Simkhada, P., van Teijlingen, E.R., Regmi, P.R. and Bhatta, P., 2010. Sexual health knowledge, sexual relationships and condom use among male trekking guides in Nepal: A qualitative study. *Culture, Health and Sexuality*, 12 (1), 45-58.

People in Nepal generally hold fairly traditional views about sex and sexual health, whilst Western tourists often have a more liberal approach towards sex and relationships. There is evidence that significant sexual interaction occurs between male trekking guides and female travellers and/or local female sex workers in Nepal. This qualitative study explored trekking guides' sexual health knowledge, sexual relationships and condom use with female trekkers and local female sex workers. A total of 21 in-depth interviews were conducted with male trekking guides. Most reported having had sexual relationships with female trekkers and local female sex workers. Explanations for intercourse with female trekkers included: financial support; getting future trekkers through word-of-mouth advertising from the women they have had sex with; and opportunities for emigration. Interestingly, sexual intercourse is reported as more likely to be initiated by female trekkers than by guides, and more so by older women. In contrast, the main reasons for having sex with local female sex workers included: romantic love or sexual excitement and novelty. Awareness regarding sexual health was high among guides, but several factors discouraged the regular use of condoms. Further research with female tourists would help understand the motivations and reasons for their sexual behaviour.

Keywords: sexual behaviour; condom use; trekking guides; Nepal; tourists

Introduction

Nepal is a developing country with a heterogeneous ethnic composition; many ethnic groups have their own norms and values on sex and sexuality (Regmi, Simkhada, and van Teijlingen 2008). Though there is a limited amount of literature describing sexual cultures in Nepal (Stone, Ingham, and Simkhada 2003), it is well recognised that sexual health is a difficult subject to address (Spotlight 2004). This is reflected in the use of English- or Sanskrit-derived terminology as opposed to Nepali terms by professionals working in the field (Pigg 2002).

In Nepal there is limited awareness of the risks of unprotected sex and the methods of practising safer sex. Whilst, traditionally, premarital and extramarital sex are not acceptable (Dahal 2008) younger people living in urban areas are increasingly exposed to more liberal Western attitudes through media, work or study. Nepal's public policies are guided by 'traditional' values that are only slowly adapting to the cultural shifts that are occurring. There are wide gender-based differences in sexual conduct and in the ability to

negotiate sexual activity. Young men are considerably more likely to report being sexually experienced than are young women (World Health Organisation 2001).

Tourism provides an important source of income in many developing countries (Brown et al. 1997; United Nations World Tourism Organization [UNWTO] 2008). It creates employment and stimulates economic regeneration (UNWTO 2009). It is a major industry in Nepal, with approximately half a million tourists every year (CJ News 2008). Its financial contribution represented 3.6% of Nepal's gross domestic product in 1998/1999 (Poudel 2004) and 250,000 local people are thought to benefit directly or indirectly (BBC 2001). Even during the Maoists' insurgency in the late 1990s and early 2000s, Nepal continued to attract large numbers of visitors. During 2007 over 360,350 people visited Nepal by air alone (Nepal Tourism Board 2008) of whom the majority came from Asia (38.3%) or Europe (30.5%) and smaller numbers from North America (8.4%) and Australia and Oceania (3.1%) (Nepal Tourism Board 2003). The main reasons for visiting Nepal include recreation (52.1%) or trekking (28.1%). Most tourists are between the ages of 16 and 45 and 42.6% are female (Nepal Tourism Statistics 2001).

There is evidence to suggest that travellers are more likely to engage in risk-related sexual behaviour when outside their own community (Bellis et al. 2004; Eiser and Ford 1995; Hawkes and Hart 1998; Mulhall 1996), making their actions and behaviour an important area for health promotion (Cabada et al. 2002). This poses a threat to both their own sexual health and that of local people (De Schryver and Meheus 1989; Melbye and Biggar 1994; Memish and Osoba 2006). Most research into the impact of sexual behaviour and tourism focuses on male rather than female travellers. Ragsdale, Difranceisco and Pinkerton (2006) recently conducted a study of mainly female US holidaymakers in Costa Rica and found that they were most likely to form relationships with local men (62%) as opposed to other tourists (23%) or both locals and tourists (15%).

Trekking in Nepal often involves travelling in isolated and rural areas and the majority of tourists require a trekking guide. There are several factors that predispose female trekkers and their male guides to engage in risky sexual practices. Trekkers are often mixing with unfamiliar travelling companions, staying with their guides for prolonged periods in remote areas and separated from their regular sexual partners. Such factors contribute to what Apostolopoulos, Sönmetz and Yu (2002) called 'situational disinhibition', which can increase the likelihood of sexual interactions between those on a trek.

HIV prevalence in Nepal has been described as signalling an impending crisis (Seddon 1998). Knowledge of sexual health issues is limited amongst both young men and women in Nepal (Mahat and Scoloveno 2006; Stone, Ingham and Simkhada 2003) and there are few written educational materials available (Furber, Newell, and Lubben 2002). Generally speaking, open discussion of sex and related issues is not acceptable in Nepalese society (National Centre for AIDS and STDs Control 2005; Sharma 2003).

The general health risks of trekking and in particular altitude sickness have been well documented (Basnyat and Litch 1997; Basnyat and Murdoch 2003; Redman et al. 2006) but little is known about sexual health knowledge, behaviour and condom use of trekking guides. A student research project found that the majority of male trekking guides in Nepal had had sexual intercourse with foreign female tourists (75.7%), with 51.3% reporting a sexual encounter within the last year (Bhatta 2003). Most guides were married (70.8%) and also reported having intercourse with local female sex workers (52.6%).

Those working in the tourism industry have to interact with a wide range of tourists and local people (Forsythe, Hasbun, and Liste 1998). Guides may meet local female sex workers whilst trekking or acting as a broker between them and tourists. Similar to tourists,

guides are also away from their local community and its social controls and may be predisposed to situational disinhibition (Apostolopoulos, Sönmetz, and Yu 2002).

Bhatta (2003) suggested that guides are ill informed about sexually transmitted infections (STIs) but it is not known whether there are other factors leading to risky sexual behaviour in this population group. Of particular relevance is how and why they get involved in risky sexual behaviour and what the barriers and facilitators are to safer sexual practice. This information is needed to allow the development of appropriate health promotion programmes. The aim of this study therefore was to explore the sexual health knowledge, behaviour and condom use amongst male trekking guides in Nepal.

Methods

Frank and open discussion of issues related to sexuality and sexual health is difficult in traditional Nepalese society. As a result, it can be difficult to conduct research on sensitive issues such as sexual behaviours (Ward, Mertens, and Thomas 1997). Our study adopted a qualitative approach using in-depth interviews (Bowling 2002), which are particularly appropriate for researching sensitive issues (van Teijlingen and Forrest 2004).

Twenty-one, semi-structured in-depth interviews were conducted with male trekking guides during 2005. These were conducted in the urban areas of Kathmandu and Pokhara and the trekking routes in Annapurna, Langtang and Everest to facilitate easy access to the guides, who are highly mobile. The interviews were conducted by the fourth author, who is a native male Nepali speaker trained in conducting in-depth, face-to-face interviews.

The interviews explored respondents' sexual health knowledge, behaviour and relationships. In particular they sought to elicit information about sex with female trekkers and local female sex workers and condom use. The majority of interviews took place in separate rooms to ensure privacy. This created a more comfortable atmosphere to discuss potentially sensitive issues with the interviewer. The interviews lasted between 30 to 60 minutes. Prior to the main study, three in-depth interviews were carried out as a pilot study (Simkhada, Bhatta, and van Teijlingen 2006), which are not included in the full study. All interviews were audio-recorded with the guides' permission.

Following a larger scale quantitative survey of trekking guides (Simkhada et al. 2006), we used purposive sampling (Bowling 2002) to recruit a sub-sample for in-depth interviews until data saturation was reached. Individuals were chosen based on age, education, marital status, ethnic background and sexual history. The interviews were transcribed in Nepali then translated into English and any identifiable characteristics of interviewees removed. The translated version was cross-checked by the third author who is a native Nepali speaker. Where the translator and the third author disagreed the text was discussed in detail to ensure the most appropriate translation. A thematic approach was used to analyse the qualitative data, that is, categories (or themes or codes) were developed from the dataset. Relevant quotes are presented to illustrate the key themes. Ethical approval for this study was provided by the Nepal Health Research Council.

Results

Socio-demographic characteristics of respondents

Trekking guides came from a wide range of backgrounds (Table 1). Of the 21 respondents, eight were aged 20 to 29 and two were over 40 years old. Most of the respondents were married.

Table 1. Socio-demographic characteristics of respondents.

	Number of respondents ($n = 21$)
Age group	
20–29	8
30–39	11
40–49	1
50 and above	1
Ethnicity	
Brahmin	7
Chhetri/Giri	2
Shrestha/Dongol	2
Ghale/Tamang/Sherpa/Rai	6
Nepali/VK	4
Marital Status	
Married	19
Unmarried	2
Education status	
Illiterate	1
Primary/read and write	6
Secondary (SLC Passed)	11
University	3
Work experience as a guide	
1–5 years	8
6–10 years	7
10 years and above	6

Sexual health knowledge and behaviour

Knowledge of STIs including HIV and AIDS was fairly high, some guides were able to name individual STIs and others were even able to cite statistics on rates in Nepal. Most guides knew where to get treatment for STIs and some had been for check-ups for suspected infections:

> I had sexual intercourse without a condom. After one week, I got fever and had a blood test, thinking that I got an STI. (Shyam, age 28)

Male guides reported unsafe sexual practices despite having adequate knowledge, especially irregular condom use:

> … I didn't use last time but I used (a condom) in previous sexual intercourse. But last time we had sexual intercourse without condoms because we didn't remember to use them. It happened in such a rush. (Hari, age 35)

Although most respondents claimed that foreign tourists were responsible for bringing HIV to Nepal, this is unlikely to be the main source of HIV transmission, especially in light of the huge number of Nepalese workers who migrate to countries such as India for short- and long-term employment. Some respondents cast trekking guides as 'innocent boys' who are sexually victimised by international tourists:

> … some female sex workers also come in Nepal as a tourist and go to trekking with unknown innocent boys. They use these boys. When they return to their countries, nobody knows the problems faced by those boys … (Arjun, age 28)

This same guide also suggested that foreign sex workers come to Nepal as tourists. Although this is possible it is likely that the majority are simply female tourists with more

Table 1. Socio-demographic characteristics of respondents.

	Number of respondents ($n = 21$)
Age group	
20–29	8
30–39	11
40–49	1
50 and above	1
Ethnicity	
Brahmin	7
Chhetri/Giri	2
Shrestha/Dongol	2
Ghale/Tamang/Sherpa/Rai	6
Nepali/VK	4
Marital Status	
Married	19
Unmarried	2
Education status	
Illiterate	1
Primary/read and write	6
Secondary (SLC Passed)	11
University	3
Work experience as a guide	
1–5 years	8
6–10 years	7
10 years and above	6

Sexual health knowledge and behaviour

Knowledge of STIs including HIV and AIDS was fairly high, some guides were able to name individual STIs and others were even able to cite statistics on rates in Nepal. Most guides knew where to get treatment for STIs and some had been for check-ups for suspected infections:

> I had sexual intercourse without a condom. After one week, I got fever and had a blood test, thinking that I got an STI. (Shyam, age 28)

Male guides reported unsafe sexual practices despite having adequate knowledge, especially irregular condom use:

> … I didn't use last time but I used (a condom) in previous sexual intercourse. But last time we had sexual intercourse without condoms because we didn't remember to use them. It happened in such a rush. (Hari, age 35)

Although most respondents claimed that foreign tourists were responsible for bringing HIV to Nepal, this is unlikely to be the main source of HIV transmission, especially in light of the huge number of Nepalese workers who migrate to countries such as India for short- and long-term employment. Some respondents cast trekking guides as 'innocent boys' who are sexually victimised by international tourists:

> … some female sex workers also come in Nepal as a tourist and go to trekking with unknown innocent boys. They use these boys. When they return to their countries, nobody knows the problems faced by those boys … (Arjun, age 28)

This same guide also suggested that foreign sex workers come to Nepal as tourists. Although this is possible it is likely that the majority are simply female tourists with more

liberal attitudes towards sex and relationships. The concept of a women having casual sex without being a sex worker seemed to be difficult to accept. The belief that the woman was a sex worker did not deter him from having intercourse and he subsequently became concerned that he had caught an STI from her:

> She looked like a sex worker. I was 90% sure that I had an STI but I got a negative result. (Suberna, age 28)

Sexual relationships with female trekkers

Although sexual relationships outside marriage are generally frowned upon in Nepalese society and most guides were married, sex was commonly reported with foreign female trekkers. Reasons included demands from female trekkers, attraction, use of alcohol, entertainment, pleasure and financial rewards. Guides generally suggested that it was often female trekkers who suggested they have sexual intercourse:

> ... she said, it is my holiday and I came here only for fun and entertainment. I need sex at any cost. I don't care about my husband. (Prem, age 31)

Particularly older women were described as being more forthright:

> ... we were going to Everest and there was an old woman in that group. She frequently asked me for sexual intercourse ... She asked me to sleep together but I didn't... (Santosh, age 32)

The interviewee reported that the trekker became 'very angry', when she was rejected. Guides may lack control in negotiating whether they want a relationship and many reported serious repercussions for refusing sex. Some claimed to have had to discontinue trips after they refused to have sex with foreign women:

> She asked me for sex. I didn't agree and I said 'Being a guide is my profession so I can't do that'. When I refused to have sex with her, she asked me to go back. (Pravin, age 29)

Walking and teasing in the trekking areas creates a potential environment for sexual intercourse for both female trekkers and male guides. Some women appeared to plan sexual encounters by asking the trekking company to arrange a guide to have intercourse with, for example:

> ... she had asked my office to arrange a guy for sexual intercourse but I didn't know about that. Then the office asked me to go with the lady. I was not directly asked by that lady but she had desire to do that. I knew that later ... (Chering, age 26)

Financial rewards were one of the benefits of these relationships and were especially important where the women were not perceived as attractive:

> If they are beautiful then we want to have sex with them; otherwise we do it for money ... we hope to get some money from foreign girls. (Temba, age 31)

Most interviewees claimed to have had at least several sexual relationships with foreign female trekkers, with some, but not all, for money:

> ... I have had sexual relation with many girls on treks. I still have a relationship with some girls. ... returning from Annapurna Base Camp, I had sexual relation with a 42-year-old woman. Actually I did it for money. (Kajiram, age 31)

Some guides received longer-term financial support from tourists, which lasted beyond the actual trek. One interviewee described being taken to visit India:

> We had started sexual intercourse after ten days. After that trek, she took me to India. We stayed there for three months and she paid everything. She took me there

> for sex. I had never visited India so I got a chance to go there. I had fun too. (Nakul, age 43)

Guides felt that sexual relationships with female trekkers could help with repeat business, arguing that female trekkers would return to that particular guide. Others described word-of-mouth advertising, as they reported that certain female trekkers had sent friends from their home country for trekking in Nepal:

> They email or fax us from their country ask to be a guide for their friends. They may send group for trekking from their country. It is all due to the sexual relation with them. (Hariom, age 52)

Alcohol played a vital role in initiating sexual relationships. Interviewees described the impact of inebriation on their decision-making process. Sexual intercourse was most likely to occur when they were both intoxicated:

> They all drink beer, alcohol, whisky and lose their sense. … We see them as beautiful even if they were very ugly. It is very easy for sexual intercourse if they also drank. … We can understand their psychology. … They give hints. But, most of time it happens when they drink. All trekkers and guides drink beer … and we feel tired, so entertainment and fun are necessary. (Phanindra, age 31)

Some respondents continued their sexual relationships with the same female trekker for several years. In one particular case, the relationship had not started until after they had returned from a trek:

> … we had sexual intercourse only after the trekking. We started it in Pokhara and continued for seven years. (Shambu, age 31)

Long-term relationships were more likely to develop with foreign female trekkers who also worked in Nepal and were able to meet frequently with the guides. However, even amongst those women who resided abroad there were some who were able to maintain a long-distance relationship and return intermittently:

> … whoever I had sexual intercourse, many of them kept in touch and some of them still came here and went trekking. (Gakul, age 32)

Some female trekkers took the guides with whom they had relationships on holiday to other countries. India was mentioned by a few guides:

> Their [foreign girls] main purpose is fun and entertainment … she took me to different parts of Nepal and even overseas for fun and sexual intercourse. She took me Goa (in India). (Angkaji, age 28)

Sexual relationships with local female sex workers

All the respondents knew girls or women involved in sex work in trekking areas. Some guides described tea shops and residential hotels having 'kept' girls for sexual activities with foreign guests and guides. Interviewees suggested that these local girls were a key attraction for male tourists and that they were essential to the hotels' survival. Some guides had had sexual relationships with local female sex workers whilst on a trek, although others actively avoided even talking to them:

> … I never cared for them. I used to stay with guests. I don't go to local hotels (Bhatti) either. But you know not all guides are the same. Some guides go there. If you wish, you can get girls. Some of my friends have done so. (Temba, age 31)

Others mentioned having sex with local female sex workers on special occasions, which were often associated with alcohol consumption:

> It was on New Year's eve. There was a street festival. We had dinner together and we drunk till 3am. Later we had sexual intercourse. I met her on the same day. There are lots of local girls found on the way who want sex. (Dorja, age 26)

Some noted that there were many female sex workers in the valleys of Kathmandu and Pokhara and that they visited local female sex workers and massage centres. They felt it was very easy to approach them:

> ... one day my friend asked me to go to the massage centre. I had never known about that. I was interested to see that so I decided to go. ... It was like brothel. I have never been there again ... (Narayan, age 42)

Condom use

As most of the trekking areas are remote and mountainous, condoms are not easily available but both male guides and female trekkers sometimes carried and used them. The main motive identified for using them was to avoid pregnancy:

> ... because, we don't want child. They [foreign girls] don't want child either because nobody will be responsible for the child. Who provides food to the child? Who cares them? So, we used a condom. This is the main reason why we use condoms. (Santosh, age 52)

Also:

> ... I have found them very sensitive towards condoms. Some of them gave me condoms and some girls even put on condoms themselves. You know, some of them even checked whether it is properly used or not. (Sagar, age 26)

Attitudes towards condoms among trekking guides were generally positive. Some respondents mentioned that they always kept condoms readily available in their pockets. Sexual intercourse was sometimes deferred due to the non-availability of the condoms in the trekking areas:

> ... when we were ready and decided for sex, she asked me to use condom. I had no condom either, so that we did not have sexual intercourse. When we got the condoms after three days, we started sexual intercourse ... (Mohan, age 30)

The reasons given for failure to use condoms included: non-availability in the trekking areas, having trust in sex partners, unplanned sex, arousal, young partner, influence of alcohol, interference with sexual pleasure and partner's wishes. Problems with availability are highlighted by the following quote:

> It's not possible to find condoms in the high trekking areas but we can find it in some towns. That is our main problem because we can't get or buy condoms whenever we need. (Nabin, age 28)

Moral and cultural obstacles towards selling and buying condoms were also highlighted by some guides. These were especially prevalent in the more remote and more traditional areas:

> We get it in established markets and health posts but it is very difficult to get in remote areas. Moreover, our Nepali culture doesn't allow keeping condoms and people feel shy to sell and buy condoms. (Harka, age 32)

A sense of powerlessness was described by a few interviewees. The average female trekker from a developed country has considerably more disposable income than the male trekking guide, creating a potentially very unequal relationship:

> ... we can not ask them for sexual intercourse. Whenever they say, we have to be ready for that. So, sometimes it's very difficult to manage condoms. (Ganesh, age 35)

The following quote clearly illustrates the complexities of sexual negotiation:

> No … we did not use. In the beginning we were planning to use a condom but when she asked me not to use, we didn't use. She said, she doesn't enjoy with condom … (Kapil, age 29)

There were also examples indicative of a more equal power balance within the sexual relationship:

> … because I thought she is not promiscuous. She was nice so I assumed that I can do without condom. She also agreed. We felt nothing bad during sex without condom. (Sagar, age 28)

Discussion

This qualitative study explored issues around sexual health knowledge and sexual relationships with female tourists and local female sex workers in male trekking guides. It also examined condom use practices and identified reasons for risky sexual behaviours. Awareness of HIV and other common STIs was fairly high, but unsafe sexual practices still prevailed. These findings were consistent with a previous study of the wider male population in Nepal (New Era 2001). Exposure to the press and electronic media, friends and tourists had contributed to the guides' knowledge of HIV. However awareness and knowledge of STIs other than HIV was somewhat lower. This could be due to the focus of Nepalese media on HIV and AIDS with little attention paid to other STIs.

The key attraction of Nepal for foreign women included visiting the trekking areas in the Himalayas. Spending large amounts of time, including nights, alone with guides and previously unknown partners contributed to a proportion engaging in sexual activities. Studies conducted in other tourism settings also showed similar results (Arvidson, Hellberg, and Mardh 1996; Bauer 2007; Matteelli and Carosi 2001). Although premarital and extramarital sex is not generally acceptable in Nepali society, such activities were found to be as common among the guides as in other high-risk groups (Puri and Cleland 2006) and the prevalence was probably higher than the general population (Demographic and Health Survey 2007). We would argue that the guides operate culturally and socially between the traditional Nepalese society in which they and their family live and the Western modern or even post-modern society which they share with tourists whilst trekking. From a public health perspective, this suggests that the guides are putting themselves and their partners at risk. The risk is increased by the taboo on purchasing and carrying condoms, especially in the more remote areas of Nepal (Limbu 1997). However, our analysis suggests that on some occasions both female trekkers and guides felt able to initiate discussions about, and use, condoms.

Our study suggests that sexual intercourse is more likely to be initiated by female trekkers than by guides and more so by 'older' women. Although these reports may be biased as we have only interviewed the male guides, other literature suggests that some women holidaying in developing countries may have expectations of romantic and/or sexual encounters (Herold, Garcia, and Demora 2001; Nyanzi et al. 2005; Ragsdale, Difranceisco, and Pinkerton 2006; Romero-Daza and Freidus 2008; Sánchez Taylor 2001).

Trekking creates an environment conducive to forming new sexual relationships. Both male guides and female trekkers (1) need to be physically fit; (2) spend prolonged periods of time together in close proximity day and night; (3) may use alcohol and drugs; while (4) being away from usual social controls. The latter is a particularly interesting phenomenon as both female trekkers and guides are outside their normal social and cultural environment, which may offer the opportunity to do things one would not do at home.

Hence both female trekkers and male guides can be regarded as being in situational disinhibiting circumstances.

There is a growing awareness of the health impact of tourism on local communities (Bauer 2003). Foreign trekkers can potentially exploit locals, as relatively rich female tourists will have a considerably higher disposable income than the trekking guides. For example, several respondents reported that foreign tourists tempted them with foreign employment, travel abroad, marriage proposals or financial support. The high socio-economic status of tourists sometime offers certain opportunities to the guides. Although they are relatively well paid in Nepalese context, these guides mainly depend on tips (appropriately also called 'gratitudes') from trekkers as their main source of income rather than on a fixed salary.

However, we need to question 'whether power should be always identified with the tourist, and whether the exercise of power is one-sided and exclusively repressive' (Cheong and Miller 2000, 372). The interviewees portrayed themselves in sometimes contradictory ways. On the one hand, there was the image of the innocent victim, whereby the guide is at the whim of the rich powerful female tourist and, on the other hand, the image of the smart entrepreneurial guy who strives for sexual and financial gains. Sanchez Taylor (2006) highlighted recently that we need a more detailed theoretical understanding of the complex relationship between female tourists and local male trekking guides, which includes notions of exploitation (i.e. of local men involved in types of sexual economic exchange) without 'also having to think in terms of passive victims and malicious victimizers and the explore the significance of race for their experience of exploitation' (46).

Cheong and Miller (2000) have highlighted how power is inextricably wedded to knowledge and that tourists do not have the monopoly of power in the tourist-guide relationship since tourists operate from insecure positions. At the more extreme end of the scale, Brown (1999) noted that 'some women who visit Nepal are being raped and subjected to sexual abuse and sexual exploitation of various kinds by men in the travel industry' (107). Generally, female trekkers find themselves in an unfamiliar political and cultural environment and often do not speak Nepali, in other words they depend considerably on their guides. Tourists see Nepal through the eyes of the guides, as the latter choose the interesting things to see, the routes for trekking and the best places to stop. Cheong and Miller (2000) argued that guides construct the so-called 'tourist gaze', through their esoteric 'local knowledge' and their specific guide skills, including 'casually arranged impromptu services' (384).

Our study identified several factors that regularly discouraged the use of condoms, such as non-availability, reduced pleasure and partners' refusal. The first factor could be addressed by providing condoms through local health services delivery points, tea shops/hotels in the trekking areas, general stores in conjunction with the dissemination of information and implementation of awareness-raising activities. Some guides had delayed sexual intercourse due to the unavailability of the condoms in the trekking areas. This showed that they were aware and had taken on the responsibility of preventing STIs, HIV and unwanted pregnancies. Our analysis also suggested that guides think that some female tourists are concerned about these issues as they carried condoms and used them. Similarly, in Peru a proportion of female tourists, but not all those at risk, reported carrying condoms with them (Bauer 2007). Sánchez Taylor (2001) described only two-thirds of female tourists to the Dominican Republic and Jamaica using condoms during intercourse with local men.

The use of alcohol and drugs may predispose people to risky sexual behaviour because of the impact on decision making. Studies conducted in other settings (Bellis et al. 2004; Lee, Bell, and Hinojosa 2002; Matteelli and Carosi 2001) found some association between alcohol use and sexual behaviour. Respondents spoke about having sexual intercourse after alcohol consumption. Taking alcohol before and during sexual intercourse may lead to unsafe sexual practice among Nepalese men (Tamang et al. 2001). Generally, alcohol use increases the chances of not using condoms (Halpern-Felsher, Millistein, and Ellen 1996), although the evidence is equivocal (Santelli et al. 2001). Frequent alcohol use has been associated with sexual intercourse that was later regretted (Bellis et al. 2008). Interviewees suggested foreign women may provide alcohol to guides and both may drink before the sexual encounter. Guides suggested that after using alcohol, women may be less inhibited and be more likely to propose having sexual intercourse. Moreover, their decisions regarding safer sex could also be affected by alcohol use.

This study contains a number of limitations: first, it was conducted only in a limited selection of trekking areas which makes it more difficult to generalise to other trekking and tourist areas in Nepal; and, second, as a retrospective study, some of guides may have been referring to their behaviour over 10-year time span, which might have lead to recall bias of their sexual behaviour. As with all sexual health research there is the question to what extend is there a tendency to show off their masculinity or so-called 'sexual prowess' or to portray oneself as a victim rather than an active participant in activities that are fairly unacceptable in Nepalese traditional society.

In order to examine the pattern of sexual behaviour this study incorporated sexual issues, which are considered as culturally sensitive in Nepal. Sex and sex-related matters are not easily talked about nor shared openly and it is still largely a taboo in Nepalese society (Sharma 2004). Despite this, many seemed to speak freely during the in-depth interviews. However, we found it culturally difficult to ask questions to male guides about having sex with male tourists.

Conclusion

Our study aimed to improve understanding of sexual health knowledge, sexual relationships and condom use among male trekking guides in Nepal. Findings support the call for greater awareness amongst male guides about the consequences of unsafe sex with multiple and previously unknown sexual partners. There is an important role here for sexual health promotion to this mobile population. Although guides received some training about first aid, cookery and trekking, components of sexual and reproductive health should be incorporated into their existing training programme.

Sexual interactions among male guides and female trekkers and local female sex workers are complex. We would warn the reader therefore against adopting a too black-and-white view concerning the power relationships between male guides and female trekkers. Better access to condoms, especially in the remote and rural areas of Nepal is, however, essential. Restricting condom provision to health centres may be insufficient and distribution of condoms in tea shops and hotels may make them more accessible and help to increase the condom use.

Further research with guides in other areas of work, for example rafting guides and the very few female trekking guides working in Nepal, is necessary as our study was restricted to a specific group. In addition, further research with female tourists would help to verify the findings; study the perceptions of female trekkers; identify the risky sexual behaviour among tourists and trekking guides; and understand the power relationship between them.

Acknowledgements

The authors would like to thank all the trekking guides and organisations who facilitated access to the sample. We would like to acknowledge Roger Ingham and Nicole Stone for their support during the research planning, fieldwork and writing up stage, also Janine Thoulass for her helpful comments and advice on the final paper. We also valued the comments made by anonymous reviewers for *Culture, Health & Sexuality* on previous drafts. The study was supported by a grant from the DFID-funded Safe Passages to Adulthood Knowledge programme, Centre for Sexual Health Research at the University of Southampton. We would like to acknowledge the Nepal Health Research Council for granting ethical approval for this study.

References

Apostolopoulos, Y., S. Sönmetz, and C.H. Yu. 2002. HIV-risk behaviours of American spring break vacationers: A case of situational disinhibition? *International Journal of STD and AIDS* 13: 733–43.

Arvidson, M., D. Hellberg, and P. Mardh. 1996. Sexual risk behaviour and history of sexually transmitted diseases in relation to casual travel sex during different types of journeys. *Acta Obstetricia et Gynecologica Scandinavica* 75: 490–4.

Basnyat, B., and D. Murdoch. 2003. High-altitude illness. *Lancet* 361: 1967–74.

Basnyat, B., and A. Litch. 1997. Medical problems of porters and trekkers in the Nepal Himalayas. *Wilderness and Environmental Medicine* 8: 78–81.

Bauer, I. 2007. Understanding sexual relationships between tourists and locals in Cuzco/Peru. *Travel Medicine and Infectious Disease* 5: 287–94.

Bauer, I.L. 2003. Inca trail porters: The health of local tourism employees as a challenge for travel medicine. *Journal of Travel Medicine* 10: 94–9.

BBC. 2001. Fears for tourism in Nepal. BBC News, 5 June 2001. BBC. http://news.bbc.co.uk/1/hi/world/south_asia/1371382.stm

Bellis, M.A., K. Hughes, A. Calafat, M. Juan, A. Ramon, J.A. Rodriquez, F. Mendes, S. Schnitzer, and P. Phillips-Howard. 2008. Sexual uses of alcohol and drugs and the associated health risks: A cross sectional study of young people in nine European cities. *BMC Public Health* 8: 155.

Bellis, M., K. Hughes, R. Thomson, and A. Bennett. 2004. Sexual behaviour of young people in international tourist resorts. *Sexually Transmitted Infection* 80: 43–7.

Bhatta, P. 2003. Sexual behaviour of trekking guides: An analysis of knowledge of condom use and STDs and HIV/AIDS in Nepal. MA diss., Tribhuvan University.

Bowling, A. 2002. *Research methods in health*. London: Open University Press.

Brown, H. 1999. Sex crimes and tourism in Nepal. *International Journal of Contemparary Hospitality Management* 11: 107–10.

Brown, K., K. Turner, H. Hameed, and L. Beteman. 1997. Environmental carrying capacity and tourism development in the Maldives and Nepal. *Environmental Conservation* 24: 316–25.

Cabada, M.M., J.I. Echevarría, C.R. Seas, G. Narvarte, F. Samalvides, D.O. Freedman, and E. Gotuzzo. 2002. Sexual behavior of international travelers visiting Peru. *Sexually Transmitted Diseases* 29: 510–3.

Cheong, S.M., and M.L. Miller. 2000. Power and tourism: A Foucauldian observation. *Annals of Tourism Research* 27: 371–90.

CJ News. 2008. Nepal sees record high tourist arrival in 2007. CJ News. http://www.cjreport.com/news/2319/nepal-sees-record-high-tourist-arrival-2007.html

Dahal, G.P. 2008. *Sexual and contraceptive behaviour among men in Nepal: The need for male-friendly reproductive health policies and services*. Lewiston, NY: Mellen Press.

De Schryver, A., and A. Meheus. 1989. International travel and sexually transmitted disease. *World Health Statistics Quarterly* 42: 90–9.

Demographic and Health Survey. 2007. *Nepal demographic and health survey 2006*. Kathmandu: Ministry of Health and Population/New ERA Kathmandu/Macro International Inc. USA.

Eiser, J., and N. Ford. 1995. Sexual relationships on holiday: A case of situational disinhibition? *Journal of Social and Personal Relationships* 12: 232–9.

Forsythe, S., J. Hasbun, and M.B. Liste. 1998. Protecting paradise: Tourism and AIDS in the Dominican Republic. *Health Policy and Planning* 13: 277–86.

Furber, S., N. Newell, and M. Lubben. 2002. A systematic review of current knowledge of HIV epidemiology and of sexual behaviour in Nepal. *Tropical Medicine and International Health* 7: 140–8.

Halpern-Felsher, B.L., S.G. Millstein, and J.M. Ellen. 1996. Relationship of alcohol use and risky sexual behavior: A review and analysis of findings. *Journal of Adolescent Health* 19: 331–6.
Hawkes, S., and G. Hart. 1998. The sexual health of travellers. *Infectious Diseases Clinics of North America* 12: 413–30.
Herold, E., R. Garcia, and T. Demora. 2001. Female tourists and beach boys: Romance or sex tourism? *Annals of Tourism Research* 28: 978–97.
Lee, D., C. Bell, and M. Hinojosa. 2002. Drug-use, travel and HIV risk. *AIDS Care* 14: 443–53.
Limbu, R. 1997. Breaking down sexual taboos in Nepal. *Populi* 24: 4.
Mahat, G., and M.A. Scoloveno. 2006. HIV/AIDS knowledge, attitudes and beliefs among Nepalese adolescents. *Journal of Advanced Nursing* 53: 583–90.
Matteelli, A., and G. Carosi. 2001. Sexually transmitted diseases in travellers. *Clinical Infectious Disease* 32: 1063–7.
Melbye, M., and R.J. Biggar. 1994. A profile of HIV-risk behaviours among travellers: A population based study of Danes Visiting Greenland. *Scandinavian Journal of Social Medicine* 22: 264–8.
Memish, Z., and A. Osoba. 2006. International travel and sexually transmitted diseases. *Travel Medicine and Infectious Disease* 4: 86–93.
Mulhall, B.P. 1996. Sex and travel: Studies of sexual behaviour, disease and health promotion in international travellers – a global review. *International Journal of STD AIDS* 7: 455–65.
National Centre for AIDS and STDs Control. 2005. *Cumulative data of HIV and AIDS*. Kathmandu: National Centre for AIDS and STDs Control.
New Era. 2001. *Nepal demographic health survey*. Kathmandu: New Era.
Nepal Tourism Board. 2003. Trekking in Nepal. Nepal Tourism Board. http://www.welcomenepal.com/arrivalstat.asp
Nepal Tourism Board. 2008. Visitors arrival by nationality (by air only). Nepal Tourism Board., http://www.welcomenepal.com/brand/images/Statistics/Arrival_by_Air_March2008.xls
Nepal Tourism Statistics. 2001. *Annual statistical report*. Kathmandu: Nepal Tourism Statistics.
Nyanzi, S., O. Rosenberg-Jallow, O. Bah, and S. Nyanzi. 2005. Bumsters, big black organs and old white gold: Embodied racial myths in sexual relationships of Gambian beach boys. *Culture, Health and Sexuality* 7: 557–69.
Pigg, S. 2002. Expecting the epidemic: A social history of the representation of sexual risk in Nepal. *Feminist Media Studies* 2: 97–125.
Poudel, P. 2004. Poverty alleviation through ecotourism, Kathmandu Post, July 11. Kathmandu Post. http://www.kantipuronline.com/kolnews.php?&nid=14243
Puri, M., and J. Cleland. 2006. Sexual behaviour and perceived risk of HIV/AIDS among young migrant factory workers in Nepal. *Journal of Adolescent Health* 38: 237–46.
Ragsdale, K., W. Difranceisco, and S.D. Pinkerton. 2006. Where the boys are: Sexual expectations and behaviors among young women on holiday. *Culture, Health, and Sexuality* 8: 85–98.
Redman, C.A., A. MacLennan, E. Wilson, and E. Walker. 2006. Diarrhoea and respiratory symptoms among travellers to Asia, Africa, and South and Central America from Scotland. *Journal of Travel Medicine* 13: 203–11.
Regmi, P., P. Simkhada, and E. van Teijlingen. 2008. Sexual and reproductive health status among young people in Nepal: Opportunities and barriers for sexual health education and services utilization. *Kathmandu University Medical Journal* 6: 248–56.
Romero-Daza, N., and A. Freidus. 2008. Female tourists, casual sex, and HIV risk in Costa Rica. Springer. http://www.springerlink.com/content/a7354501kn034145/fulltext.pdf
Sánchez Taylor, J. 2001. Dollars are a girl's best friend? Female tourists' sexual behaviour in the Caribbean. *Sociology* 35: 749–64.
Sanchez Taylor, J. 2006. Female sex tourism: A contradiction in terms? *Feminist Review* 83: 42–59.
Santelli, J.S., L. Robin, N.D. Brener, and R. Lower. 2001. Timing of alcohol and other drug use and sexual risk-behaviors among unmarried adolescents and young adults. *Family Planning Perspectives* 33: 200–5.
Seddon, D. 1998. HIV/AIDS in Nepal; The coming crisis. *Bulletin of Concerned Asian Scholars* 30: 35–45.
Sharma, N. 2003. HIV AIDS awareness for migrant communities in the rural hills of Nepal. *Sexual Health Exchange* 2: 9–10.
Sharma, B. 2004. Sex education. Gorkhapatra. http://www.gorkhapatra.org.np/pageloader.php?file=2004/07/28/editorial/editorial2

Simkhada, P., P. Bhatta, and E. van Teijlingen. 2006. Importance of piloting a questionnaire on sexual health research records. *Wilderness and Environmental Medicine* 17: 295–6.

Simkhada, P., P. Bhatta, P. Regmi, and E. van Teijlingen. 2006. Sexual health knowledge and risky sexual behaviour among trekkers guides in Nepal. Paper presented at the 9th International Congress of Behavioural Medicine, November 29–December 2, in Bangkok Thailand.

Spotlight. 2004. Cause of concern. Spotlight 29, 11. http://www.nepalnews.com.np/contents/englishweekly/spotlight/2004/nov/nov05/national7.htm

Stone, N., R. Ingham, and P. Simkhada. 2003. Knowledge of sexual health issues among unmarried young people in Nepal. *Asia-Pacific Population Journal* 18: 33–54.

Tamang, A., B. Nepal, M. Puri, and D. Shrestha. 2001. Sexual behaviour and risk perception among young men in border towns of Nepal. *Asia-Pacific Population Journal* 16: 195–210.

The United Nations World Tourism Organization. 2008. *Tourism and community development: Asian practices*. Madrid: World Tourism Organization.

The United Nations World Tourism Organization. 2009. Global economic crisis: UNWTO's response. *UNWTO World Tourism Barometer* 7: 15.

van Teijlingen, E., and K. Forrest. 2004. The range of qualitative research methods in family planning and reproductive health care. *Journal of Family Planning and Reproductive Health Care* 30: 171–3.

Ward, H., T.E. Mertens, and C. Thomas. 1997. Health seeking behaviour and control of sexually transmitted disease. *Health Policy and Planning* 12: 19–28.

WHO. 2001. *Sexual relations among young people in developing countries: Evidence from WHO case studies*. Geneva: Department of Reproductive Health and Research, World Health Organization.