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Introduction

Forewarned is forearmed

The spread of HIV-AIDS--whether considered as a global phenomenon or as a matter of national concern--can be characterised as a long wave disaster, in which the social and economic consequences are only fully recognised well after the epidemic has become established. In Nepal, at present, the number of reported cases of HIV infection remains relatively small, as does the number of deaths from AIDS. There is reason to believe, however, that over the next decade, the development of HIV-AIDS in Nepal will be dramatic, with substantial social and economic consequences for a country poorly equipped to deal with them. It is not alarmist, I suggest, to speak of a coming crisis.

Early identification, however, of the factors which will determine the spread and incidence, and the eventual impact, of HIV-AIDS in Nepal (drawing on experience from elsewhere but also identifying the distinctive characteristics of Nepalese economy and society), will help those concerned to prepare for eventualities and thus perhaps reduce the adverse effects.

In this note, I introduce and consider briefly a number of issues associated with the development of HIV-AIDS in Nepal. (I propose to explore some of these issues in greater detail subsequently in *The Himalayan Research Bulletin* and elsewhere). First, however, I provide a sketch of the wider context in which the development of HIV-AIDS in Nepal needs to be seen.

AIDS as a long wave global disaster

Over the last decade, the spread of the HIV virus and the associated development of AIDS have become a source of very considerable world-wide concern. It is increasingly apparent not only that the AIDS epidemic constitutes a major public (and private) health problem but also that the long term social and economic consequences are likely to be substantial. Some commentators suggest that "AIDS, as an event that impacts in a decisive and adverse way upon a population, can be studied by social scientists in terms of the concept of a disaster" (Barnett & Blaikie 1994: 6). It is now evident that the HIV-AIDS epidemic is best considered as a 'long wave' disaster, in the sense that, by the time the scale and significance of the disaster is recognised and fully appreciated, a considerable time may have elapsed and the social and economic consequences already reached alarming proportions.

Globally, the epidemic is in its early stages, although the impact has already proved extremely serious, particularly in the USA and sub-Saharan Africa (in terms of the numbers infected with HIV and subsequently dying as a result of AIDS), and the social and economic consequences very considerable. Given increasing physical mobility, both national and international, the spread of the epidemic within and between continents is likely to be difficult to check. In all countries, the official figures are significantly lower than the real numbers involved; even so, the available data indicate a crisis on a world scale.

According to the World Health Organisation in 1995, more than 4.5 million people world-wide have developed AIDS or died from it since 1981 (when AIDS was first identified). More than 6,000 people are now newly infected with the HIV virus every day (roughly two women are infected every minute) and over 14 million people currently have the HIV virus or AIDS (8 million men and 6 million women). It is estimated that by the year 2000 this figure will have increased to between 30 and 40 million. By then, 90 per cent of AIDS patients will live in developing countries. These data indicate a crisis of particular significance in the developing world.

Cuts in the aid budgets of many developed countries will certainly have an adverse effect on the capacity of

the international community and the governments of developing countries to deal effectively with the growing epidemic, unless it is assigned a priority which is hard to justify in the light of so many other needs and demands on resources. According to the WHO, $1.5 to $3 billion is needed for basic prevention of HIV in the developing countries; at present, only 10 per cent of these funds are available.

Identified originally in 1981, HIV-AIDS was predominantly associated with the male gay community in the USA and Western Europe, and was seen as a moral as much as a social and health issue. Even in 1993, 40 per cent the reported cases of AIDS worldwide were still in the USA. By the late 1980s, however, it had become clear that the scale of the epidemic, and the social and economic consequences, were likely to prove even more far-reaching and disastrous in the developing world--and particularly in sub-Saharan Africa--than in North America and Western Europe (where, incidentally, there are now signs of a slower growth than originally feared).

By the early 1990s, between 8 and 11 million persons in sub-Saharan Africa were estimated to be infected with the HIV virus (compared with around 1 million in North America), largely through heterosexual intercourse, with a further anticipated increase of 47 per cent between 1992 and 1995. The full death toll for the subcontinent, however, would not be experienced until later in the decade and into the next millennium. In other words, the full impact of the long wave disaster has not made itself felt even now in Africa, despite the appalling toll already taken by the virus.

Asia: the sleeping giant of AIDS

But while roughly 60-70 per cent of those infected with the HIV virus are thought to be in Africa, the disease is now spreading rapidly in Asia where rates of infection are increasing dramatically. At the beginning of the decade, it was anticipated by some that the annual incidence of HIV infections in Asia would exceed the annual incidence in Africa sometime during the mid-to late-1990s (cf. "Update on AIDS," in the Weekly Epidemiological Record, 66, 48, 1991: 289-90). The potential threat is underlined by the fact that more than half of the world's population is to be found in Asia, and the population of sexually active adults in India alone is two and a half times greater than the population of sub-Saharan Africa.

The cumulative total of AIDS cases in Asia reported to the WHO amounted to only 1,254 at the end of 1991 (as compared with 237,436 in the Americas, 120,547 in Africa, and 56,178 in Europe). The Asian country with the largest number of reported cases of AIDS by the end of 1991 was Japan, with 405; Thailand had an official figure of 119, and India a mere 85. But "the recognition that HIV has established more than a toe-hold in Asia, that the spread of HIV infection is linked with poverty and the prevalence of sexually transmitted diseases (STDs) and that no society is immune has caused the WHO to dub Asia the sleeping giant of AIDS" (FitzSimons 1993: 22).

It was estimated, even as early as 1991, that there might be as many as 1 million HIV-infected persons in India alone, with a further 200,000-400,000 in Thailand. Furthermore, it was observed, "Thailand and India are not alone. Indonesia, the Philippines and Pacific nations with high rates of STDs will face problems if HIV establishes itself" (FitzSimons 1993: 31). In mid 1993, it was suggested that, with over 1.6 million people infected with the HIV-AIDS virus in South and South East Asia by 1992, this region would see a dramatic 66 per cent increase by 1995, while East Asia, which had only 25,000 to 30,000 cases in 1992, would experience a virtual doubling by 1995 (*Asiaweek* November 3rd 1993: 26-8).

In Thailand and the Philippines, where the links between the international sex-trade and the spread of HIV-AIDS have been the focus of attention for several years, rates of increase are particularly significant and the number of reported cases (far below the number of actual cases) growing rapidly. Women and children are particularly vulnerable. In Thailand, which had an estimated total of around 450,000 cases of HIV infection in 1993, more than half the prostitutes in some northern provinces are HIV-positive; in the cities, children frequently work in sweatshops, massage parlours and brothels, where they are exposed to sexual abuse and, thus, infection. But the number of infected men is also rising sharply, and it is anticipated that these will contribute to the spread of infection to their wives and partners as well as to professional sex workers.

According to one source, officials in the Philippines knew of only 416 cases of AIDS and HIV-positives in 1993, but it was estimated that for every recorded case there were at least 100 in reality (*Asiaweek* November 3rd 1993: 28). By mid 1993, Burma alone had an estimated 150,000 cases of HIV infection, with Indonesia and Bangladesh both recording very conservative figures of around 20,000. According to the WHO Global Programme on AIDS, there were some 3.5 million HIV-infected adults alive as of mid-1995 in South and South East Asia, with a further 50,000 plus in East Asia and the Pacific. These data, reported in *The Guardian* on December 1st 1995 (World AIDS Day), led commentators to conclude that "on a global level it is clear that the virus is winning, with rapid spread in many parts and a feared explosion in Asia, including the most populous countries, China and India."

AIDS in India

The AIDS epidemic officially reached India in 1986 with the detection of HIV infection in a number of female prostitutes from Tamil Nadu who had been working in Bombay's 'red-light district' (Rajan 1992). The WHO predicted in 1992 that India's AIDS epidemic

would outstrip even that of sub-Saharan Africa to make it the most severely affected country in the world within five years (WHO 1992). Today, some 1 to 2 million people are already thought to be HIV-positive and it is estimated that, if transmission rates remain at current levels, more than 5 million could be infected by the year 2000, and the number of AIDS cases exceed 1 million. Some are even more pessimistic, foreseeing somewhere between 9 and 18 million infected by the HIV virus by the year 2000 (cf. *Asiaweek* November 3rd 1993: 27).

An initial tendency to identify 'foreigners' as primarily responsible for the spread of the HIV-AIDS virus is fading as the number of Indians infected rises, but immigrant workers, particularly those in the sex trade, are still widely regarded as a major source of infection. However, it is now increasingly recognised, at least by many of the agencies working on AIDS in India, that if it becomes an epidemic in India, as predicted, it will be the poor who are most at risk, particularly poor women. "Women in the slums are doubly vulnerable," according to the Executive Director of the Madras Christian Council of Social Services, which runs an AIDS awareness programme in the slums of Madras, "because rights are denied to the poor and because rights are denied to women" (quoted in *Christian Aid News,* October-December 1995, p.8).

There has been, and remains, a tendency--in India as elsewhere in South and South East Asia--to focus attention on women, both as sources of infection (prostitutes) and as the main victims. While understandable, this tends to result in an under emphasis of other factors which contribute to the spread of infection and the development of the epidemic. The economic and social pressures which force women into prostitution, and men to make use of commercial sexual services, and the economic rewards which lead men to organise the sex trade as a source of profit, also need to be analyzed and understood. Not only men and women are at risk; children--particularly girls--are also directly at risk: some 1.8 million children work in Indian cities; and girls are most frequently employed in domestic service jobs, in massage parlours or as prostitutes, where the risks of sexual harassment and exploitation are considerable; and many children suffer when the adults in their family are ill or die.

The rapid spread of HIV-AIDS in India is of major direct significance for the future development of AIDS in Nepal, given the constant movement of large numbers of people between the two countries and the reliance of the Nepalese economy at all levels (national, regional, local and household) on maintaining such mobility. The Indian experience (or experiences, as Tony Barnett [1995] emphasises, drawing attention to the diversity of Indian society) may also be of indirect relevance, given some similarities between Indian and Nepalese conditions, although it is crucial to recognise that "the epidemic has a particular 'shape' in each society" (Barnett 1995: 1).

AIDS in Nepal

In Nepal, the level of AIDS infection remains, for the time being, relatively low. The first HIV-AIDS case was diagnosed in 1988. In 1991 there were only 24 reported cases of HIV infection, of which six involved foreigners, eight Nepalese men and ten Nepalese women. According to FitzSimons (1993: 20), Nepal had a total of five reported cases of AIDS at the end of 1991. It is certainly the case that "there have been deaths from AIDS in Nepal which were not recognised. Similarly, there are probably people ill with AIDS today whose condition has not been diagnosed" Gurubacharya 1992: 42). All the indications are that the situation is likely to change rapidly over the coming years. Current data (UNDP 1994) indicate 208 reported cases of HIV-AIDS (103 males, 105 females) and 31 cases of AIDS (11 males and 20 females), but estimates of the number of those infected with the HIV virus suggest around 5,000.

AIDS in Nepal: Issues

Identifying the determinants of the development of AIDS

As Tony Barnett has observed, "in many respects, each society's HIV-AIDS epidemic will differ in its particulars, reflecting aspects of the cultural, social, economic and political life of that country" (Barnett 1995: 2). Nevertheless, on the basis of the various sub-Saharan African experiences, and the Indian experience to date, it should be possible to identify certain general key characteristics which will play an important role in determining the pattern of development of the HIV-AIDS epidemic, in Nepal as elsewhere.

It is suggested that these will include: 1) demographic characteristics, notably population density and mobility, and rural-urban relations; 2) the level of vulnerability of different sections of the population both to infection and to the impact of the epidemic (including health status, degree of poverty, social status); 3) patterns of sexual behaviour, gender relations and 'openness' about sex and sexuality; 4) the capacity of the state and 5) the capacity of civil society to respond effectively to the spread of HIV-AIDS and to the economic and social impact of the epidemic; and 6) the capacity of local communities and households to cope with the economic, social and psychological impact of the HIV-AIDS epidemic.

All of these factors will require detailed consideration for a full analysis of the economic and social context of the epidemic in Nepal. In what follows, however, I shall simply introduce some issues which will certainly be of importance in any more detailed discussion.

International migration and mobility

Migration in search of employment abroad has always been an important feature of Nepalese economy and society (cf. Seddon 1995), and men working abroad (particularly those in the British or Indian army) have been, for over a century, a source of sexually transmitted diseases (STDs) in Nepal itself. Despite a significant decline in the numbers of those employed by the British army, the total number of Nepalese men working abroad has continued to increase as the Nepalese economy fails to generate sufficient domestic employment. Whether identified as permanent, semi-permanent or seasonal, the scale and significance of international migration between Nepal and the outside world is undoubted, and its relevance for the development of HIV-AIDS in Nepal obvious.

The relatively large numbers of Nepalese men and women working outside the country in other parts of Asia-and particularly in India-but returning periodically to their homes and local communities are seen to constitute a major potential source of infection by the HIV-AIDS virus. But it should also be noted that immigration into Nepal from the densely populated states of north India has been significant over the last few decades (cf. Gaige 1973: 58-86), and immigrants from India may also spread infection into Nepal.

Not only those that can be identified as migrants, however, are involved in international travel. Truck drivers taking loads to and from India; smugglers operating across the borders; officials making formal visits; merchants and traders traveling on business; small farmers involved in seasonal or temporary labour migration-all of these are internationally mobile-and have become increasingly so-and may contribute to the spread of HIV infection into Nepal.

Despite the evident importance of international migration and mobility, by both men and women, most of the attention has been paid, so far, to the numerically relatively insignificant involvement of women in mobility across the borders between India and Nepal. This is largely because of the fact that much of this movement of women is associated with the 'sex trade' and with prostitution. As one commentator has argued, "the overwhelming focus on AIDS spread through prostitutes might be considered unfair targeting, especially because male migrant labourers who work in India (and visit brothels) and Nepali men who visit sex houses in Bangkok or Hong Kong are also potential carriers of the HIV-virus. However, the fact remains that a prostitute is much more susceptible to infection..." (Rana 1991: 19). This is debatable, but the view is prevalent.

As Dr Gurubacharya (chief of the AIDS Prevention and Control Project) argues, "there is a gradual increase in the number of street girls working in Nepal's urban centres; some of them have returned after working as sex workers in foreign brothels. It is very probable that a proportion of these women have been infected with the HIV-virus while working abroad. Although some effort is being made to trace these women and counsel them, it is not an easy job. As there are no definite red light areas in most Nepali urban centres, the safer sex campaign and condom promotion must be directed at traditional sex workers" (Gurubacharya 1992: 46).

Prostitution and international 'trafficking'

Most of the discussion about AIDS in Nepal to date has concentrated on the potential threat associated with Nepalese women working as prostitutes in Indian cities and their periodic return to Nepal-either to their home villages or to the cities of Nepal. As one commentator observed at the beginning of the 1990s, "the fact that returning prostitutes are a major source of AIDS introduction in Nepal is borne out even by the limited data available. Of the 24 cases of HIV infection reported in Nepal, six were among foreigners, eight were Nepali men and the remaining ten were Nepali women. One woman contracted the infection through blood transfusion, the other nine were all prostitutes who had returned from India, mostly from Bombay" (Rana 1991: 19).

It is frequently stressed, in the popular media as well as in the more academic and professional journals, that numerous Nepalese women work as prostitutes in India, mainly in the major northern cities (notably Bombay), and return periodically to the villages from which they originated; this movement is associated with a large-scale 'trafficking' in women for the sex industry. Rana reports that "figures made available by ABC, an NGO working to stop the trafficking of girls indicates that as many as 200,000 Nepali prostitutes might be operating in India, while more conservative estimates of the Indian Health Organisation, puts the figure at 100,000" (1991: 17). Nepalese women are to be found working as prostitutes in Madras, Bangalore, Kanpur, Varanasi, Lucknow, Calcutta and Delhi; but the major concentration is in Bombay, where at least 30,000 to 40,000 are estimated to live and work.

Such research as there has been indicates that there have developed strong links between the Indian centres of prostitution and specific regions of Nepal, from which the majority of Nepalese recruits into the Indian sex industry originate. The region to the north of the Kathmandu Valley, including Kavre, Nuwakot, Sindhupalchok and Dhadhing districts, appears to be the main source of Nepalese prostitutes in India.

In these districts, a high proportion of the population are identified as Tamangs. The Tamangs have long provided a source of cheap labour-whether as porters or other menial workers-for the urban areas of the Kathmandu valley and for the more affluent classes of Nepal (cf. Campbell 1993). In Bagmati Zone, made up of Bhaktapur, Kathmandu and Lalitpur districts, more than half the population are Tamang speakers. There are strong indications that the Tamangs, from the

Kathmandu Valley and its hinterland are particularly strongly represented among the sex workers in the Indian brothels. According to Parshuram Tamang, "Tamangs more than any other hill community are engaged in the flesh trade in Indian metropolis and Nepali towns. The women have their origin in the economically deprived areas in the northern neighbourhood of the Valley. The tragic distinction of being the first recorded Nepali to die of AIDS has fallen on a Tamang woman" (Tamang 1992: 26).

But despite the undoubtedly heavy involvement of women from this particular social group (whose definition is somewhat problematic in any case) there is evidence of a much wider involvement of poor women from the hill regions in the Nepali-Indian 'sex trade'. In a research visit to the brothels of Bombay, public health specialist Shanta Dixit found not only Tamangs and Gurungs, but also Tharus, Bahuns, Chhetris, Newars and other groups represented (Rana 1991: 18). Others point out that, in addition to Tamangs, "Rai are particularly at risk, as well as other caste groups like the blacksmiths and tailors. Again, there is no hard data to support this, and...different groups are likely to be involved" (Ghimire 1992: 6).

Increasingly, over the last decade or so, the survival strategies of poor Nepalese households have included the international migration of women, as well as men, in search of employment. Given the limited range of employment opportunities, many have inevitably found jobs in the 'sex industry' in one capacity or another. There is some evidence of Nepalese women's employment in the sex industries of Thailand, the Philippines and elsewhere in Asia, but this appears to be little researched.

However, it is certainly the case that a relatively large number of Nepalese women are now employed in domestic service or in other menial jobs, in India or elsewhere in Asia, or even farther afield. Many of these women are subject to harassment and abuse, often physical and sexual, by their employers, and may become infected with HIV as a result. Relatively little is known about the significance of this form of international migration and employment for the spread of STDs generally and of HIV-AIDS in particular.

Migration and mobility within Nepal

Increasing physical mobility, linked both to improvements in transport and communications and to the search for work in a context of continuing economic crisis in the hill regions, has undoubtedly increased the opportunities for a rapid spread of infectious and contagious diseases within Nepal.

Rural-urban migration within Nepal has increased dramatically in the last decade and a significant number of recent immigrants to the towns and cities work in the informal sector--notably in the hotel, catering and 'service' industries (including the massage parlours and brothels that are increasing in numbers also)--as low paid and often temporary workers. The 'draw' of the towns and the difficulties experienced in maintaining livelihoods in the rural areas explains a good deal of this migration.

Dr Gurubacharya, of the AIDS Prevention and Control Project, suggests that "another major risk group is the male migratory labour force to urban centres in Nepal and in India. Since they are at a sexually active age and away from their families, the chance of contact with a sex worker is high. Many of these migrants do not know about safe sex; even if they know, they may not be willing to use condoms" (Gurubacharya 1992: 46).

But, in addition to labour migration (often a response to poverty), there is also the greater mobility that results from increasing commercialization of goods produced in the rural areas for sale in the towns: merchants, traders and petty commodity producers travel to town to sell their merchandise; porters carry it to the road-head and trucks transport it onwards to the larger towns. Increasing general mobility, as a result of improvements in transport infrastructure (road construction), leading to better transport facilities and lower transport costs, means that there is a greater circulation of persons not only from the rural areas into the towns but also back to the rural areas from the towns. One of the activities which studies have shown is positively associated with the improvement of transport infrastructure is 'visiting for personal reasons' (Blaikie, Cameron & Seddon 1980: 173-4). Such movement is by no means one-way or permanent, but increasingly 'perpetual'.

The transport industry itself, by increasing road traffic, has contributed to the growth of both passenger transport and goods haulage and this in turn has contributed to the development of road-side facilities and road-side settlements, particularly where important porterage trails meet the road-head, or where roads meet. Porters, drivers and passengers alike make use of these facilities intensively, and the constant interaction at these road-side locations increases the chances of the spread of disease.

Prostitution in Nepal

Many of the road-side settlements that have sprung up over the last two decades offer facilities for sex for truckers and travelers. Such centres as Walling on the road from Pokhara to Bhairahawa, for example, have acquired notoriety as centres of prostitution (cf. Blaikie, Cameron & Seddon 1980: 133). Truck drivers on long hauls in particular stay overnight in such centres and take advantage of the facilities provided. The growth of this aspect of what might be termed the 'indigenous sex trade' has been little discussed.

More attention has been paid to the growth of the 'tourist-related sex trade' in urban centres where the

influx of foreign tourists (particularly from North America, Western Europe and Japan)-the number of tourists increased from about 181,000 in 1985 to over 293,000 in 1995-has given rise to new patterns of demand and new facilities to cater for that demand. Towns like Pokhara and Kathmandu are particularly prone to this particular aspect of the sex trade, and much was made of the fact that six of the 24 reported cases of AIDS in 1991 were foreigners. Nepal in general and Kathmandu in particular have long been popular with foreign 'travelers' and the apparent increase in the use of injected drugs - and of infections associated with drug use - is often explained as a result of the influx of foreign drug users and the corruption of the Nepalese youth.

Recent measures introduced by the Indian health authorities to test prostitutes for HIV have led to many Nepalese women being deported. Some of these then have sought employment in Kathmandu or other towns in Nepal, where the demand for commercial sex is reputedly growing. The return of Nepalese women from centres of commercial sex abroad, not only to their own 'home' communities but also to Nepalese centres of prostitution' has been much discussed in Nepal. Not all are as concerned about the welfare of these women as MP Asta Laxmi Shakya, who raised the issue in the national assembly, alleging that women who tested HIV-positive were being discriminated against by medical staff in hospitals. But she, like many others, are explicitly concerned about the wider implications of a failure to treat these women. According to one report (*Everywoman* April 1994, p. 10), she stated that "there is an urgent need to provide proper treatment to the AIDS-infected women returning from India in order to check the spread of the disease in Nepal."

In 1991 it was suggested that "about 5,000 prostitutes operate in the valley, increasing by a few hundred every year" (Rana 1991: 19). Today, an estimated 25,000 prostitutes operate in Kathmandu alone, many of them undoubtedly HIV infected. But as Sujata Rana emphasises, "part of the problem is that there is extreme paucity of data regarding prostitution." She points out that much of the discussion to date has been based on very scanty information and not on careful empirical research, and calls for "a detailed study of the extent of women trafficking" to identify "the danger areas in the Nepali hinterland" to inform government policy and aid "work in concert with international and voluntary agencies."

The relationship between prostitution and the spread of the HIV-AIDS virus--which has been a major issue for those concerned about the spread of AIDS in Nepal--cannot, of course, be ignored. But the spread of the HIV-AIDS virus cannot be seen only as determined by the growth of prostitution and even less as determined only by the sexual behaviour of women.

The causal nexus is more complex than that and involves the changing pattern of rural and urban livelihoods, and in particular the growth of poverty, as well as changing patterns of sexual behaviour by both men and women in response to changing macro-economic and social conditions.

The underlying economic pressures

The links between poverty in the hill areas and the search for alternative forms of employment and sources of income explain in broad terms the impetus behind the sex trade, as it does migration in search of work more generally. The physical mobility which has increased both the effective demand for commercial sex and also contributed to the rapid spread of infection as greater numbers become involved in sexual relations with multiple partners is also explained by the changing structure and dynamics of the Nepalese economy.

It is not surprising that the highest incidence of HIV-AIDS infection appears to be in the Kathmandu Valley and surrounding areas, given the role of the capital as the hub of the Nepalese economy and society and as the country's major population centre to which increasing numbers are attracted in search of employment and other economic opportunities.

But if the 'pull' effect of the capital's economy is significant and explains in part the growing numbers migrating permanently or temporarily to Kathmandu, the 'push' effects of rural poverty and environmental degradation also explain a good deal. The resources of the hill areas in the hinterland of the Kathmandu Valley urban centres, perhaps more than anywhere else in the country, have been progressively degraded and depleted as demand for wood fuel has increased over the past decades. With increasing land degradation and inadequate access to forest resources or land for agricultural production, the inhabitants of these areas have become increasingly reliant on selling their labour and their bodies to provide their families with a living income.

But if the communities in the regions closest to Kathmandu are perhaps the most seriously and evidently implicated, other resource-poor hill areas are also increasingly prone to the rural exodus. This is as relevant for the development of the sex trade as for any other economic 'sector'. Poonam Thapa, speaking at a SAARC conference in 1990 on 'the girl child', referred to the large number of women and girls from among all of the poorest groups in Nepalese society who were involved in the flesh trade (cited in Tamang 1992: 26). And, as Rana observes, "a look at the socio-economic map of Nepal will show that the majority of women who leave, come from the more destitute areas of Central and Eastern Nepal" (Rana 1991: 18). Ghimire refers to the areas most affected as "Sindhupalchowk, Makwanpur, Khavre, Dhadhing and some parts of Western Nepal" (Ghimire 1992: 7).

The clear implication is that it is the degradation of resources and poverty that creates vulnerability and drives the rural poor, particularly from certain

identifiable regions, into economic survival strategies that take them away from their homes to work elsewhere; migration is a necessity and, as far as employment is concerned, "beggars cannot be choosers."

Vulnerable communities and local coping capacity

As noted above, the likely centres of the epidemic are the urban areas, and smaller road-side settlements, where an increasingly mobile population congregates and interacts; from these, however, it is probable that the epidemic will spread back to the local communities from which migrants and travelers originate and to which they return.

The lines along which the infection will spread are the lines of human traffic, along the roads that are gradually linking the different regions of Nepal (as part of the development process), and along the trails, as far as the greater part of the country is concerned.

But eventually, it is 'back home'--wherever that may be--that infected individuals will pass on the HIV virus to their sexual partners or seek support, as they become more seriously affected by AIDS, from families and relatives. It is in these local communities that the individual and personal impact of the development of HIV-AIDS will be most acutely felt; it is in these communities also that the vulnerability of individuals and households is perhaps greatest.

It is already possible to identify specific vulnerable regions, with relatively high rates of infection per capita and known cases of AIDS, from which originate and to which sometimes, eventually, return the vulnerable individuals from specific identifiable communities. The regions to the north of Kathmandu, the local communities of Tamangs in these regions, and the women in particular from these communities who are heavily involved in prostitution and the sex trade, have been provisionally identified as particularly vulnerable.

Remarkably little is known in detail of the social and economic conditions which create and perpetuate this vulnerability, although a useful general analysis of the burdens of Tamang identity and the particular circumstances of Tamangs in the vicinity of Kathmandu is provided by Ben Campbell (1993). Other studies by social anthropologists (e.g. Clarke 1980; Euler 1984; Fricke 1986; Fricke, Thornton & Dahal 1990; Fricke, et al 1991; Hofer 1969, 1978; Holmberg 1989; March 1979; Panter-Brick 1993; Steinmann 1987; Toffin 1976, 1986) of communities in the region to the north of Kathmandu provide further insights both into the social and economic forces at work which create vulnerability to the AIDS epidemic and into the capacity of 'civil society' at the grassroots to respond to and cope with the impact of the epidemic. Campbell's study of reciprocal labour and broader patterns of inter-household relations among the Tamang (1993), for example, provides some indication that the more vulnerable local communities do have strong traditions of mutual support.

It is at the level of the local community, where the nexus of inter-household and inter-personal relations is closest (but in a crucial sense also most threatening), that strategies and capacities for coping with the personal crises and disasters that characterise the local impact of the epidemic are most likely to be crucial. It is at this level that the distinctive patterns (associated with ethnic group, caste, status and income) of entitlements, rights and obligations as between individuals and households regarding the care and welfare of those falling seriously ill and unable to provide for themselves or their families, and for those left without the means of effective support by the death of a family member, will pertain.

In the areas of sub-Saharan Africa most seriously affected by the AIDS epidemic, the deaths of adults have left large numbers of orphans - defined in India (according to Barnett 1995: 12) as children with one parent deceased. The capacity of the so-called extended family, or of other groupings of close kin, to cope with the care and welfare of orphans will vary as will the particular coping mechanisms available to those within the local community who consider themselves morally and socially responsible. The loss of adults through death from AIDS (as from other diseases or accidents) also creates problems for the care of the elderly. The local impact of a rapidly changing dependency ratio will depend upon the particularities of each local community.

In general, different household structures and dynamics, and different inter-household relations and resources, will give rise to different capacities and strategies for the support of AIDS victims and those indirectly affected. For poorer households, the network of social relations is likely to be more limited and to dispose of fewer resources.

More research is required to establish an understanding of the range of local resources and capacities available, and the limits to local coping strategies.

Non-government organisations

Already several NGOs have begun to become actively involved in identifying the needs of individuals and local communities affected by HIV-AIDS, albeit in the context of more general development assistance. Most appear at the moment to be concentrating on 'raising awareness' and general 'health education'; some are working in the context of an existing commitment to programmes of maternal and child health and to family planning.

Many NGOs in Nepal are already actively involved in the areas of primary health care-particularly focusing on maternal and child health (MCH) and on family

planning. Increasingly, over the last decade, NGOs have developed approaches in which community-based activities and forms of collective action are encouraged and promoted as a key to successful adoption by individuals and households of appropriate measures to improve health and reduce risk of disease. These are likely to be deployed in future to encourage and promote local community responses to the threat of HIV-AIDS.

Other NGOs, like ABC (originally Agro-forestry, Basic Health and Cooperatives) and CWIN, have changed their orientation and increasingly focused attention on promoting awareness about trafficking and the attendant risks of AIDS in rural areas and in the capital. ABC reports that "we have used different media to get over the message-cassettes, radio and TV programmes, newspaper articles and street theater. Our objective is also to mobilise policy makers, administrators, police and the general public through publicity campaigns. We want to organise women's groups against the issue, and to provide them with income generation opportunities" (ABC 1992: 7).

Responses have been strongly directed towards medical intervention and research, and increasingly towards education and awareness raising linked to encouragement of use of condoms. The links between 'family planning' initiatives and the importance of 'safe sex' education have been emphasised. This is important, but limited. The concern of organisations like ABC with alternative income generation opportunities for women, both to reduce the likelihood of their involvement in commercial sexual activities and to provide some degree of support in cases of infection and ill-health is well placed. So too is the objective of encouraging collective action by women around the issue, as long as this does not lead to the demonisation and 'scape-goating' of the victims of the HIV-AIDS epidemic and concentrates on women's rights.

There is, however, a real danger that the prospect of an epidemic will attract organisations and individuals whose interest lies more in the resources that are now being made increasingly available to NGOs for work on HIV-AIDS related issues and will not serve the interests of those directly and indirectly threatened by the disease. Already it seems that "everyone in Kathmandu seems involved, everyone after money, that is" (according to one expatriate commentator, pers. comm.).

There is a need for all NGOs, operating in regions where vulnerability is relatively great and where the probabilities of a rapidly increasing incidence of infection are relatively high -whether northern NGOs with relatively substantial resources or local NGOs with generally more limited resources - to be obliged to consider carefully whether they have the financial, technical and human resources, and whether they wish to develop the rather specific capacity required, to become usefully involved in assessing and responding to the AIDS epidemic.

A couple of years ago, it was argued that "voluntary agencies have only just begun to function and are not yet geared up to tackle the task of AIDS prevention and control; neither do they have a forum in which to coordinate their activities" (Dixit 1992: 54). The situation has changed significantly in the last few years, but there is still a lack of overall coordination and strategic planning, even among the northern NGOs. Most NGOs at least now recognise, if only in a general way, the likelihood that the social and economic consequences of the development of HIV-AIDS within their sphere of operations may be very considerable indeed, and may affect the effectiveness of their programmes in a variety of ways. They need, however, to develop a sharper appreciation of the potential implications of the development of HIV-AIDS in Nepal and to devise appropriate strategies, both individually and collectively, to encourage and support local communities and government efforts.

Foreign aid agencies

Bilateral and multilateral agencies which provide various forms of development assistance to Nepal, also need urgently to recognise the potential scale and social and economic implications of a rapid development of HIV-AIDS in Nepal, and to determine, in collaboration with the Nepalese government and the NGO community, what will be the most effective strategy-in general and in particular-for responding to the coming crisis. They also need to consider, together, what will be the most effective division of labour and specialisation between government, foreign agencies, NGOs and local communities in approaching the various responses required.

Most of the major aid donors to Nepal are already aware in general terms of the need to confront these issues; most have also supported the activities of NGOs, particularly in programmes concerned with health and family planning, and with 'education and awareness'. But increasingly tight aid budgets will tend to reduce the scope and funding even for emergency programmes and there is relatively little indication so far the major foreign donor agencies have developed appropriate strategies in concert for Nepal in the light of the experience of HIV-AIDS in sub-Saharan Africa and elsewhere. Shanta Basnet Dixit argues that "while the WHO and the other international agencies in Nepal, particularly UNDP, are well aware that the government has neither the manpower nor the capability to prevent and control AIDS, they have so far been unable to coordinate their efforts and develop a comprehensive action programme to control the AIDS situation before it spirals out of hand" (Dixit 1992: 54).

Government capacity and public responses

Foreign aid is of particular significance in Nepal, where the resources and the capacity of the Nepalese government to respond rapidly and effectively to the

coming crisis associated with the AIDS epidemic are strictly limited.

The public health service operates at a rudimentary level and reaches very few, let alone the poor. Health infrastructure is severely underdeveloped--in most parts of Nepal it is several hours walk at the least (and often considerably more) to the nearest health post, which often lacks staff or supplies. The system is plagued by a range of institutional and service delivery weaknesses. Resources spent on the health service are low in quantity-only 5.5 per cent of the national budget is spent on health and per capita expenditure, at about $1.5, is less than half the average for low income countries as a whole -and low in quality (according to the World Bank Country Study, World Bank 1991: 88-9). Despite the long-standing existence of a national family planning programme, its impact has been extremely limited; and contraceptive use in particular (including use of condoms) remains low in Nepal, in comparison even with other Asian countries.

In 1991 it was suggested that "it is unfortunately... time for HMG's Ministry of Health as well as voluntary organisations to set up curative facilities for those who have 'full-blown' AIDS. Medical practitioners, for their part, must play a leading role by showing their willingness to treat HIV/AIDS cases, admit such cases to hospital and dispense humane treatment" (Rana 1991: 19).

And certainly it has been publicly argued that "within Nepal there should be counseling as well as medical facilities for HIV and AIDS patients" (Rana 1991: 20). But with only around 130 hospitals and health centres, just over 800 health posts, and a mere 1,500 registered doctors, to cover the needs of the entire Nepalese population of nearly 20 million, the prospects an effective response through the formal public health system are poor. Shanta Dixit has observed that "there is one nurse per 4,680 and one doctor per 32,710 population, about the worst statistics compared to anywhere in the world. Half the doctors and health facilities are concentrated in the Kathmandu Valley where less than 5 per cent of the population lives, thus leaving many areas of the country without a doctor" (Dixit 1992: 51).

Furthermore, although there is certainly a need to recognise and respond to the medical and health care implications of the epidemic, other forms of intervention are also required: measures to provide alternative sources of income; measures to ensure adequate social security and welfare for those deprived of incomes themselves or deprived of support through the loss of a breadwinner; and measures to provide adequate counseling and personal support for those suffering from the HIV virus and AIDS. Finally, as Jonathan Mann (the AIDS 'guru') has increasingly argued, there are important issues of human rights and basic needs involved in confronting the development of AIDS, in which the government, through legislation and official policy, should be taking a lead.

Shanta Dixit concluded, a couple of years ago, that one of the striking aspects of Nepal's confrontation with AIDS was "the Government's almost complete inability to tackle the problem. A countrywide AIDS prevention strategy has not been developed" (Dixit 1992: 49).

There has been some response from HMG Nepal. Since the mid 1980s, the Women Development Division of the Ministry of Labour and Social Welfare has run a skills development programme for the victims of HIV-AIDS in areas where the infection rate is high. In 1988 the government established an ambitious AIDS Prevention and Control Programme, with assistance from the WHO. The programme was designed to run for three years (with a budget of nearly $2 million). Dr Gurubacharya of the AIDS Prevention and Control Project reported in 1992 that the following measures had been introduced: 1) compulsory screening to prevent transmission through blood; 2) a counseling programme and the screening of i/v drug users in some urban areas to reduce infection through needle sharing; 3) a mass education programme (through electronic and print media) together with condom promotion; 4) production and distribution of educational materials, directed particularly at specific target groups; 5) sentinel surveillance in different parts of the country to monitor particularly sex workers, those suffering from STDs and migrant labourers; 6) health education by health workers in the rural areas, supplemented by a street drama education campaign; 7) special education campaigns and outreach health clinics adopting a community-based approach making use of interpersonal networks and oral culture; and 8) workshops and training seminars for health workers, teachers, students, social workers and community leaders.

The effectiveness of these measures has not been systematically evaluated, but Shanta Dixit remarked in 1992 that, since 1988, "three years have come and gone but little has been done. Testing for HIV infection was the major focus, but still less than 50,000 people have been tested so far. Much of the budget was not used, and was allowed to lapse" (Dixit 1992: 53). She observed that "the AIDS Prevention and Control Project is currently in its second phase, which lasts for two years (1992-93). Even as the threat of AIDS looms larger than ever, however, its budget has been slashed to $167,000. And over half of this amount goes towards the salary of a single consultant of the World Health Organisation" (ibid. 54). She concludes that "this shows that the donor agency as well as the Government does not really take the issue of AIDS seriously". She argues that "very little has been introduced to curb the spread of the epidemic. Innovative educational programmes have not been tried, and alternative sources of income for high risk occupations have not been explored. More importantly, the few identified AIDS victims have not received proper treatment, which does not bode well for

voluntary disclosure in the future" (ibid. 55). She suggests, even more negatively, that "none of the target groups has been adequately reached, and there is no sustained public information programme" (ibid. 54). Finally, she argues, "the Government continues its legacy of inaction, while the international agencies bicker over questions of turf. Meanwhile, the AIDS virus spreads, and in the end, will debilitate the economy-whether or not the data are available will make no difference" (Dixit 1992: 55).

Conclusion

Whether such a critical and dismal assessment is appropriate today, several years later and ten years after the identification of the first AIDS cases in Nepal, remains to be seen. A more detailed and critical evaluation of more recent developments is required than has been possible in this short note. I hope to be able to develop some of the themes and explore further some of the issues raised here, in the near future.

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