that? Who assisted you in getting the health care you needed for that problem? (Probe: self, friends, brothels, owner)
यदि रोग लागेको भए कुनै उपचार गराउनु भयो? कहां उपचार गराउनु भयो? स्वास्थ्य संस्थामा जान कसले सहयोग गर्‍यो? (साथी, मालिक आदिको बारेमा विस्तृत जानकारी लिने) ।

23. Did you ever want to go to a health service but were not able to go while you were in the brothels?
तपाई कोठीमा हुदा चाहेको बेला स्वास्थ्य जांच गराउन जान पाउनु हुन्थ्यो कि थिएन?

24. Was there any regular health check up provision? (probe: how often, what services, any vaccination)

के **Lüwê**मा नियमित उपचारको व्यवस्था थियो? (कति पटक, कस्तो उपचार, कुनै खोप वा सुई आदिको बारेमा विस्तृत जानकारी लिने)।

25. Can you tell me the reaction from your boss when you became sick? Was there any discrimination between Indian and Nepalese girls for health and other facilities?
तपाई बिरामी हुदां कोठी मालिकहरुले कस्तो प्रतिकृया जनाउथे? स्वास्थ्य तथा अन्य सुबिधाहरु लिनमा नेपाली र भारतियहरुमा कुनै भिन्नता वा भेदभाव थियो?

26. Did you know any of girls who became pregnant while in the brothel? Were there many? What happen than? (Probe: outcome of pregnancy-abortion where, how, when)
के तपाई **Lüwê**मा कहिल्यै गर्भवती हुनु भयो? त्यस्ता थुप्रै थिए? त्यसपछि के भयो? (गर्भवती भएपछिको अवस्था तथा गर्भ पतनको तरिका, ठाउं र समय आदिको बारेमा विस्तृत जानकारी लिने) ।

E. Awareness about Sexual health
यौन स्वास्थ्यको बारेमा सचेतनता

I would like to ask you some questions about sexual health and Sexually Transmitted Infections. Please don't feel shy, this information is very important to this study.
अब म तपाईलाई सुरक्षित यौन सम्पर्क तथा यौन रोगहरुको बारेमा केहि जानकारी लिन चाहन्छु। कृपया लाज नमान्नुहोला किनकी यो कुरा असाध्यै महत्वपूर्ण छ।

27. Have you heard about AIDS? What about other STIs? How and when did you learn about it? (Probe: Source of information, attitudes towards AIDS/STIs)
के तपाईले एड्स रोगको बारेमा सुन्नु भएको छ? अन्य यौन रोगहरुको बारेमा नि? यो कुरा कसरी सुन्नु भयो? जानकारीको श्रोत, एड्स र यौन रोगहरु प्रतिको धारणा आदिको बारेमा विस्तृत जानकारी लिने) ।

28. Can you tell me how to avoid getting AIDS and STIs? Do you know the measures to be followed to prevent from AIDS? (mode of transmission , preventive measures)
के तपाईले एड्स र अन्य यौन रोगहरुबाट कसरी बच्ने भनेर बताउन सक्नुहुन्छ? के तपाईलाई एड्स रोगबाट कसरी बच्ने भनेर थाहा छ? सर्ने तरीकाहरु र बच्ने उपायहरुको बारेमा विस्तृत जानकारी लिने ।

29. Have you ever experienced of the symptoms like Sores (Ulcer) around the private part, discharge of pus, too much pain during intercourse or any others (HIDDEN DISEASE SYMPTOMS)? (Probe: when,)
के तपाईलाई गुप्तांगमा घाउ आउने, पिप वा पानी बग्ने, यौन सम्पर्क गर्दा दुख्ने, वा अन्य कुनै लुकेका समश्याहरु छन्? (के, कहिले देखी शुरु भयो, आदिको विस्तृत जानकारी लिने।

30. What were the reasons you were unable to go? (Probe: knowledge, freedom, cost, distance, social stigma etc)
नपाउनुका कारणहरु के थिए?(ज्ञान नभएर, स्वतन्त्रता नभए।, पैसाको कारणले, टाढा भएर, सामाजिक कारण, आदि) ।

31. Where did you go for the treatment of those symptoms? How were you treated by the health personnel? (probe: attitudes towards the health workers and health institution)

ती समश्याहरुको लागि उपचार गराउन कहां जानु भयो? तपाईलाई स्वास्थ्य कर्मीले कस्तो व्यवहार गरे? स्वास्थ्यकर्मी र सस्थाप्रतीको धारणाबारे उल्लेख गर्ने ।

32. How did you know where to go for health care in this situation? (Probe: friends, radio TV, magazine)
त्यो स्वास्थ्य सुविधा लिन जाने बारे तपाईले कसरी थाहा पाउनु भयो? रेडियो, टि. भी., साथी, पत्रिका आदि ।

33. Have you needed to access health services now that you have left the brothels? did you experience any difficulties in getting the health care you needed?
वेश्यालय छोडेपछि पनि तपाईलाई स्वास्थ्य संस्थामा जचाउन जान परेको छ? तपाईले चाहेको स्वास्थ्य सुविधा लिनमा के तपाईलाई कुनै असजिलो परेको छ? उल्लेख गर्ने ।

F. Process of exit and life in Rehabilitation Centre /Transit Home:
Lüwê छोडेको तरिका र पुनरुत्थान केन्द्र वा स्याहार केन्द्रको जीवन अवस्था

I would now like to discuss how you came to leave the brothels
म तपाईले कसरी **Lüwê** छाड्न सफल हुनु भयो भनेर जानकारी लिन चाहन्छु ।

34. Did you have any contact with your family while you were in brothels? (Probe: how regular)
तपाई कोठीमा हुदा तपाईको परिवारसंग सम्पर्क थियो? (कत्तिको नियमित सम्पर्क थियो?)

35. How long had you been working in brothels?
कोठीमा कति समयसम्म काम गर्नु भयो? (वर्ष, महिना) ।

a) What were the good things about the life in the brothels?
कोठीमा हुदाको राम्रा पक्षहरु के के थिए?

b) What were the bad things about the life in the brothels? (probe: income, separation from family, customers)
कोठीमा हुदाको नराम्रा पक्षहरु के के थिए? (आम्दानी, परिवारसंग विछोड, ग्राहकले दिने कष्ट आदि) ।

36. Can you describe how you came out from the brothels? (Probe: a – escaped, b-rescued, c-released by brothels)
कोठीबाट कसरी बाहिर निस्कन सफल हुनु भयो? (भागेको, उत्थान गरेको वा निकालिएको) ।

You have been here for few months/days, please tell me about the place where you are living now.
तपाई यहां बसेको केहि महिना वा वर्ष भएछ, यहांको जीवन कस्तो चल्दैछ, केहि बताई दिन सक्नु हुन्छ कि?

37. When did you come here? How did you come to this centre/home (probe: date, voluntary choice, no alternative)

तपाई यहां कहिले आउनु भयो? कसरी आई पुग्नु भयो? (मिति तथा आफैले रोजेर आएको, कसैले पठाएर आएको, कुनै उपाय नभएर आएको आदिको विवरण लिने)।

38. What are you doing with your time now ? What type of facilities are you getting from this centre? (Probe: training, other jobs, counselling, treatment for physical problem)
तपाई यहां कसरी समय बिताई राख्नु भएको छ? यस केन्द्रबाट कस्तो सेवा पाई राख्नु भएको छ? (तालिम, रोजगारीका अवसरहरु, परामर्श तथा स्वास्थ्य सुविधा)।

39. Is it better now that you are here? Are you in touch with your family? Are you thinking to go back to your family? (Probe: future plan, relationship with family/community, fear of stigma)
तपाईलाई यहां बस्न कस्तो लागि रहेको छ? पहिला भन्दा राम्रो छ? के तपाईको परिवारका सदस्यहरुसित सम्पर्क भई राखेको छ? के तपाईले परिवार भएको ठाउंमा बस्न जाने विचार गर्नु भएको छ? (भावी योजना, परिवार र समुदायसितको सम्बन्ध तथा सामाजीक घृणाको डर, आदि) ।

G. Expectations
अपेक्षाहरु (भावी आकांक्षाहरु)

Can we now talk about your suggestions and what you would like to do in the ***future*****.....**

तपाईको सल्लाह तथा भावी योजनाहरुकोबारेमा केहि छलफल गर्न सकिन्छ?

40. In your opinion, what are the root causes of trafficking and how can we prevent it? (Probe: poverty, illiteracy, knowledge etc).
तपाईको विचारमा महिला बेच विखनको मुख्य कारणहरु के के होलान्? यसलाई कसरी रोकथाम गर्न सकिएला? (गरिवी, अशिक्षा, अज्ञानता आदिको बारेमा उल्लेख गर्ने) ।

41. What type of health and social services you think is necessary for trafficked women?
बेचिएकी चेलीहरुको लागि कस्तो प्रकारको स्वास्थ्य र सामाजिक सेवाहरुको आवश्यकता पर्छ होला?

42. Are there any other comments you would like to make on the issues we have talked about?
हामीले छलफल गरेका विषय (कुरा) हरुमा तपाईको अन्य कुनै थप प्रतिकृया तथा राय सुझावहरु छन् कि?

THANK YOU VERY MUCH (अन्तमा सहयोगको लागि धेरै धन्यवाद)

APPENDIX – 5

SOCIO-DEMOGRAPHIC INFORMATION OF RETURNED TRAFFICKED WOMEN AND GIRLS COLLECTED FROM REHABILITATION CNTRE

Rehabilitation Centre/Name of Place:

Date:

Form filled by:

Please answer the following questions (information) by using instruction guide.

SN	Questions and Filters	Coding Categories	Skip
1	Ethnic origin	Aryan (Brahmin/Chhetri) --------------------1 Mongoloids (Tamang/Gurung/Magar)-----2 Untouchable (Dalit)---------------------------3 Others--4 Record unavailable/Don't know-----------99	
2	Religion	Hindu ---1 Buddhist ---------------------------------------2 Muslim--3 Others--4 Record unavailable/Don't know-----------99	
3	What was her age when she was trafficked to India?	*Write in years* ________________ Record unavailable/Don't know----------99	
4	Marital Status (At the time of trafficking):	Unmarried -------------------------------------1 Married--2 Divorced/Widow/Separated-----------------3 Record unavailable/Don't know-----------99	
5	Where was her natal family home?	Village/town_________________ District______________________ Record unavailable/Don't know---------N/A	
6	How did she traffic?	Home (Natal/marital) -Direct to India-------1 Home (Natal/marital)- to Second place to India---2 Others way (specify) _______________3 Record unavailable/Don't know-----------99	
7	What was her Education?	Non-literate-----------------------------------1 Primary/Non formal Education-------------2 Secondary education (grade 6-10)--------3	

		Higher education (above 10)----------------4 Record unavailable/Don't know----------99	
8	Who lured/motivated her to go to India?	Relatives --1 Known person but not relatives-------------2 Unknown persons-----------------------------3 Others--4 Record unavailable/Don't know-----------99	
9	What was the main motivation? (What was the "recruiting" method used by the traffickers?)	Promise of marriage--------------------------1 Promise of jobs--------------------------------2 Visit /Holiday -----------------------------------3 Force (kidnapping, deception etc)---------4 Others --5 Record unavailable/Don't know-----------99	
10	Who was the person who brought her to India? Or Who took her to India?	Relatives--1 Known person but not relatives------------2 Unknown persons----------------------------3 Record unavailable/Don't know-----------99	
11	How much money did broker bribe from the brothel when she was sold?	Amount in IC________________________ Record unavailable/Don't know-----------99	
12	Where did she Traffic (Name of Indian City)?	Mumbai--1 Calcutta---2 Delhi---3 Others---4 Record unavailable/Don't know----------99	
13	How many times was she sold within the brothels?	Total times in Number________________ Not at all---0 Record unavailable/Don't know-----------99	
14	How many times did police arrest her when she was in brothels?	Total times in Number________________ Not at all---0 Record unavailable/Don't know-----------99	
15	How long did she stay (work) in India?	Duration: __y___m___d (Total in M____) Record unavailable/Don't know----------99	
16	How many times did she try to	Total times in Number________________	

	come out of the brothel?	Not at all---0 Record unavailable/Don't know-----------99	
17	How did she come out of brothels?	Rescued---------------------------------------1 Escaped/left---------------------------------2 Released by brothel owner----------------3 Record unavailable/Don't know-----------99	
18	When did she arrive to Nepal?	Write date_____/______/________ *Year month day* Record unavailable/Don't know--00/00/00	
19	Has/Had she been/lived on Rehabilitation Centre (RC)?	Yes--1 No---2	--20 --End
20	When did she come to the Rehabilitation Centre?	Write date_____/______/________ *Year month day* Record unavailable----------------00/00/00	
21	Is she still living in RC?	Yes--1 No---2	--23 --22, 23
22	How long did she stay in the Rehabilitation Centre?	Duration: __y___m___d (Total in M____) Record unavailable-------------------------99	
23	What was her health condition when she arrived in RC?	(List down the disease according to her medical record- more than one answer is possible)	
	HIV Status	Known positive (tested)----------------------1 Known negative (tested)---------------------2 Unknown---------------------------------------3	
	T.B.	Yes--1 No---2	
	STIs	Yes--1 No---2	
	Skin diseases	Yes--1 No---2	
	Anaemia/malnutrition	Yes--1 No---2	

APPENDIX 6

GROUPING OF UNTOUCHABLE CASTES

CARE (as quoted in CERID 1997, p.4) has identified the following caste/ethnic groups who fall under the low social status (Untouchable) group:

Kami (blacksmith), Sunar (goldsmith), Damai (tailor), Sarki (cobbler), Gaine (buskers), and Badis (community entertainers cum flesh traders) among the hill caste groups;

Kasai, Pode, Chyame, Kusle, and Halhule among the Newars.

Dom, Halkhor, Dusadh, Chamar, Khatwe, Musahar, Kaut, Tatma, Teli, and Sundhi among the Terai caste groups.

Reference

CERID (1997): Social Assessment of Educationally Disadvantaged Groups. Kathmandu: author.

(CERID = Research Centre for Educational Innovation and Development)