A STUDY OF GENDER AND HIV/AIDS IN CONTEMPORARY NEPAL

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CERTIFICATE

This is to certify that the dissertation titled "A STUDY OF GENDER AND HIV/AIDS IN CONTEMPORARY NEPAL" has been submitted by Shirisha Amatya in partial fulfillment for the award of the Degree of Master of Philosophy. This dissertation has not been submitted for any other degree to any other University and is her own work.

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DEDICATED

TO

MY FAMILY,

MY INSPIRATION

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INTRODUCTION

The body of knowledge associated with the Human Immunodifiency Virus (hereafter refer to as HIV) and the Acquired Immunodeficiency Syndrome (hereafter refer to as AIDS) represents complexity not present in any other disease. HIV infection is not only an extremely complicated disease process, but it also transcends the boundaries of biomedicine. Various domains shape the construction of HIV/AIDS as chronic disease with the societal construct circumscribing the body of knowledge concerning the pathological, mirroring the complexities of the malady itself. Disease, and the respective body of knowledge, co-exist within a social reality; consequently, a controlled vocabulary designed to facilitate knowledge organization and access relative to HIV/AIDS must reflect the complexities of this socially constructed reality. Social constructionists posit that reality is constructed through dynamic socialization and that the sociology of knowledge must examine the process in which this reality construction occurs (Berger & Luckmann, 1966, p. 1).

In the absence of a straightforward medical inoculation or cure, understanding of the spread of HIV/AIDS and advice about how to intervene to limit its spread, should be largely social scientific in nature. Therefore, the social sciences should provide the main components of the relevant knowledge base. The very considerable regional differences of social phenomena require a particular mobilization of social science knowledge about each particular society or regional grouping of like societies.[1]

[1] Singh A, 2004

Review of Literature

Jonas Salk wrote before his passing that the evolution of "modern man" would be conditioned more by "survival of the wisest" than the more traditional Darwinian prediction of fitness.[2] In turn, it has been said that wisdom accrues from repeated errors and the acquisition of understanding from those errors. If such is true, then a examination of public health's (and indeed society's) response to the AIDS pandemic over the past 20 years would give us some insight into our errors and, in the end, add to our wisdom.

"Our social constructions of AIDS (in terms of global devastation, the threat to civil rights, the emblem of sex and death, the 'gay plague,' the postmodern condition, whatever) are based not on objective, scientifically determined 'reality' but on what we are told about this reality" (Treichler, 1999, p.15).

Few researchers have explored the theoretical and pragmatic implications of the social construction of AIDS as a disease that "has gender." Gender differences in health in developing countries have, until recently, received little attention from researchers, health programmers and international development efforts. Even in the industrialized world, women's issues were not part of the overall health care agenda prior to the 1980s.[3] Social issues have been relatively neglected in current HIV/AIDS research. Most of the existing social science research on the AIDS pandemic has focused on the transmission and spread of HIV. Numerous factors impede the integration of social science knowledge and practice into HIV research and programmes: many health personnel overlook the different, complementary disciplines of social science and their prospective interaction with their own fields of activity. [4]

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[2] Salk J, 1973
[3] ibid. p.1
[4] J.S Murphy, 1988

Sociology of knowledge deals not only with empirical knowledge relative to various societies but also with the processes by which bodies of knowledge become established as social realities. In essence, reality evolves through continued socialization, yielding outcomes that result from social interactions, negotiations, and power. Where the HIV and the AIDS are concerned, social construction of reality is grounded in the spatialization and politicization of the pathological.

AIDS teaches us lessons that go beyond Africa and the West. These lessons enlarge our understanding of the significance of socio-economic, cultural and political influence on the spread of infectious diseases. In the hardest hit countries, AIDS is dramatically reducing life expectancy and economic potential, increasing the vulnerability of future generations by creating millions of orphans and diminishing the capacity of public and private sectors.

The emergence of AIDS as a social phenomenon can be explained through two analytical concepts: ***'quantity to quality transfer'*** **and** ***'collective conscience'***. AIDS is incurable in nature, because of which, the number of deaths rapidly increases showing a quantitative change that transforms itself into a qualitative change when basic social norms and practices of a society are affected.

Quantitative change could be understood in two ways: the things that existed exit no more, and the things that did not exit have gained existence. New social phenomena have emerged because of the increasing AIDS infections, such as --discriminatory practices, personality disorganization, family disintegration, etc. It also hits the ***collective conscience*** of the society by increasing death rate and hence is also a social fact. If the death rates were normal, society would absorb the consequences but because of excessive and uncontrolled death, society's collective conscience gets affected. Thus, AIDS emerges as significant social phenomena of modern times.[5]

[5] Pandey H N, 2002

It is widely accepted that the drivers or determinants of HIV infection rates are largely social. The biological success of the virus - its ability to replicate and spread - is directly attributable to the fact that it takes advantage of the social nature of being human. The survival of HIV is predicated on the way we structure our societies and live our lives within those structures. It is for this reason that the social determinants of HIV are regarded as so critical in controlling the pandemic.

The last two decades of the 20th century saw the establishment and development of a cohesive body of scholarly works, collectively known as the "Sociology of AIDS". From its origin during the pandemic of the early 1980's "Sociology of AIDS" have fine examples of the contributions sociologists can make to disease related social groups at risk of the disease, the marking of behaviors or social conditions that augment the risk and the study of issues pertaining to collective an individual change.[6]

As the body of work grew in volume, the studies diversified with some sociologists working on applied social research projects, such as formulation of HIV preventative strategies, while other focused on the personal experience of people living with HIV, the provision of HIV care and the implementation of social network analysis in building models of HIV transmission. Despite the variety of sociological studies, the field of AIDS related social research remains limited by its roots in 19th century venerealogy[7]

HIV epidemic is being fuelled by society's inequalities. While poverty, caste, class and sexuality have great impact on the spread of HIV, gender places the burden of the epidemic on women. The risk of getting HIV is gendered risk, one that strongly depends on the actions and behaviors of individual men and women, playing our gender roles that society had constructed for them.

[6] WHO, 1998

In biological commonsense terms, what distinguishes women from men is the differences between their reproductive systems. These anatomical and hormonal variations are the basis upon which individuals are allocated to a particular sex. However, they represent only a part of the complex set of criteria by which we all learn to distinguish femaleness from maleness. Equally important are the socially defined characteristics that different cultures assign to those individuals defined as female and those defined as male i.e. ***gender.*** These apparent differences are sometimes justified with reference to biology. Women are given certain sorts of jobs for instance, because their biological capacity for motherhood is said to make them more 'caring'. In reality however, gender differences are social constructions that can potentially be changed in ways that most biological characteristics cannot.[8]

Most pertinently women's inability to negotiate sex, let alone safer sex, their economic and societal reliance on men, their lower positioning within the family and social structures and their traditional roles as nurturers and care-givers make it next to impossible for most women to ensure protection from HIV; obtain quality care and social support, if infected; and cope with the immense and unequal burden that falls on them- of providing care to those infected in the family, and the economic and social support to the rest of the family members.[9] Defining AIDS as a disease of gay white men focused attention away from women. As a result, many women are unaware of their potential risk for HIV infection.

This disease changes the ratio of dependents to producers. Caste, class and wealth are no protection, nor is marriage (at least for women), all are at risk whoever have unprotected sex with another person. Stigma and discrimination is everywhere, especially in case of women.

[8] ibid
[9] Current Sociology 2002

As Richardson notes, "in our society, it is impossible to talk about sex without also talking about power". The unequal social relations of gender in modern society have to do with the ways in which society differentially reproduces gendered subjectivities of masculinity and femininity, which perpetuates the existing power structures. [10]

The Western and African experiences tells us that AIDS festers on the fault lines of the societies throwing into sharp relief the flagrant inequalities between the rich and the poor; mean and women; urban and rural; and the educated and the uneducated. It provides evidence that the origins of the epidemic are historical and structural and its effects appear over a very long period of time. Poverty, inequality, social cohesion has been shown to increase the susceptibility of individuals to the virus.[11]

Estimates of HIV prevalence in a number of ***African*** countries assumed roughly equal levels for males and females from the beginning of the epidemic, but early research also hypothesized an association with socioeconomic status.[12]

A study is Zambia in the mid 1980's for example, suggested that there was greater propensity for those who were more highly educated to be infected. Data from surveys of women attending ante-natal clinics in 1994 continued to show a strong gradient among infected women on the basis of education, as well as of residence in urban areas, with rates as high as 42% among those with post secondary education in urban areas, and 32% in rural areas, as against figures of 13% and 7% respectively for those with no education.[13]

[10] Miles L,
[11] Barnett and Whiteside, 2002
[12] Barnett T& Blaikie P, 1992
[13] I.O. Orubuloye, 1993

Women, who in most Africa are dependent upon their husbands for their economic well being, generally do not have the standing to assert their preferences, for example to insist upon the use of a condom.[14]

A West African study showing that men tend to have more ***extramarital relations*** during the period when there wives are 'unavailable' thanks to childbirth and cultural practices of abstaining after childbirth led the researchers to recommend that women reduce their period of post-partum abstinence. While culturally prescribes practices vary in regard to the duration of abstinence, the wandering of husbands before and after a birth of a child appears to put new mothers at risk.[15]

In many African countries, ***polygamy*** is legal; in only a few countries have some attempts been made to legislate against it (Togo and Cote d'Ivoire, for example). There are traditional rules to ensure that co-wives are treated equally, sometimes even going so far as to establish a rota for the sexual relations between the husband and his wives. The marriage of one man to several wives speeds up the transmission of HIV.

Moreover, for ***economic reasons***, it is becoming increasingly common for young women living in cities to be asked, without hesitation or shame to cater for the needs of their families in the village. The severity with which the sexual mobility and sexual activity of unmarried women are controlled also varies greatly. Extreme cases are the exclusion of women in the Muslim societies of northern Africa, and the various kinds of sexual mutilation of women such as infibulations, found in many societies disturbed in a wide belt across the African continent.[16]

[14] ibid
[15] ibid
[16] ibid

Other sociocultural factors can be found such as high rates of emigration and gender differences in the access to land, which make women even more vulnerable: many divorced or unmarried women are barred from the use of the land and left with no option but to engage in ***prostitution*** in order to survive.[17]

The ***levirate system*** is common in patrilineal societies: a woman forms part of her husband's property and her reproductive potential belongs to his family. The widow is therefore required to marry one of her dead husband's brothers, who see this act as perpetuating the male principle through her. If a husband dies of HIV/AIDS without anybody being told, the brother who marries the widow may contract the virus, particularly as the remarriage is usually celebrated very quickly, before any blood tests can be carried out.[18]

There are social dimensions associated with AIDS, which have negatively affected Africa in terms of development. Some examples: 85 percent of prostitutes in Nairobi were found to be HIV positive.[19] Life expectancy in Uganda has declines from 60 to 40 years for a child born today.[20] In some cases, the segment of the population most severely affected is the educated elite. Perhaps 20 percent or more of the entire population of Malawi or Zambia is estimated to be HIV positive. By the year 2010, 37-46 percent of the Tanzanian adult will be HIV infected. Life expectancy in Malawi is predicted to drop less than 30 years by 2010.[21]

[17] Keogh P, Allen S. Almedal C and Temahagili B, 1994
[18] ibid p.21
[19] US department of commerce, 1996
[20] The New York Times, 1990
[21] US Bureau of the Census, HIV/AIDS in Africa.

During the 1980's, when Africa was the negative center of attention with respect to AIDS, ***Nepal*** took refuse in postures of denial on the ground that AIDS was a foreign disease. It was believed that the traditional socio-cultural norms of monogamy, universal marriage and therefore heterosexual relations and virtual non-existence of homosexual behaviors and societal proscriptions against an explicit focus on sex and sexuality in public social interactions and discourse, provided the necessary shelter from a predominantly Sexually Transmitted Disease (hereafter refer to as STD).

Huge social inequalities based on caste and render relations, exacerbate the role of economic disparities in making for unequal access to important development inputs. Women are marginalized from birth by socio-cultural pressures. Rural families, especially women and girls experience great difficulty in sustaining themselves, because of a limited resource-base and the social constraints that women face in the household decision-making about existing resources. [22]

From the perspective of ***Western religion***, there is direct contradiction to social customs, for example, a Christian response to the epidemic, "*If people were monogamous, the virus would not spread.*" The Catholic Church opposes *artificial birth control*-which condoms are perceives to constitute, even when used for disease prevention.[23]

Popular discourse is full of comments which assume certain forms of "natural" sexuality: men are assumed to be naturally promiscuous, women to be naturally monogamous; sexual attraction is attributed to 'body chemistry'; homosexuality is condemned by traditional moralists as unnatural or justifies by reference to the fact that it can be found in many animal species.

[22]. Poudel M and Shrestha A, 1999
[23] ibid

Hollway (1995), identifies in her research three discourses centering around sexuality. Although one of the tenets of this approach is that any discourse will be historically and culturally specific, thus discourses delineated in one context cannot simply be applied elsewhere; the three which Hollway identifies are frameworks for the dominant construction of sexuality in western society. She calls these,

The male sexual drive discourse;
The have/hold discourse; and
The permissive discourse

Hollway suggests that all of these discourses have a central notion the idea that sexuality is an unmediated, biologically based drive in the individual. The male sexual drive discourses that a central feature of masculinity is the desire/need for sex, and that men's sexual impulses are basically animal and difficult to control. Women are seen as the boundary keepers for these impulses. This idea is ratified by rape law, marriage laws and propounded in the popular media. Its includes the idea that men have sexual rights over women. Both men and women are interrelated by the have/hold discourse, although women are more strongly subjects of the desire it procure a man in one in which the ideal is the free expression of sexual impulses, for both men and women.

At the other extreme is what one might call a postmodern constructionism, one that defines sexuality as a total product of ***culture*** without any reference to its biological basis. [24]

Gilman suggests that AIDS is linked to a set of images of a "morally repugnant disease" already present in the culture. The metaphors of AIDS contribute to the stigmization of the disease and the consequent construction of a putative social division between those who are seen to be 'at risk' and the general community, which is not. Notions of risk group confirm an identity for AIDS suffers which is essentially blame-worthy, deviant and delinquent.

[24] Altman Dennis,

This stigmization has manifested in discourses of AIDS in South Africa, where is early representations (mainly appear in the media), AIDS was constructed as demonic killer and homophobia, racism, sexism were prevalent subtext. For example, distinctions were made between "African AIDS and White AIDS' (*The Star, 13 September 1987,p.9),* and the South African government represented foreign migrant workers as reservoirs of the disease (*The Citizen, 4 September 1987,p.2).* In the same period there was a spate of newspaper articles representing prostitutes as rampant sources of HIV infection.[25]

Sexuality was already politicized before AIDS, whether in rich countries-where arguments around abortion, pornography, homosexuality etc seemed to have inherited the passion formerly reserved class disputes, or in developing ones, where basic questions around women's sexuality and reproduction were often the base for unstated conflict around he basic rights of women and human rights in general. AIDS has made it harder to deny enormously political significance of what is often defined as belonging to the personal sphere and hence regarded as the preserve of religion or tradition. With HIV it is no longer possible to believe that Papal pronouncements against birth control, or Hindu and Islamic prohibitions of homosexuality are merely questions of personal values or traditional beliefs; people will live or die depending on how far traditional prejudices and superstitions are allowed to survive.[26]

The story of HIV/AIDS begins in 1979 and 1980 when doctors in the US observed clusters of previously extremely rare diseases. These included a type of pneumonia carried by birds (pneumocystis carinii) and a cancer called Kaposi's sarcoma. The phenomenon was first reported in the Morbidity and Mortality Weekly Report (hereafter refer to as MMWR) of 5 June 1981, published by the US Center for Disease Control in Atlanta. The MMWR recorded five cases of Pnenmocystis carnii. A month later, it reported a clustering of cases of Kaposi's sarcoma in New York. Subsequently, the number of cases of both diseases-which were mainly centered around New York and San Francisco-rose rapidly, and scientists realized that they were dealing with something new.

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[25] Miles Lesley,
[26] ibid p.11

The first cases were among homosexual men. As a result, the disease was called ***Gay-Related Immune Deficiency Syndrome (hereafter refer to as GRID).*** American epidemiologists began to see cases among other groups, initially mainly hemophiliacs and recipients of blood transfusions. Subsequently, the syndrome was identified among injecting drug users, and infants born to mothers who used drugs. It was apparent that this was not a 'gay' disease. It was renamed **"Acquired Immuno Deficiency Syndrome"**, shortened to the acronym **AIDS.**[27]

Furthermore, AIDS research encouraged the production of quantitative work on sexual attitudes, lifestyles and behaviors, providing ample opportunity for social scientists to study the personal and cultural effects AIDS has had on sexuality and sexual behaviors.

Social structural effects have far greater significance in the spread of disease than individuals' lifestyles (Ham, 1992).[28] Indeed, improving living and working conditions have been argued to have had a greater impact on health than public and clinical medicine combined (Turshen, 1989).[29] Social structural effects include income, education, nutrition, housing, and the process of production, distribution and consumption all of which contribute to disease and illness. Unemployment has also been found to be a risk factor for ill health, including infectious diseases (Fitzpatrick & Chandola, 2000).[30]

Many theorists have tried to find an explanation for the rapid spread of HIV/AIDS in (southern) Africa. Hunt (1996) distinguishes between theories that are based upon ***biological explanations*** and theories that are based upon ***social explanations.***

[27]Barnett T and Whiteside A,
[28] Health Policy in Britian
[29] The Politics of Public Health
[30] Halsey & Webb, 2000

The first category emphasizes the biological determination of the HIV/AIDS epidemic, while the theories in the second category have a historical-materialist or cultural nature. Webb (1997) further distinguishes different approaches within social epidemiology. There is a structuralist approach, which emphasizes the importance of structures or macro issues. Economic and political processes (e.g. the debt crisis, poverty, urbanisation and government policy) influence the AIDS epidemic (Webb, 1997: 31). This approach situates epidemiology in a historical, economical and political context and has a strong focus on power relations within societies.

The structuralist approach emphasizes that individual human behavior is partially determined by global economic and political structures that act on an international and national level, but also locally (Lurie, 2001; Webb, 1997). Epidemiology is the study of epidemics, i.e. the study of rapidly spreading infectious diseases. Biological based theories include a natural history explanation and an explanation that uses race, as a significant on the opposite side of the structuralist approach is the *anthropological approach*, which examines the heterosexual spread of HIV from a bio-anthropological point of view.

Cultural variables are the main study object of this approach (Webb, 1997: 29) and the focus is on sexuality and the psychology of individual (sexual) behavior. It is in this context that some theorists speak of the promiscuity of African men and the tolerance of African societies towards multiple sexual partners. There are certain dangers inherent to both approaches. Both the structuralist and anthropological approach have the same deterministic nature. The former implies that in any given area with the same structures, people should develop the same behavior patterns. The latter can easily lead to ethnocentrism and universalism that will lead to the simplification of the real life situation or the denial of the heterogeneity of African societies.

Moreover, the biased focus on cultural and psychological elements of societies ignores the importance of political and economic structures and their impact on the spread of HIV/AIDS. Both approaches are individually not capable of explaining local and regional diversity in sexual behavior (Webb, 1997: 30-32). It is thus not only psychological factors that determine the spread of HIV, but also sociological, economical, political and historical factors.

Webb conceptualizes the social epidemiology of HIV as the study of the constantly changing interrelationship between culture, individual action and socio-political factors. Instead of a narrow focus on one aspect of HIV/AIDS epidemiology, epidemiologists have to look at the interplay of different factors that facilitate the spread of HIV.

A Feminists Response to the AIDS Epidemic

Feminism remains a controversial and misunderstood concept in the social sciences. It has been viewed both as an ideology of women's liberation and women's movement aiming to create a world for women beyond simple equality.

Oakley(1989: 462) has compared the impact of feminists work in sociology to the effect of a small meteorite's impact, the earth is marked by a small crater which people observe as they walk past it, but the rest of the ground appears relatively undisturbed and the earth itself continues to spin on its axis as it always did. However, the meteorite's impact does make people somewhat more careful of the soil they till or tread on.

Marxist Feminists argument that the decline in women's status occurs as a result of the establishment of private property, the evolution of the nuclear family, and the changes in the social organization of wealth.[31] The oppression of the women follows after the transition from subsistence to cash cropping. Urban migration, high unemployment of both men and women and the integration of underdeveloped countries into world economic system are concomitant results.[32]

Socialist Feminists have criticized Marxist Feminists for subsuming the problems of women under the more general critique of capitalist industrialization and international economics. Socialist Feminists have argued that women will not be liberated by the socialist revolution alone. The socialist revolution is instead a precondition for the feminists revolution, which must follow. The approaches to women's; iberation favored by Socialist Feminists include the elimination of class and sex hierarchies through revolution and radical societal transformation.

[31] Fredrick Engels, 1972
[32] Nash J and Safa H, 1976

Their emphasis on patriarchy had brought criticism from Classical Marxists who argue that Socialist Feminism has undermined the Materialist base of Marxism and weakened revolutionary consciousness. Social Feminists scholars focus on the family as the point at which capitalism and patriarchy intersect. [33]

Initially feminists spokespersons, like the public in general, tended to perceive AIDS as a gay man's problem and paid it scant attention.[34] However it has become apparent that AIDS is an issue for heterosexual men, feminists writers began to address the different positions and interests of women and men in the post-AIDS reconstruction of sexual scripts.

Feminists assessments of this epidemic show that the explicitly homophobic politics of the U.S. AIDS epidemic rely on the ongoing mainstream deployment of traditional gender-oppressive and racist stereotypes of masculinity and femininity. Feminists analyses such as Gena Corea's *Invisible Epidemic* (1992) demonstrate that homophobic, racist and gender –oppressive public policy discourses and research agendas have perpetuated the invisibility of specific groups of women whose lives have been and continue to be devastated by the epidemic.[35]

Feminists commentary on AIDS reiterates the argument that dominant sexual ideologies reflect and reinforce the sexual privileges and power of men.[36] It emphasizes that contemporary Western sexual scripts equate 'real sex' with penetrative sex, take to for granted that men are 'naturally' less able to control their sexual desires than women, define sexual prowess as a central aspect of masculinity and assign activity and control to men. AIDS: [37]

[33] Dr. Mathur D, 2001
[34] Segal, 1987
[35] Kate Mehuron, 1987
[36] Coward 1987;Segal 1987;Richardson, 1999;Holland et al, 1991
[37] Macmillan Student Encyclopedia of Sociology; 1983.

Feminists were also concerned with ***Sexuality***. They campaigned successfully to abolish the Contagious Diseases Acts, which permitted policemen to forcibly examine and lock up any woman suspected of being a 'common prostitute'. They petitioned successfully to raise the age of consent to protect young girls from the White Slave Trade. Feminists were divided over contraception: some supported women's right to enjoy sex and control their own fertility, other, notably working class women, feared *Malthusian and* eugenicist elements in the birth control movement; other distrusted the 'normality and joy of married heterosexuality' movement on grounds of the undesirability of marriage.[38]

Feminists analysis of violence and sexual abuse provides an important critique of dominant modes of organizing sexuality. It asserts that contemporary sexual scripts are the domain of male sexual privilege and irresponsibility, may not meet the sexual pleasure of women through their obsession with penetrative sex and are now life threatening.

Twenty years ago, AIDS was known as Gay Related Immune Disease – so associated was it with gay men. Today, the face of AIDS has changed. It is now black, female, and extremely young.

The pandemic will have profound effects on the burden of reproductive work that women do, and this in turn will have far-reaching consequences for the participation of women in politics, the economic sector, and other sectors of society. The very maintenance of the household, the work that feminist economists like Marilyn Waring, Diane Elson and others tell us keeps the world running, may no longer be possible. A recent article by Noeleen Heyzer, UNIFEM's Executive Director begins to formulate some arguments about why in the context of AIDS, women can no longer wait for equality with men.[39]

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[39] www.csmonitor. Com, 2002

Dr. Heyzer points out that it takes 24 buckets of water a day to care for a person living with AIDS – to clean sheets fouled by diarrhea and vomit, to prepare water for bathing (sometimes several times a day), to wash dishes and prepare food. For women who must walk miles, and still do all the other chores that always need doing, the burden becomes unbearable.

AIDS related feminist theory has identified few needs for women, which are as follows,

- The enforcement of women's regulatory inclusion in AIDS-related research and clinical trials;
- Only AIDS related research and clinical trials to offset the paucity of data on the effect of HIV infection on women resultant from a decade of exclusively male trials;[40]
- A national health care system which provides geocentric health care for women across socioeconomic strata;
- Scientific research on and aggressive corporate investment in the development and marketing of female controlled prophylaxes against HIV (Stein and Goilub 1993);
- Federally mandated educational initiatives, which nonmoralistically and specifically use the sexual vernaculars of diverse communities of women in national AIDS preventive education;
- Advocacy for the health care needs and protection of female sex workers from discriminatory civil and police actions in their local neighborhoods;
- Subsidized housing for homeless people with AIDS that are safe shelters from sexual assault and violence[41]; and
- The systematic reform of the National Cancer Institute's policies and priorities with respect to both breast cancer research and research regarding HIV-infected women (Solomon 1992).

[40] Quinby, 1994 & Eisenstein 1994
[41] Guillen 1990 & Brake 1991

Latest trends in AIDS epidemic

At the start of the new century, the AIDS epidemic is finally receiving high-level attention on the international stage. In 2001, the UN Security Council and General Assembly held special sessions on its dangers. Committees of the US Congress and the British Parliament held similar hearings. A meeting of African heads of state declared it 'a continental emergency'. Emboldened by this attention, Kofi Annan, the UN Secretary-General, led a push to create a $10 billion fund to battle the spread of the disease, personally meeting nearly every major world leader. At the Davos meeting of the World Forum, the annual gathering of the world's economic and political elite, Microsoft billionaire Bill Gates, the world's richest man, donated $100 million to the fund and urged the rest of the world's wealthy states and individuals to follow suit.

The UNAIDS/WHO report clearly indicates that there is no single, "African" AIDS epidemic. The epidemics throughout the continent are highly varied. Southern Africa continues to be the worst hit region with HIV prevalence rates surpassing 25%. In Botswana, Lesotho, and Swaziland, prevalence rates still exceed 30% among pregnant women. Life expectancy has dropped below 40 years in nine countries in the region.

Despite modest declines in HIV prevalence rates in East Africa, notably in Uganda and parts of Ethiopia and Kenya, the epidemic is far from being reversed. In Addis Ababa, HIV prevalence fell to 11% by 2003, down from a peak of 24% in the mid-1990s. In Kenya, HIV prevalence fell from 13.6% in 1997 to 9.4% in 2002.

The Caribbean continues to be the second worst affected region in the world. HIV transmission occurs largely through heterosexual sex, although sex between men, which is highly stigmatized, is also fuelling the epidemic. AIDS has become the leading cause of death among adults aged 15-44 in the region.[42]

[42] WHO, 2003

In North America and Europe, an increasing number of people are becoming infected through unprotected heterosexual sex. In the United States, AIDS disproportionately affects African American and Hispanic women, with AIDS ranked among the top three causes of death for African American women aged 35-44 years. [43]

There are strong indications that the main risk factor for many women acquiring HIV is the often-undisclosed risk behavior of their male partners. An estimated 39.4 million people in the world are living with HIV, 4.9 million of these having acquired it in 2004 and 3.1 million people died of AIDS in the past year. In every region of the world, the number of people living with HIV has increased with the biggest increases occurring in East Asia, Eastern Europe and Central Asia. Sub-Saharan Africa however, remains the most severely affected region as it has 64% of all HIV positive people and 76% of all women living with HIV. [44]

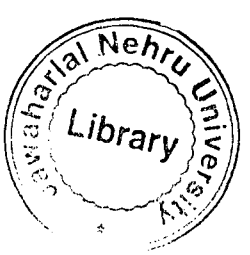
There has been a marked improvement in the global response to HIV/AIDS since 2001. Global funding has increased from about USD 2.1 billion to USD 6.1 billion in 2004. There has also been an increase in the transmission of AIDS education and in the number of people accessing Voluntary Counseling and Testing (hereafter refer to as VCT) centres. In the global South, the number of women who receive services to prevent mother-to-child transmission of HIV has reportedly increased by 70% while the number of people receiving antiretroviral therapy has increased by 56%. The improvements have been uneven, for example that 90% of people who need antiretroviral treatment, most of them in sub-Saharan Africa, do not receive it. [45]

[43] ibid
[44] AIDS Epidemic Update 2004,
[45] ibid

The only way that the global spread of AIDS can be stopped, is that the AIDS treatment can be affordable and sustainable is if HIV prevention is effective. There is enough knowledge about simple, inexpensive and effective HIV prevention strategies, but there is inadequate implementation of such strategies particularly in the global South where, for instance, less than 1% of adults aged 15-49 years access VCT services. [46]

AIDS affects women most severely where heterosexual sex is the main mode of HIV transmission such as in the Caribbean and sub-Saharan Africa. In other parts of the world HIV, infection occurs mainly through unsafe commercial sex, the use of contaminated equipment to inject drugs and sex between men. However, this does not mean that HIV/AIDS is confined only to those sectors of the population and more women in those parts of the world are also becoming infected. Many women and girls use sex as a commodity in exchange for money, goods, services or accommodation. These sexual relationships are often with multiple, older male partners and reflect men's superior economic power and access to resources. Women and girls lack the power to decide the terms of such relationships and are vulnerable to abuse and exploitation.[47]

Research confirms that violence against women increases their vulnerability to HIV infection. The fear of violence also prevents women from accessing HIV information, getting tested and seeking treatment. Violence against women is most commonly perpetrated by their intimate partners. The studies carried out in Rwanda, Tanzania and South Africa, which showed that women living with HIV who were in stable relationships were more likely than those who did not have HIV to have experienced physical and sexual violence from their male partners. HIV-prevention strategies therefore need to be implemented alongside strategies to reduce violence against women and girls.[48]



[46] The AIDS Epidemic Update, 2004
[47] AIDS Newsletter, 2004
[48] ibid

Education levels amongst women also have a role to play in their chances of contracting HIV. In the global South, more boys than girls go to school. Studies in different African countries show that HIV infection is lowest amongst girls and women who have achieved higher levels of education. However, that in some places going to school also places girls at risk of sexual harassment and violence and this increases their vulnerability to HIV. [49]

Women's access to adequate prevention and treatment options is largely restricted. There is as yet no widely available female-controlled HIV prevention method. Female condoms are more expensive than male ones and less socially accepted, and their use is still dependent on male cooperation. The microbicides, which assist to prevent HIV, are a promising new development that will allow women to exercise greater control of their health. Several countries are involved in trials of microbicides and their general availability is still about five to seven years away. In general, men have better access to AIDS care and treatment particularly in the private sector.[50]

Women tend to bear the burden of caring for people with AIDS and provide most of the home-based care. This reflects the unequal division of labor within households. An increasing number of grandmothers are now caring for orphans whose parents have died of AIDS. As most governments around the world do not provide adequate health care to people with AIDS, women and girls providing home-based care are overburdened. This has a negative impact on their income generating efforts and their ability to further their education and this exacerbates their poverty. [51]

Women's vulnerability to HIV is increased due to their unequal property and inheritance rights. This reduces their economic security and often means that they must endure abuse relationships. They also face destitution after the death of their partners or parents. Ensuring that women's rights to own and inherit property are legally secured will assist to cushion the economic impact of HIV and AIDS. [52]

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[49] ibid
[50] ibid
[51] Baylies C, 2000
[52] ibid

"In many countries, we are still seeing a mismatch between prevention spending priorities and the evolution of the epidemic," said Dr Piot. "Men who have sex with men and injecting drug users continue to be neglected. More needs to be done to target them and increase access to prevention programmes for people at high risk of HIV infection."

More people will die from AIDS than from any other disease outbreak in human history, including the global influenza epidemic of 1918-19 and the bubonic plague in the 1300's. Over 22 million people worldwide have already been killed and it is projected that at current rates, another 100m more will be infected with HIV by 2005.[53]

[53] ibid

Statement of the Problem

The global HIV/AIDS epidemic has a paramount impact on human and socioeconomic development. The epidemic has led to the near collapse of already fragile infrastructures, and is rapidly eroding the ability of households to cope with the growing threat to a sustainable livelihood. The rapid spread of the virus in rural areas is diminishing existing capacity to mitigate the consequences of HIV/AIDS. The dramatic dimensions of the epidemic have created formidable setbacks to development across formal and informal institutions.

The epidemic is deepening poverty, reversing human development achievements, worsening gender inequalities, eroding the ability of governments to maintain essential services, reducing labour productivity and supply and hampering economic growth in the countries worst affected for decades to come.

Social science research is needed to understand the social institutions and individual behavior affecting the spread of the epidemic, and for developing effective anti-HIV/AIDS approaches and response strategies. Such research provides insight into not only the behavior of individuals and communities, but also the applicability and/or social implications of possible solutions that have come out of biomedical research.

Social research helps to break the silence and can also be used as an advocacy tool to encourage more and different organizations to take action. In a society where organizations are assisted and expected to become HIV/AIDS-competent, infection and individual suffering are more likely to decrease. In addition, such competence will enable the organizations to plan for the future, thereby helping to reduce the overall effect on development in the country.

Objectives

The main objective of the study is to find out how Gender Imbalance makes women vulnerable to HIV/AIDS in Nepal.

Specific objectives include the following:

- To explore the social, cultural, economic and gender dimensions of the HIV/AIDS crisis
- To study the Feminists perspectives on Gender HIV/AIDS
- To examine to current situation of Gender and HIV/AIDS in the context of South Asia
- To explain the area of gender, globalization and HIV/AIDS

Methodology

This study has been deprived from any empirical investigations and has therefore relied essentially on secondary sources - These include; articles, books, conference papers, newspapers, reports (census/ human rights/ GOs, NGOs and INGOs) and websites. An extensive literature survey has been undertaken by means of reading, articles, magazine newspaper, reports (dissertation works of research students from various universities) and books journals.

Government data, though limited, has been one of the basic sources used in this study. Reports of the Ministry of Health, various NGOs and INGOs have been studied in detail.

Limitations of the study

This study is constrained by certain limitations, both in terms of methodology and content. The most obvious of these is the nature of the data used for the research. The study relies entirely on secondary data, and primary sources are not explored. While this does restrict the scope of the study, it enables a comparative picture various perspectives on the issue.

The availability of data on the subject in Nepal is limited. The government has not undertaken much study on the subject of HIV/AIDS, and the present situation of political unrest makes it difficult to collect data especially from remote rural areas. The study is therefore based solely on UN and non-governmental sources of data.

In terms of content, the present analysis focuses on the situation of women suffering from HIV-AIDS. It touches upon socio-cultural factors underlying the treatment that these women have to face, and the reasons why this treatment is different from the treatment that men face. However a detailed theoretical inquiry into the sociology of discriminatory treatment to women suffering from AIDS has not been carried out. Apart from this detailed analysis of the increasing trend in both number and percentage of AIDS cases in Nepal has not been done in this study. Both these areas require further insight and research.

Organization of the Study

The study is divided into four parts that deals with "Gender perspective of HIV/AIDS".

The first is the introduction, where the issues explain the literature on HIV/AIDS, its theoretical arguments and see it through the feminists' lens.

The next chapter i.e. Chapter I deals with the *HIV/AIDS in Nepal,* deals socio-economic background of the country, its ethnography and demographic data. It also includes the history of HIV/AIDS in Nepal. How it has come through a long journey of being a foreigner's disease to one of the most disastrous epidemic in the history. The chapter concludes with explication of government's policy and programmes in preventing the disease and the contributions of various, organizations and donors in fighting HIV/AIDS.

Chapter II describes the relation between Gender and HIV/AIDS. It tells us how gender plays and important role in contributing to the vulnerability of the disease. Then it goes on to explain about the growing challenge among women and AIDS, and how women are the disadvantaged group in Nepal.

Chapter III talks about the globalization and HIV/AIDS in Asia, highlighting the South Asian countries. It also shows the globalization process in Nepal. It deals with the cultural aspect of globalization as well as globalization in relation to gender.

CHAPTER I

HIV/AIDS IN NEPAL

Socio-Economic Background

Nepal is a highly heterogeneous country in terms of geography, ethnicity, language and culture. The Kingdom of Nepal is landlocked; sharing borders with India and China and is made up of 75 districts divided into five different development regions (Far-Western, Mid-Western, Western, Central and Eastern). The Himalayas cover the northern third of the country from east to west, bordering China. To their south lies a long east-west stretch of lower mountains (the hilly region) whose southern flanks flatten into the Terai, a fertile, sub-tropical plain spanning the border with India. These contours have played a major role in helping to determine the geographical and social diversity that characterizes the nation. Nepal is ethnically as diverse as it is geographically with several races and tribes, languages and religions.

In the Human Development Report (hereafter refer to as HDR) 2003, Nepal features among the economically poorest countries in the world. Nepal's social indicators remain well below the average for the South Asia region. Official statistics for 1996 estimate that more than 40 percent of the population is poor, while estimates are based on poverty line of US $ 1 a day per person put the figure at more than 50 percent. 48% of all children below 5 years are underweight and nearly 60% of all adults are unable to read or write.[1] Additionally, women have traditionally a lower status than men do and gender inequality is deeply rooted. Nepal is one of the few countries worldwide in which men live longer than women. More boys than girls receive any form of education, women generally work longer hours than men do, and men have better access to services, including health.[2]

[1] UNDP, 2001
[2] HDR, 2003

The country's social indicators are well below the average for the South Asia region. Life expectancy at birth is 59.9 years, and infant mortality is among the highest in the region at 66 per 1,000 live births.[3]

The country's economic development started late compared to the rest of South Asia. Still, some sectors recorded progress. Nearly 72 percent of boys and girls get themselves enrolled in primary school (UNDP 2001), irrigation coverage has reached 25 percent of cultivated land, road networks have increased from 124 kilometers in 1956 to 15,000 kilometers and the number of households served by electricity has increased from less than 1 percent in 1956 to 15 percent (HDR 2003).

The number of health workers delivering health services was 28,000 prior to the decade. It has tripled now. Infant mortality fell from 102 in 1990 to 66. The average life expectancy has risen to 59.9 from 49.5 in years.[4]

However, a rapidly increasing population undermines these advances. The pressure of population growth has led to fragmentation of land and depletion of forest products upon which most of the rural population depends. Nepal's population of 24.1 million [5] is growing at 2.3 percent per year, and the ratio of population to arable land (around 600 persons per square kilometer) is one of the highest in the world. Of the 90 percent of Nepal's population living in rural areas, less than half has access to safe water and less than 6 percent has access to sanitation. Many Nepalese in the hills still live more than a day's walk from a road, social and political unrest adds to the social strain. Only 28 percent of the population has access to improved sanitation Over-exploitation of government forests has made firewood and fodder extremely scarce in most areas. The time spent collecting water and firewood prevents women from engaging in more productive activities. [6]

[3] ibid
[4] World Bank, 2001
[5] ibid
[6] ibid

Between 1994 and early 2004, there have been eleven different governments (including six coalitions), resulting in a lack of a coherent drive to promote economic development.

Annual Gross Domestic Product (hereafter refer to as GDP) growth rate is 4.1%. The latest growth figures are based in part on a bumper harvest due to favourable weather, and a sharp increase in exports to India, as a result of a new trade treaty.[7]

The health of the rural population is an important element of their productivity and ability to build better lives. Progress in improving health standards-most importantly reducing unwanted pregnancies-is hampered by very low levels of government spending ($2 per capita, as compared to over $6 per capita in out-of-pocket expenditure).

The relatively low level of human capital development is compounded by the fact that rural people must spend large amounts of time in labor-intensive activities such as, fetching potable water, wood, fuel and fodder.

Ethnic Composition and Demographic Data

In 2001 Nepal had a population of 23.2 million people. Nepali society has a ***caste hierarchy*** that dates back to the Civil Code of 1854. Even though the caste system was abolished in, 1961 is still deeply entrenched. Nepali law lists 59 janajati (nationalities) groups, which is still a contentious issue. Census data of 2001 lists people belonging to 102 caste/ethnic groups. Constitutionally, Nepal is a Hindu state. Together, indigenous people comprise 37.2 percent of the population; the largest among them are Maar (7.1 percent), Tharu (6.7 percent) and Tamang (5.6 percent).

[7] World Bank, 2002

Based on census figures, Hindus comprise the largest religious group (80.6 percent), followed by Buddhists (10.7 percent), Muslims (4.2 percent), Kirat (3.6 percent), Christians (0.45 percent) and others 0.4 percent. People belonging to the different ethnic groups reside in specific regions, where their numbers are highest. For example, Nepal's hills have large populations of people belonging to the Kirati stock (of Tibeto-Burman descent and not Indo-Aryan). Similarly, Nepal has a large population of Tharu people residing in the Mid-Western plains. Nepal has not had ethnic violence. People from ethnic groups do have genuine grievances; many say they are exploited by people from the Indo-Aryan stock, something the Maoist insurgents have been trying to capitalize on.[8]

The population grew by 2.3 percent between 1991 and 2001 per annum - one of the highest in the world. Women comprised 50.1 percent of the population. Nepal has 58 designated urban areas and in 2001, the urban population was 14.2 percent.

Languages

Majorities speak Nepali, the "official" language. Nepal has more than 125 languages and dialects. The 2001 Census listed 92 languages spoken in Nepal. All languages other than Nepali have been designated as "national" languages, while Nepali is the language of official use. English is used by a large number of Nepalis, more by the educated urban populations, but many people living in tourist areas communicate in the language. The Devnagari (Nepali) script resembles Hindi in grammar and structure, and like Hindi, is rooted in Sanskrit. The government is introducing school curricula in languages other than Nepali, but implementation has been slow. There is growing demand for developing and promoting non-official languages. However, an attempt by some municipalities (local government bodies) to use the language of the dominant population groups in the respective areas was barred by the Supreme Court.

[8] CBS, 2004

Religious Composition And Major Religious Organizations

All major religion is found in Nepal. The Nepalese people have faith is animism, Bon, Kirata, Buddhism, Christianity, Hinduism, Islam, Jain, Sikh, Bahai, Osho-Rajnish and so on.[9]

Hinduism is the dominant religion, and also the religion of state. The minorities hold that domination of lesser religions has resulted from state support. There are increasing demands for making the state secular, which is also what the Maoists promise. Hinduism dominates not only the culture and social life of the country, but also politics, because Hindus - mainly from rural areas - regard the king to be an incarnation of the Lord Vishnu. The deep-rooted caste based discriminations, and class, make the socio-cultural chasm deeper. There is now growing recognition for equality for all, both in state policy - the government has announced affirmative action policies - and civil society but implementation remains frustratingly slow. The Maoists, meanwhile, promise "self-rule" to people living in different areas where there are large ethnic and linguistic groups. It is illegal to proselytise in Nepal.[10]

Nepal has not had major religious and communal clashes, even though there have been occasional clashes where minority groups have been attacked. Following the killing of 12 Nepali laborers by extremists in Iraq, violent mobs attacked several mosques in the capital and other parts of the country on 1 September 2004. Nepal has religious organizations representing different groups, including Hindu groups that claim affiliation with those in India.

The ***family*** is the most important unit of the social structure in Nepal. ***Marriage*** is the foundation of the family. Marriage in Nepalese society can be classified broadly into three categories:

1. Monogamy 2. Polygamy and 3. Polyandry

[9] Bhattachan, 2002
[10] ibid

Monogamy is the common norm. However, certain sections of the society also adopt polygamy. Polyandry may still be practiced by Sherpas, Manangbas and Bhotias.

Nuclear and Extended families are the two types of family system in Nepal. The nuclear family is becoming more popular in the urban areas. Existence of large extended families amongst the Newars of the Katmandu Valley. The increasing "nuclearization" of the families are creating new pressures as the safety net provided by a large family is now not so evident and child care which used to be the responsibility of grandparents, is now more of a problem for young mothers. Decision-making is usually the role of the elder family members.[11]

Social Classes and Stratification

In terms of differences in wealth and access to political power, Nepalese society could be divided into a small ruling elite; a growing, intermediate-sized group of government officials, large landholders, and merchants; and the vast majority of the population, consisting of a peasant base. These divisions are descriptive, functional class categories rather than social class entities based on the Marxian concept of the social relations of production. In a way, all three classes were a long continuum in Nepal's social structure because most members of the ruling elite and government functionaries had their direct roots in the rural landed class, which was one stratum of the farming population.[12]

Even though the agricultural sector as a whole faced similar economic and technological circumstances, it was diverse and contained several strata in landholding, relative economic dependence, and independence. The numerically small intermediate stratum of the farmers was only slightly less diverse than the rest of the rural population in terms of members' ethnic and geographical backgrounds. The relative economic and educational advantages of this group and its occupational activities, however, made its members

[11] Dr Mathur D, 2001
[12] ibid, p. 37

relatively homogeneous in terms of shared interest. They generally aspired to achieve a middle- or elite-class status.

The smallest and least diverse of the three categories was the ruling elite, largely composed of high-caste, educated Paharis, namely different strata of Brahmans and Chhetris. At the zenith of this class was the monarch, whose authority was derived from the orthodox Hindu contention that the king was the reincarnation of Vishnu, whose assigned role in the Hindu trinity is protection. The monarch's authority was not based on electoral support.

The continued expansion of the bureaucracy was a direct response to a consistent increase in the educated population. Because of the lack of development, a large number of educated people failed to find gainful employment upon graduation. Because they constituted the most potent revolutionary force, and happened to be geographically concentrated in urban centers, the ruling class was almost compelled to absorb them into an already bloated bureaucracy in order to neutralize any sociopolitical disturbance they might cause.

In the 1980s, a significant number of college- and university educated people residing in Katmandu Valley cities discovered a second employment outlet. Development consultant firms and associated services have emerged throughout Katmandu. Because of the growing pressure on foreign donors to hire Nepalese consultants for development feasibility and evaluation projects, these firms were able to tap into the large pool of foreign aid money and have generated a significant number of jobs. This opportunity has allowed many of the more educated to attain middle class status.[13]

[13] ibid

Epidemiological Situation of HIV/AIDS in Nepal

The first HIV infection in Nepal was identified in 1988 (NCASC, 2002). In the context of Nepal, poverty, the open conflict, gender inequalities combined with low level of literacy and education are the key risk factors that are likely to hasten the spread of the disease. The denial, stigma and discrimination that surround HIV/AIDS are additional factors hindering an effective prevention and an appropriate handling of the disease.

Poverty produces an increase of trafficking in women and male migrant workers. Consequently, those who are most likely to be infected are persons in the remote poverty-stricken mountain villages, causing poor families with HIV-infected family members to sink even deeper into poverty. The potential for the spread of HIV in Nepal is large because of the extensive use of commercial sex workers, high rates of sexually transmitted diseases, low levels of condom use, and pocket of intravenous drug users.

In January 2004, Nepal's Ministry of Health (hereafter refer to as MOH) reported 3,388 HIV infections and 708 AIDS cases. It is estimated that 0.5 percent of population in the age group of 15-49 years in Nepal are HIV positive, and the male-to-female ratio of infection is 3 to 1. Given the existing medical and public health interventions in Nepal and the limitations of the surveillance system, the actual number of cases is estimated to be many times higher. Nepal has entered the stage of a "concentrated epidemic" with HIV/AIDS prevalence consistently exceeding 5 percent in one or more high-risk groups, such as sex workers, their clients, and injecting drug users. The main rate of transmission continues to be heterosexual sex and the fact that the STD rates are rising is an ominous sign.

Michael Hahn, the director of UNAIDS in Nepal, estimates that the number of infections is likely to rise to 150,000-about 1.5 percent of adults-by the end of 2005. He also warns that AIDS will be the main cause of death for the 15-49 age bracket within 10 years if the

epidemic is not controlled through education and the distribution of condoms and clean needles.

Risk and Vulnerability

The geographical distribution of HIV sentinel sites for different population groups in Nepal demonstrate that HIV/AIDS incidence is prevalent in major urban areas and transportation routes where high-risk sexual behavior prevails. Those most at risk include migratory populations, commercial sex workers and their clients, and intravenous drug users. Adolescents and youths who constitute the largest segment (32 percent) of the total population in Nepal are predominant among those at risk. Similarly, street children, migrant children, scavengers, hotel and restaurant workers, transport workers, refugees, industrial labors, construction workers, police, military, prisoners and people living urban slums are vulnerable to HIV infection due to their low earning for subsistence living. [14]

Migrant Populations

The migrant populations are one of the most vulnerable to STI/HIV infection. There are different types of migrant people in Nepal, which are as follows:

Periodic and Seasonal Job Migrants (National and International)

Pervasive poverty has multiplier effect on the overall socio-economic development in a debt-ridden poor country like Nepal. About 42 percent of the total population live below the absolute poverty line with a daily earning of less than 1 US$ (UNDP, 2001). Poverty forces the economically active people to move from their residence within and outside the country to earn subsistence living for their families. The total number of periodic migrants mobile in search of job was as registered in official statistics 400,000 in 1981 Central

[14] AIDS Newsletter. 2003

Bureau of Statistics (hereafter refer to as CBS, 1982), which rose to 660,000 in 1991 and 762,181 in 2001 (CBS, 2002) constituting about 6 percent of the active labor force aged 15-59 in 2001. Independent estimates reveal that the number of periodic migrants is even higher than it is recorded in official statistics.

About 800,000 people cross the southern boarder as seasonal migrant labors to India every year and approximately 350,000 labors migrate from one part of the country to another for wage earning.[15] Overwhelmingly, both the periodic and seasonal migrants are males most of them from the western part of Nepal. The periodic and seasonal migrants working in India, overseas countries and within the country itself live alone i.e. without their spouse, for a long time, which force them to come to or establish sexual relationship with Female Sex workers (hereafter refer to as FSWs). Most of these migrants do not have access to information, condoms, supportive services which enable them to have safer sex. They are likely to take the virus back to their wives who could transmit it to their babies and at the same time work as HIV/AIDS breeding populations. The poor and the illiterate are equally less able to cope with consequences of being infected with HIV. [16]

Migrant Children

There are about 80,000 migrant children in Nepalese cities [17]who work in motor garages, restaurants, hotels, brick factories and as shoe shiners in the street, saw mill employees, street venders, porters, carpet industry workers, rag pickers, stone quarry labors, domestic servants and tourism assistant etc Especially the migrant girls are exploited sexually or under-pay, which again put them at, an increased risk of HIV infection.[18]

[15] MEH and REGHED, 2000
[16] ibid
[17] ILO, 1995
[18] CWIN, 2000 and 2002

Migrant Students

About 100,000 rural students, both male and female, come to urban centers for higher education annually. They are barely supported by their parents with tiny incomes generated from subsistence agriculture, which are not enough for their living in the city centers. Thus, the female students are involved in other part-time works particularly in restaurants, hotels and tourist centers for extra money. Employed in part-time, they get very small amounts from their employers and, occasionally, they are involved in sex trade when they face financial crises. Besides, other female migrant students, who receive no enough support from the parents and unable to get part time jobs in the city center are involved in sex trade for subsistence living, which makes them vulnerable to HIV infection. [19]

Mobile Transport Workers

Altogether there are 135,000 transport workers, 130,000 male and 5,000 female, in Nepal. The males are mainly drivers, conductors, and female work at ticketing satiations. The drivers, conductors and cleaners plying vehicles on long routes are highly susceptible to HIV infection because they establish sexual relationship with commercial sex workers and hotel and restaurant girls/women at their night halt stations. Cash at hand collected on regular basis from the passenger's increases their ability to pay for sex. Their sexual relationship at one station will carry HIV to the next that is why they are considered as breeding people. They are HIV susceptible to their wives as there is no practice of using condom during sex.[20]

Female Sex Workers (FSWs)

Girls trafficking and flesh trade is highly associated with pervasive poverty in Nepal. It is estimated that about 5000-7000 rural women, mostly girls are trafficked to India across the open boarder. Altogether there are more than 200,000 Nepalese women currently engaged

[19] CBS, 1999
[20] ibid

in flesh trade in India.[21] The practice of migration of Nepalese women to Gulf and other Asian countries is also increasing. It is estimated that about 60 percent of the Nepalese female sex workers at the brothels in Mumbai are infected with STI/HIV/AIDS. The brothel owners release them when they are infected, after which they return to Nepal to spread new infection among young adults. Similarly, there are about 20,000 female sex workers in Nepal of whom 7000 are in the Katmandu valley[22] and 500-1500 in other major regional towns. [23]

These FSWs are engaged in twelve types of professions in places such as cabin restaurants, massage parlors, dance restaurants, discos, business offices, factories, street-based prostitution, and so forth. The FSWs engaged in other professions get nominal salaries so they engage in sex works for extra money. The cabin girls are highly susceptible in-group sex. Army personnel and drivers usually involve in-group sex. Similarly, many kinds of sex business can be seen in different parts of Nepal. In the Western and Far Western Development Regions religionized women 'Jhumas' and 'Deukis' (they are consecrated to gods) often find themselves bound to the sex profession. Religiously, they are deprived of the right to marry and live in families. 'Badenis' the traditional dancers, are engaged in sex industries in the Mid western and Far Western Development Regions in an organized way. Many other female sex workers are active in every geographic region and administrative zone in Nepal in various forms and their main concentration could be found on highway routes, bus parks, hotels, lodges, parks etc.[24]

Injecting/Intravenous Drug Users (hereafter refer to as IDUs)

IDUs with their high-risk behavior are most vulnerable to HIV/AIDS epidemic in Nepal. There are about 200,000 drug addicts in Nepal (CWIN, 2002), of whom 30,000 are injecting drug users, of whom again approximately 40 percent are HIV infected. The

[21] ibid, p. 41
[22] ibid, p. 40
[23] ibid
[24] ibid, p. 37

Kathmandu valley alone has 10-15 thousands IDUs and 50 percent of them are HIV infected. They are the main instruments of transmitting HIV to new people. [25]

Bonded Children

Still there are 40,000 bonded children in Nepal kept by affluent families as domestic servants and farms laborers. Particularly the bonded girls are sexually exploited by the employers and other people increasing their vulnerability to HIV infection.[26]

Street Children

Every year around 500 children are landed in the streets of Katmandu. There are about 400 to 600 children living in the streets in the Katmandu valley alone. The total number of street children in the country is 5000. Growing up without social background or kinship and without access to social service, they suffer from starvation, illiteracy, and non-information and become non-immune to violence and sexual exploitation. The street girls are more vulnerable to HIV infection because IDUs and other vulnerable groups abuse them sexually.[27]

Refugees

There are more than 100,000 Bhutanese refugees living in six refugee camps in eastern Nepal- particularly in the Morang and Jhapa districts. The living conditions of the refugees are extremely poor and they survive on food assistance provided by international relief agencies. Their surroundings exacerbate the spread of diseases including HIV/AIDS but no surveillance research on HIV/AIDS epidemic among the refugees has yet been conducted. However, there is news in local newspapers on involvement of women and girls in

[25] MoH, 2002
[26] CWIN, 2000 and 2002
[27] ibid

prostitution. Therefore, refugee camps may turn into the centers of HIV/AIDS proliferation in adjoining districts if appropriate measures on HIV/AIDS prevention and control are not undertaken in due time.

Prisoners

Altogether there are about 8,529 prisoners in Nepal 6,268 male and 2,261 female, in the 73 prisons in Nepal. Isolate and destitute living make them susceptible to practice sex with same sex. There is no appropriate segregation of HIV and non-HIV inside the prisons. It is suspected that some of the prisoners imprisoned in criminal cases are already infected with HIV.

While they establish sexual relationship with others there is high chances of HIV transmission among the prisoners. Therefore, the prisoners in Nepal are at high risk and undoubtedly very susceptible.[28]

Construction Workers

Altogether there are 344,000 construction workers, 292,000 male and 52,000 female, in Nepal. They work in a folk at construction sites, particularly in road, irrigation, hydro, and building construction project areas. They live in poorly managed temporary makeshift houses during the construction period. Some of the skilled workers move from one project to another with no change on the living style. Deprived of the means of entertainment they establish sexual relationship with multiple partners at night within and outside their communities. Sexual relationships with multiple partners make them susceptible to HIV infection.[29]

[28] PMD, 2002
[29] CBS, 1999

Industrial Laborers

Altogether, there are 553,000 industrial laborers employed in 3,557 industrial establishments, of whom 366,000 are male and 186,000 female (CBS, 1998 and 1999). Both the males and the females work together, and many of them live alone inside and outside the industrial complexes. They are poorly paid- about Rs. 2700/month on an average (CBS, 1999), which is less for family living. They establish sexual relationship with outsiders and with their fellow workers for entrainment and extra money. Yet, surveillance study is not conducted on their vulnerability to HIV infection, even though there is a consensus among health professionals about this high-risk behavior. The low literacy profile of the workers and insufficient access to STI/HIV/AIDS preventive information and counseling expose them to vulnerability.

Hotel, Restaurant, Beauty Parlor and Massage Workers

Altogether there are 115,000 people, 63,000 males and 52,000 females working in hotels and restaurants, beauty parlors, massage centers, tourist offices and as trackers and porters in Nepal (CBS, 1999). They work 56 hours per week (average) and get nominal payments (below Rs 2,000/month) from the employers, which is not sufficient even for a single person in the urban areas. Especially the women workers establish sexual relationship with hotel and restaurant visitors and outsiders to generate extra income for their survival. It is expected that some of the visitors who comes for sex are already infected with HIV and could become high-risk people.

Adolescents and Youths

Adolescents and youths (aged 10-24) constitute the largest segment (32 percent) of the total population of Nepal. They carry boundless energy and infinite curiosities and opportunities to experiment, and conceptualize different aspects of human life such as sex, sexuality and relationship (Richoi Associates, 2000). A study conducted by Family

Planning Association of Nepal (hereafter refer to as FPAN) in 1998, in the Palpa district on adolescent sexuality reveals that about 44 percent of the adolescents (aged 13-15 years) and 56 percent of youths (aged 16-18 years) have had sexual relationship before marriage. The national data on pre-marital sex of the adolescents and youths are not available small scale independent researches claim the existence of pre-marital sex in Nepal. Pre-marital sexers are not adequately aware of precautionary measures such as the use of condom before sex. Therefore, they fall among the high-risk groups susceptible for STI/HIV infection. [30]

Army and Police

There are more than 100,000 army and police service employment in Nepal. Juniors by post usually live in the barracks without their spouses for a long time. They are therefore interested to have extra sexual relationship even they had enough sexual experience with their wives during their home leave. Some of them establish sexual relationship with sex workers, hotel and restaurant workers, industrial laborers, street vendors, operators, migrant workers and women living in urban slums (based on their ability to pay) before leaving the barracks. Thus, the army and police people are at high risk for inviting HIV infection.[31]

Urban Slum People

Out of 23 million people in Nepal, 3.2 million accounting 14 percent of the total population, live in urban centers (CBS, 2002). About 10-15 percent of the urban people live in slum areas in poor sanitation and housing conditions and with a low female literacy profile. Women and girls, whose husbands and fathers are unable to earn for the family, involve in sex trade for their subsistence earning, as they have no better option in the off-

[30] FPAN, 1998
[31] ibid, p. 45

farm sector due to their weak technical knowledge and persistent illiteracy. Thus, they are at high risk and vulnerable to HIV infection.

Men who have Sex with Men

Some people, particularly males, are involved in same sex relationships in Nepal. Some of them are voluntarily engaged in homosexual relationships while others especially young boys and street children are forced on it. Eventually they also establish sexual relationship with females, which further increase the chance of HIV infection. Some of the homosexuals are already infected with HIV/AIDS and others with STI. Their sex with multiple partners whether voluntary or enforced, puts them at high risk of HIV infection.

Knowledge and Practice of STI/ HIV/AIDS Prevention and Control in Nepal

There is no universal knowledge of STI/HIV/AIDS prevention and control in Nepal. About 50 percent of women and 72 percent of men have heard about HIV/AIDS, and 38 percent of women and 66 percent of men believe there is a way to avoid HIV/AIDS. The knowledge varies by geographic region and socio-economic background of the people. Knowledge on HIV/AIDS is higher in the hills than within Terai and mountain regions. Similarly, education has positive impact on HIV/AIDS knowledge in all segments of the population. For example, 99 percent of women with education (SLC and above) have heard of HIV/AIDS, while 37 percent of illiterate women have not.[32]

Various action researches were conducted to identify the knowledge and practice of condom to prevent the STI/HIV/AIDS epidemic in Nepal. All female sex workers insist that their clients wear condoms. A behavior surveillance survey on female sex workers showed that the knowledge of condom is as high up as 98 percent among them.[33]

[32] DoH and New Era, 2002
[33] FHI and New Era, 2001

Previously the use of condom during sex soared up to 93 percent and last use was recorded at 86 percent though the consistent use condom was found to be only 51 percent among female sex workers. The use of condom ranges from 87 percent to 97 percent among the sex workers in the Katmandu valley but the use was highly irregular and high incidents of STI were reported in the case of female sex workers. A large number of FSWs experienced problems like sore and itch around the genital area, and white discharge. [34]

A study conducted on young factory workers (CREHPA, 2002) reveals that having girl/boy friends, physical contacts such as holding hands, kissing, petting, and even sexual intercourse are common among these people. Awareness of at least one contraceptive method is almost universal (95 percent) among them. Correct knowledge of the method is generally higher among boys than among girls. The use of Condom is the most frequent method (90 percent) among boys. However, only 60 percent of the girls have ever seen a condom. A large majority of the young factory workers have heard about sexually transmitted diseases. Knowledge on STI is higher in boys (80 percent) than girls (62 percent). Knowledge of AIDS is higher in the boys than in girls.

HIV prevalence is high up among injecting drug users (from 2.2 percent in 1995 to nearly 50 percent in 1998), and nearly 50 percent of the county's drug users fall within the age group of 16-25 (UNICEF, 2001). Of the 200,000 drug users in Nepal, 30,000 intravenous drug users who live in urban areas, and about 40 to 50 percent of them are HIV infected (CREPHA, 2002). The use of condom by these people during sex is not regular and they transmit HIV/AIDS to new people.

A mini research conducted on risk behavior and knowledge and use of condom for STI/HIV/AIDS prevention among the migrant people in the far western district of Achham showed HIV prevalence of 3.7 percent among international migrants, 3 percent among migrants within the country and 0.7 percent among non-migrants (New Era, 2001). Similarly, STI prevalence is recorded at 19 percent among international migrants, 8 percent

[34] CREHPA, 2002

among the migrants within the country, and 8.9 percent among non-migrants. The use of condom with wives is recorded as low in all the stated segments of the population. About 76 percent of migrants knew condom as a means of STI/HIV prevention but the use is limited to 62 percent within the migrants and 29 percent with the non- migrants (New Era, 2001).

There are no other comprehensive studies covering all the segments of the population on STI/HIV/AIDS knowledge and precautionary measures. The situation outside the intervention areas is quite different and it does not represent the totality. It is believed that a large proportion of the population is unaware of HIV/AIDS and precautionary measures due to pervasive illiteracy, poverty and weak access to information and services in the country.

National response to HIV/AIDS

Government Policy, Plan and Priority

STI/HIV/AIDS prevention and control program is placed under the reproductive health package, which includes family planning, safe motherhood, child health, prevention and management of complication of abortion, human sexuality, sub-fertility management, adolescent reproductive health and life cycle issues and problems of elderly people. However, the plan does not pay much attention to the alarmingly growing epidemic of HIV/AIDS. The program activities for HIV/AIDS prevention and control are loosely integrated with the reproductive health package. The growing expansion of the HIV/AIDS epidemic was not realized during the plan formulation period.

Institutional Framework

In 1988, the Government of Nepal launched the first National AIDS Prevention and Control Program. In 1995, a national policy was formulated, emphasizing the importance

of multisectoral involvement, decentralized implementation, and partnership between the public, nongovernmental organizations, and the private sector. It also called for coordinated monitoring and evaluation, promotive actions for safe practices, counseling, and services to people living with AIDS. Provisions were made for reducing stigma and discriminatory practices against people living with HIV/AIDS, confidentiality of blood testing, and safe blood transfusion.

Towards this effort, Nepal has established a National AIDS council chaired by the Prime Minister. The Council is dedicated to leading the multisectoral response and to advocating for active participation in the fight against HIV/AIDS. The main agency responsible for HIV/AIDS and STD is the National Center for AIDS and STD control established under the Ministry of Health. The Center has updated the National Strategy on HIV/AIDS for the Tenth Five-Year Plan (2002-06). This update includes HIV/AIDS as one of two crosscutting issues of Nepal's Millennium Development Goals and also includes other commitments, which were made at the Special Session of the UN Assembly on HIV/AIDS. It also addresses management needs and defines the resource requirements for an expanded response to HIV/AIDS in Nepal. The government estimates that the budget required for the National HIV/AIDS Strategy for 2002-06 will be US$50 million. It has developed a National operational plan to implement the strategy. The government has received US$11 million from the Global Fund to Prevent HIV/AIDS and Malaria to operationalize the National Strategy with a focus on young people, migrants, and provision of care and support for people living with HIV/AIDS for a period of four years. Reorganization of the management mechanism for improving implementation is under discussion at the government level.

Antiretroviral treatment protocol has been endorsed by the Ministry of Health, and treatment has been has been started on a limited basis. Initial focus, being undertaken with assistance from UNICEF, is on mothers to prevent mother-to-child transmission. Nongovernmental Organizations (NGOs) and Private Sectors. Numerous private and voluntary organizations and NGOs implement HIV/AIDS activities funded by donors. There are currently almost 100 NGOs working in the area of HIV/AIDS. NANGAN, a

consortium of NGOs in Nepal, is working to coordinate and share information, education, and communication materials, experiences, and lessons learned. The National Network Against Girls' Trafficking, a coalition of approximately 40 NGOs initially established to tackle the problem of girl trafficking, has also undertaken the issue of HIV/AIDS. The relationship and communications between the government and the NGO community, as well as among NGOs themselves, however, are not coherent. A private business collaborative group, called FNCCI, has signed a declaration of commitment and has designed an initial HIV/AIDS-at-workplace initiative with UNAIDS and the ILO.

National HIV/AIDS Strategy 2002-2006

In the past sexually transmitted diseases were diagnosed and treated by the department of venereal diseases in all major hospitals. As the STD problems arose in the country, a STD Control Committee was formed by HMG/N in 1986. The Committee was later upgraded to a semi-autonomous organization of National Center for STDS and AIDS Control (hereafter refer to as NCASC). HMG/N formulated a short-term AIDS control plan in 1988 and a medium-term plan (1990-1992). In 1992, a National AIDS Coordination Committee, chaired by the Minister for Health, was established bringing government and non-governmental organizations for STDs and AIDS prevention and control together. Reviewing the experience of both the short-term and medium-term plans, HMG/N formulated a second long-term (1993-1997) plan. The NCASC lunched a HIV/AIDS control strategic plan (1997-2001) in 1997. However, these short and medium term plans and strategic plans had no clear-cut objectives and programs for HIV/AIDS control at national level. The HIV/AIDS prevention and control programs were loosely integrated with the RH package. In 2000 NCASC had only a 1.4 million budget, which was too low and demonstrated that HMG/N took it as a symbol or token rather than real commitment. To make up for the shortfalls of past plans and strategies, HMG/N formulated a comprehensive National HIV/AIDS strategy in 2002, to bring all sectors into the

mainstream and instructed the National AIDS Council chaired by the Prime Minister, to proclaim political commitment. [35]

Overall, the National HIV/AIDS Strategy intends to expand the number of partners in the national response of controlling the HIV/AIDS epidemic and to increase the effectiveness of the response by focusing on priority areas. Due emphasis is given to the need of care and support for people already infected and affected by HIV/AIDS. Similarly, commitment is sought not only from the Ministry of Health but also from all concerned agencies within and outside the government, and better-coordinated support is likewise solicited from external development partners. Decentralization of HIV/AIDS programs and activities at local level is given enough emphasis. In response, local governments (DDC and Municipalities) are expected to include program activities from their own local development plans. INGOs, NGOs, CBOs, civil society as well as the private sector and external development partners are invited, openly, to supplement and complement the national HIV/AIDS control program

The strategy sought multi-sectoral involvement for building an adequate response to the HIV/AIDS epidemic with primary focus on its prevention. Rights-based response is advocated with a specific focus on the rights of people infected and affected by HIV/AIDS, in particular the rights to confidentiality. Resource allocation will be made for defined priorities based on the vulnerability of various affected groups and communities. People and communities will be empowered to protect themselves from HIV infection within a supportive environment. Equal access to basic care and services is emphasized for all persons infected and affected by HIV/AIDS. Similarly, gender consideration has been considered central to the development of programs and interventions, and due consideration is given to universal precautions to counteract the possibility of HIV transmission through medical interventions. [36]

HIV testing is considered as voluntary with guaranteed confidentiality and adequate pre-

[35] MEH and REGHED, 2000
[36] NCASC,2003

and post- test counseling both in the public sector and the private sectors. Emphasis is given to the participation of the people living with HIV/AIDS in the programs including formulation of policies, strategies, programs and projects. The major strategies of the government for STI/HIV/AIDS prevention, control and management are follows:

- Prevention and control of STIs and HIV infection among vulnerable people including female sex workers (FSWs) and their clients, injecting drug users (IDUs), mobile populations, (especially migrants to India), and men who have sex with men and prisoners;
- Prevention of new infections among young people;
- Ensuring the availability and accessibility of care and support services for all people infected and affected by HIV/AIDS;
- Expansion of the monitoring and evaluation frame-work through evidence-based effective surveillance and research; and
- Establishment of an effective and efficient management system for an expanded response

Nongovernmental Organizations (NGOs).

Numerous private voluntary organizations and NGOs implement activities funded by donors. There are currently almost 100 NGOs working in the area of HIV/AIDS, and *Haatemalo*, a consortium of NGOs in Nepal, is working to coordinate and share information, education, and communication materials; experiences; and lessons learned under the guidance of the Save the Children Fund. The National Network Against Girls Trafficking, a coalition of approximately 40 NGOs initially established to tackle the problem of girl trafficking, has also undertaken the issue of HIV/AIDS. Many international NGOs act as intermediary or donor organizations and further subcontract the work to local and national NGOs. However, the relationships and communications between the

government and the NGO community, as well as among NGOs themselves, are fragmented.

Donors

A number of donors and multi-and bilateral organizations support HIV/AIDS prevention and control initiatives in Nepal, including interventions for vulnerable groups; information, education, and communication materials; condom promotion; STD control; testing and counseling; surveillance; and operational research.

UNAIDS has a coordinating theme group based in Kathmandu, and between 1990 and 1999, the UN system supported the national response in Nepal with approximately US$5 million to build capacity, integrate HIV/AIDS into reproductive health services, and initiate a decentralized response. WHO has provided funds and technical support. Other donors include the European Union, Germany, Switzerland, and the United States.

A consortium of multi- and bilateral donors (UNAIDS, UNDP, USAID, DFID, Aus Aid) has joined to collaborate with the government to address the harm-reduction needs of female sex workers, their clients, and IDUs. Family Health International is the executing partner of the US$2.6 million phased approach. Harm and risk reduction components include behavior-change communication, social marketing of condoms, harm-reduction equipment such as clean needles and syringes, STD treatment, and drug substitution therapy. Support services, such as drug counseling, HIV care and support, voluntary HIV testing and counseling, will also be established.

Capacity Analyses of STI/HIV/AIDS Intervention Nepal

There are 10 INGOs, 13 national level NGOs, five UN agencies including UNAIDS working directly on HIV/AIDS prevention, control and management programs in Nepal. Similarly, a few aid agencies are co-operating indirectly by giving technical and financial support in this endeavor. Besides, the Ministry of Health and its National Center of AIDS and STD Control, and 16 other ministries have been participating directly and indirectly in

the efforts for HIV/AIDS prevention and control. However, their participation is limited to attending workshops on HIV/AIDS. Some of the ministries have included HIV/AIDS as an integral part of population and reproductive health in their training programs. Some of them have prepared plans of action on HIV/AIDS but their implementation is constrained by shortage of budget. Besides these ministries and national level organizations, there are a good number of local NGOs and CBOs working on HIV/AIDS in small areas at village level but their exact number is not known. There are also 14 central level NGOs, consulting firm and research and teaching institutions related on population activities in Nepal but their activities are mainly centered on teaching and mini-scale research based on resources provided by the donor agencies.

About a dozen of HIV/AIDS prevention, control and management projects and their sub-projects funded by different donor agencies and INGOs operationalized at micro level were completed and about nine such short-term projects are currently being implemented in the country. However, their geographical coverage is too small and they have not been able to demonstrate much wider impact on a broad range of vulnerable and high-risk people.

Woman in Nepal have less access to income, wealth, modern avenues of employment, education and health facilities than men; they suffer from higher rates of malnutrition and morbidity than men; and have fewer legal rights than men, especially in property and family matters. In the hill communities women enjoy greater freedom in marriage and mobility in movement and have greater decision-making roles within the household, but suffer from overwork and poorer physical; and social infrastructures.[37]

A gender perspective allows us to see 'care' in the parts of the world most beset by HIV/AIDS for what it is -- a story of women sacrificing their lives to fill the gap left by governments and the global community because of their gender blindness. It is as if a massive natural disaster had erupted decades ago, and while local and international rescue teams were being mobilized to respond, women and girls were pulled from their lives and jobs and classrooms to search for survivors, tend to the wounded, nurse the doing, comfort the bereaved and bury the dead.

[37] UNICEF: Children and Women of Nepal: A Situational Analysis, National Planning Commission, HMG, UNICEF 1992.

CHAPTER II

GENDER AND HIV/AIDS

"The empowerment of women is the best vaccine we have now against AIDS." Says Noeleen Heyder, the Director of UNIFEM, the UN fund for women

'One is not born, but becomes, a woman'[1]. With these fighting words delivered in 1949 in *The Second Sex,* Simone de Beauvoir inspired almost all the newly emerging feminist writers two decades later to draw a distinction between sex and gender.

When we talk about gender, we should first demystify a popular misconception that it is about women and that it has nothing to do with men. As gender is socially constructed, it is equally important for both men and women. The notion of male supremacy has been justified, sustained and continued through different institutions (economic, polity and culture), historically. However, the notion was challenged from time to time through different ways like writing, songs and dance. In the early 19th century, different types of knowledge emerged to look at social realities. The Functional perspective, which explains everything as functional and beneficial has been challenged by the critical perspective. Karl Marx is regarded as the pioneer of this perspective.[2]

He explained the inequality that prevailed in the society in terms of production and distribution of resources. However, he was not able to explain inequality in terms of gender. Women's position was explained on the basis of their biology and biology was used to justify male supremacy in the society. However the notion could not remain static. Writings from different fields, particularly from the research work of an anthropologist, Margaret Mead challenged the concept of the male superior and the females as inferior in the early 1930's. Collective notion of male's supremacy at an international; level was started in the 1960's. It was started by breaking the silence about women's oppression, subordination and subjugation. Issues of violence, dichotomization of public and private domain, systemic exclusion of women from public arena, and

[1] Beauvior, 1949
[2] Pokharel B and Mishra M,2001

devaluation of women's work started uncovering and put forward for public debate and discussion. As a result, new concepts and approaches emerged and continued to be emerging and developing to analyze social realities. Women in Development (WID), Women and Development (WAD) and Gender and Development (GAD) are among the other powerful approaches, which provide new perspective to analyze existing hierarchical/unequal gender relation.[3]

Gender is one of the most crucial factors contributing to vulnerability to HIV and the impact of HIV/AIDS. Worldwide, AIDS currently is an "equal opportunity" disease with regard to gender. The *WHO* has acknowledged that since January 1992 women throughout the world have been becoming infected with HIV at a rate approximately equal to that of men.[4] The gender balance will shift by the year 2000, however, when women will account for the most new infections.[5]

In most societies dominant gender constructions and ideologies which determine what are seen appropriate male and female behavior, characteristics and roles make stark differences between men's and women's roles and life realms and their access to resources and decision-making authority.[6] These constructions have considerable influence and how sexuality is interpreted by and for men and women to know about sexual matters and sexual behavior. As a result, girls and women are often poorly informed about reproduction and sex, while men often know more and are expected to be sexually experienced.[7]

Gender inequalities mean that, if social, cultural and economic costs of avoiding risk are too high; women will continue to take risks over their health and lives. Gender inequalities both fuel the spread of AIDS and exacerbate its impact on one-half of the population. The challenge is to avoid this vicious downward spiral. This in turn means addressing the poverty and powerlessness that constrain people's choices to act in their

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[3] ibid
[4] Altman, 1992
[5] ibid
[6] Gupta, 2000
[7] UNAIDS, 1999

own interests and develop to their full human potential. It is here that human rights have a critical role to play.

HIV infection is the most devastating new disease to have emerged in recent history. Although, worldwide, approximately as many women as men suffer from HIV, this aggregate figure conceals marked differences in the implications of the disease for men and women. Some of these results from biological differences in sex between men and women, but more result from socially defined gender differences.

The concentration of HIV/AIDS in the developing world and in the marginalized communities of the first world confirms that the HIV/AIDS pandemic mirrors the conditions of global inequality. Tracking the path of least resistance, HIV/AIDS flourishes in conditions of poverty, conflict and inequality, and in states with weak resources and capacity. Within these broad political and economic inequalities, the intersection of HIV/AIDS and gender inequality is relatively well documented. Throughout the developing world, and on the margins of the first world, statistics show that women and girls are increasingly bearing the brunt of the epidemic. Their vulnerability relates to infection, the gendered personal and socio-economic impact of living with HIV or AIDS, and the enormous burden of care that women inevitably bear.

HIV/AIDS has become a major challenge to gender equality and the advancement of women. Yet the same gender roles and relations that enhance women's vulnerability to HIV/AIDS also increase some of the risks for men. Prevailing views about masculinity and manliness encourage men to demonstrate sexual prowess by having multiple sexual partners, and by consuming alcohol and other substances that may lead to risk taking and violence.

Both globally and nationally, AIDS is emerging as disease of women. Close to half of adults living with HIV are women. Studies have revealed that women are at the higher risk of contracting HIV/AIDS as compared to men. Male-to-female HIV transmission during sex is about twice as more likely to occur than female-to-male transmission.[8]

This is why HIV-positive women have a unique and valuable role to play, both in society and in fighting HIV and AIDS. Women hold families and communities together and they are a source of great strength in the face of HIV and AIDS. The number of people living with HIV globally has also reached its highest level with an estimated 39.4 million people, up from an estimated 36.6 million in 2002. The number of women living with HIV has risen in each region of the world over the past two years, with the steepest increases in East Asia, followed by Eastern Europe and Central Asia. In East Asia, there was a 56% increase over the past two years, followed by Eastern Europe and Central Asia with 48%.[9]

Research all over the world suggests that the HIV epidemic affects men and women differently, and its impact also varies depending on whether a person who falls ill is female or male. The differences are seen both in terms of greater biological vulnerability of women, as well as in terms of non-biological, social impact of the infection. [10]

In order to understand the nature and extent of the gender differentiated impact of HIV/AIDS; one has to study it in the context of the ***household*** and the ***community*** where gender relationships, roles, expectations etc are played out according to prescribed social norms.

[8] WHO, November 2004
[9] Geneva, 2004
[10] Mukhopadhyay S

In many instances, when a man falls ill there us likely to be a drop in disposable household income. In cultures where women are the primary source of food for the household, if a woman becomes ill there is more likely to be a problem with food security. The direct provision of care for the young or the sick is often seen primarily as women's responsibility, and the girls may be withdrawn from school to assist with household tasks which men have never learned, or which are considered unacceptable for men. In most societies gender norms influence individual and societal risk and vulnerability to HIV/AIDS. Gender roles determine how and what men and women are expected to know about sexual matters and sexual behaviour. [11]

Women are more vulnerable because of sexual subordination in many societies and cultures, compounded by factors like monogamous expectations only from women and the same case applies in Nepal too. They are also more vulnerable because of economic subordination and because women often have no say in the matter of sexual relationships. Moreover they have limited access to information and education messages and are disproportionately the recipients of blood or blood products that may be infected. Unfortunately, women are often unfairly stigmatized as being reservoirs of HIV infection and blamed for transmitting it to others, including their offspring.[12]

With the increased rate of migration, in regard to Nepal, (now also due to Maoist problem) trafficking within and across the country, child labor and injecting drug users, the HIV/AIDS rate will only go up. Those who are at higher risk comprise migrants, child labors, the younger population in general, intravenous drug users, and unborn child of infected mothers. Unprotected sex, use of intravenous unsterilized injections, and mother to child infections have been the important risk factors. But the major mode of transmission remains sexual intercourse.

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[11] ibid
[12] Current Sociology: 2001
[13] AIDS Epidemic Update, 2004

In sub-Saharan Africa, the worst affected region, close to 60% of adults living with HIV are women – or 13.3 million. These latest findings were published in the annual report by the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the WHO. The joint report was released in advance of World AIDS Day, commemorated worldwide on the first of December.[13]

There is no single AIDS epidemic worldwide. Many regions and countries are experiencing diverse epidemics, some still in the early stages. "These latest trends firmly establish AIDS as a unique development challenge," said Dr Peter Piot, UNAIDS Executive Director. "The time of quick fixes and emergency responses is over. We have to balance the emergency nature of the crisis with the need for sustainable solutions."

In East Asia, the 50% increase in HIV infections from 2002-2004 is largely attributable to growing epidemics in China, Indonesia and Viet Nam. The 40% increase in Eastern Europe and Central Asia is mainly due to Ukraine's expanding epidemic and the growing number of people living with HIV in the Russian Federation. With an estimated 860,000 people living with HIV at the end of 2003, Russia has the largest epidemic in Europe.[14]

Addressing gender through effective policies and programmes is the way forward if development objectives are to be realized. But doing so is also necessary if HIV transmission is to be reduced and if societies are to be able to respond effectively to the widening range of social, political, cultural and economic effects of the epidemic.

[13] ibid
[14] ibid

Gender in Modern South Asian Societies

The identification of gender as had important subject for analysis in contemporary South Asia is a recent phenomenon. In the 80's, a distinct branch of women's studies emerged within the study of South Asian societies. The feminist movement became firmly entrenched and is thriving well in this part of the world. This has been complemented by outpouring of writing published about explorations of women's condition in South Asia. Two streams of literature coming from feminist scholars dealing with women's condition from a indigenous feminist movement now interact and inform one another and are no longer distinct.[15]

Most studies of culture of South Asia had ignored the gender dimension and obscured the crucial role it plays within culture. For instance, scholars of marriage networks evaluate transactions in women by bypassing the meaning, which this has for the women themselves. Subaltern studies (historical studies of class formation and of class/caste articulation) have been formerly hidden from the record. But they too have remained silent on the social category of gender and how gender interacts with class and caste.[16]

However in the recent years, there has been a marked increase in gender studies in South Asia, particularly in the area of demographic behavior. The striking masculinity of South Asian sex ratio has concerned the attention of demographers, economists, anthropologists, historians and sociologists all alike. [17]

[15] Alice W, Clark, 1993
[16] DR Mathur D, 2001
[17] ibid

Sociological perspectives on Gender Issues in Changing Nepalese Society

"The universe of ideas, images and themes the symbolic modes that are the general currency of thought-have either produced by men or controlled by them. In so far as women's work and experience have been entered into, it has been on terms decided by men and because it has been approved by man."

Dorothy E.Smith, 1987

Nepal, according to the constitution of the Kingdom of Nepal 1990 is a multicaste/ethnic, multi lingual and multi cultural society. The constitution declared the country Hindu kingdom but in reality is that it is a multi- religious society. When we talk about any issues including gender issues, one must read the text in the socio-cultural context of the Nepalese Society, which has been characterized by pluralism in caste/ethnicity, language, religion, culture and region.[18]

Marriage and family system of various caste/ethnic, cultural and religious are different. In the last two-century, women have been suppressed, oppressed, depressed and exploited not only by the families and communities but also by the state controlled by so- called "high caste" men. Dalit women (and also men) have been inhumanely treated as "untouchables". Similarly, women belonging to indigenous ethnic groups continue to be further suppressed and oppressed by the predatory state by denying them to exercise their basic human rights, including minority rights, rights of indigenous peoples and right to education in the mother tongue.[19]

Religion, tradition, cultures norms and values that govern communities and families are also gender discriminatory. Among the religions, Hindu religion and the teachings of "sacred" Hindu societies are at the worst terms of gender discrimination. In spite of women's projection as the goddesses "Durga" and "Kali" *(Durga and Kali are*

[18] Statistical pocket Book,2004
[19] Bhattachan B.K, 2001

considered as Goddesses of power in Hindu mythology) as symbol of power and goddess "Saraswati" as symbol of education, Hindu religion treats women very inhumanely and derogatorily as non-human objects. Social caste hierarchy, concept of purity and pollution, high prize for chasisity and male-based life rituals from birth to death perpetuate Hindu women's status at both natal and husband's home to that of a second class status. Buddhist religion preaches for equality, including equality between men and women but there are some cases of gender discrimination but such discriminations are not as ruthless and severe as in the Hindu religion.

Social norms and values are biased in favor of boys/men/sons. In most of the communities, except some very traditional indigenous ethnic groups, sons are regarded as high value cash crop and daughters are regarded as junks. Therefore, sons get preferential treatment from birth to death, especially in foods, clothing's, toys/games, schooling/education, parental property, health care, last rites of dead parents, personal respect, social status and freedom from doing the household chores. Daughters, on the contrary, are deprived from all those privileges. They are thought to be other's property and liabilities.[20]

Women's access to land and property is derived through her marriage relationship. A married woman has no right in her paternal property. She gets an equal share in the husband's property together with her son, if she remains faithful to him and his clan. Women cannot participate in politics on the equal footing with men because of both social constraints, lack of mobility and access to resources.[21] They have been treated as a "vote banks" only by political parties and politicians alike. They are silent, invisible and disproportionately represented in Nepalese politics.[22]

[20] ibid-bhattachan 2004
[21] Acharya, 1994
[22] Shrestha K,2004

Socio-cultural based Gender Inequality at the Community/ Societal Level

Due to some traditional religious practices, some women lose their freedom to live life of their own choice. In the Baitadi, district in far-western region, some girls from the poor families are purchased by rich "high caste" people and offer them to gods as *Deuki*. Later these girls practice prostitution.

In the mountain region, Buddhist families offer their second daughter to the monasteries where they live a life of *Jhuma (monks)*. They must practice celibacy for life.

The Newars of Katmandu Valley have tradition of living goddess called *Kumari (living goddess)*. These Kumaris must live in the temples until they menstruate. After the menstruation they are no more eligible to be goddess Kumari and later many of them remain single because of the belief that whoever married them would die.

Women of one of the Dalit caste groups called *Badi* in Nepalgunj and some villages in Banke district in mid-western region and in some villages in Dhangari district in far-western region have been forced by the society to engage in commercial sex works as their only profession.[23]

Self-Projection of the Nepali State

Nepal projects itself as gender-neutral because the Constitution ensures equality between men and women. Its recognizes women as a disadvantages section of society deserving special privileges from the state, but only in limited areas such as education, health and employment. This privilege approach, unlike the empowerment approach, limits the role of the state to that of dispenser of welfare whereby using the framework of welfare programmes, the state, can only provide nominal services.

[23] Bhattachan B K, 2004

Despite their inherent potential as agents of change, Nepal's political parties and NGOs have made only token contributions to linking women's problems and needs with the formal state structures and authorities. Although women are empowering themselves through their interaction with the state's power structure, their participation in the decision-making process has yet to be properly streamlined, and they remain largely excluded from the politics, government and governance.[24] Nepali women are distant from the axis of state power, as the Human Development Report of Nepal says, "*gender empowerment in Nepal is abysmally low in relation to achievements at the regional and international level. The global Gender Empowerment Measure (GEM) is more than double that of Nepal. Women in all South Asian countries, except Pakistan, are more empowered than women in Nepal.*"[25]

State Initiatives for Women

Ideological Commitment

- Equality between men and women
- No discrimination on the basis of sex in the application of the law
- Equal pay for both men and women for similar work
- Special privilege for women in education, health and employment
- Abolition of sex discrimination
- Women's empowerment and gender mainstreaming (goal of the Ninth Five Year Plan)

Structural Adjustment

- Establishment of women's development division in the Ministries of agriculture, Education and Water Resources*
- Formation of Women's cell in the National Planning Commission
- Establishment of Separate Ministry of Women and Social service Welfare

[24] Shrestha I and Hachhethu K, 2002
[25] Nepal Human Development Report 1998.

- Constitution of a Women and Child Development Council under the chairmanship of the Prime Minister

Welfare Measures

- Scholarships for girl students
- One female teacher for each primary school
- Pensions to widows
- Recruitment of Maternal and Child health workers, and female Community Health Workers at each health post
- Women Targeted credit programmes under the schemes of Production credit for Rural Women, Small farmer Development Project and Micro credit for Rural women

Positive Discrimination on GEM sectors

- 5 percent of total candidates in each political party for parliamentary elections should be women
- 5 percent seat reservation for women in a total of 60 members in the National assembly
- 20 percent reservation for women in elections to 5-member Ward Committees
- Reservation of one seat for women among nominated members at all levels of local government: Village development Council/Village Committee, Municipality Council/Municipality Committee, District Development Council/District Development Committee
- Extension of age bar to 40 years for entering government service against 35 years for men.

- Women's Development Divisions in some other ministries, like Labor and Local Development had already been set up prior to the advent of democracy in 1990.

In comparison to the state's broad ideological commitment towards women, its practical contribution to women's representation and participation in the government and administration is negligible. There is an obvious gap between the state's manifest goal and its achievement.

Women and AIDS – a growing challenge

In 1981, the first case of AIDS in woman in the United States was identified. Since then, little attention has been paid to women in the AIDS epidemic in research, clinical practice, or in the media, causing Wiener, who called women "the invisible participants" in the AIDS epidemic, to ask, "Where are the women?" among other critics, Campbell noted that "despite women's vulnerability to AIDS, there has been a general lack of attention to the seriousness of the problem of AIDS in women."[26] A similar observation led Anastos and Marte to claim women as "the missing persons in the AIDS epidemic."[27]

By the end of the twentieth century, AIDS was the fourth leading cause of death in the world, after lower respiratory infection, heart disease and stroke. Women are more than four times more vulnerable to HIV infection than men are, women less than 20 years old are up to ten times more vulnerable and women are significantly more likely than men to experience AIDS-related discrimination after infection. The response to HIV and AIDS to date has failed to address adequately women's inability to prevent themselves from becoming infected, resulting in a thriving epidemic and huge populations of HIV-positive women who live in unsafe and undignified conditions.

Perhaps the most significant contribution to the invisibility of women in the AIDS literature has been the devaluation of women in their own right the literature on women and AIDS largely views women "in relation to", primarily in relation to their sexual partners and their children. Chavkin argues that, "the tensions between concern for

[26] Campbell
[27] Anastos & Marte, 1989

woman qua women and for women as fetal vessels or vectors of transmission of disease to others permeates all of the current efforts to target women for AIDS prevention work."[28] The failure to be concerned for women as women is exacerbated by the fact that "undervalued populations of women" have received attention disproportionate to their significance in the epidemic (i.e., as prostitutes, IV drug users, and women of color).

In his analysis, Gilman shows that people with AIDS are socially constructed as "Other," thus associated with groups, which are seen to be Other within a society. These are usually marginalized groups with less power. The primary Other in patriarchy is woman.

Globally, the incidence of HIV/AIDS among women has risen at a shocking rate. In 1997, 41 per cent of HIV infected adults were women and this figure rose to 49.8 per cent in 2001. [29]

While HIV/AIDS is a health issue, the epidemic is a gender issue. Statistics prove that both the spread and impact of HIV and AIDS is not random. It disproportionately affects women and adolescent girls who are socially, culturally, biologically and economically more vulnerable. The figures are alarming: 18.5 million of the 37 million adults (aged 15 to 49) living with HIV are women.

Women carry a **"triple jeopardy"** of AIDS: as people infected with HIV, as mothers of children infected, and as carers of partners or parents with AIDS (or, in the case of increasing numbers of grandmothers, as carers of orphans). Care, traditionally one of women's many responsibilities within a family, is provided free, but has a hidden cost. When women care for others, their labour is lost, which has a huge impact on the wealth and therefore the health not only of themselves, but also of the whole household. In the case of girls, they are often removed from school to care for sick relatives. This is also a huge economic and social loss, both for them and for their future families. HIV/AIDS is

[28] Chavkin, 1990
[29] UNAIDS,2002

thus contributing to the acceleration of feminized poverty across the world and the Asia-Pacific region is no exception.[30]

In North Africa and the Middle East, 54 per cent of the HIV positive adults are women; in the Caribbean, the proportion has reached 52 per cent. [31] In most regions, an increasing proportion of people living with HIV are women and girls, and that proportion is continuing to grow, particularly in Eastern Europe, Asia and Latin America, as shown in Figure 1

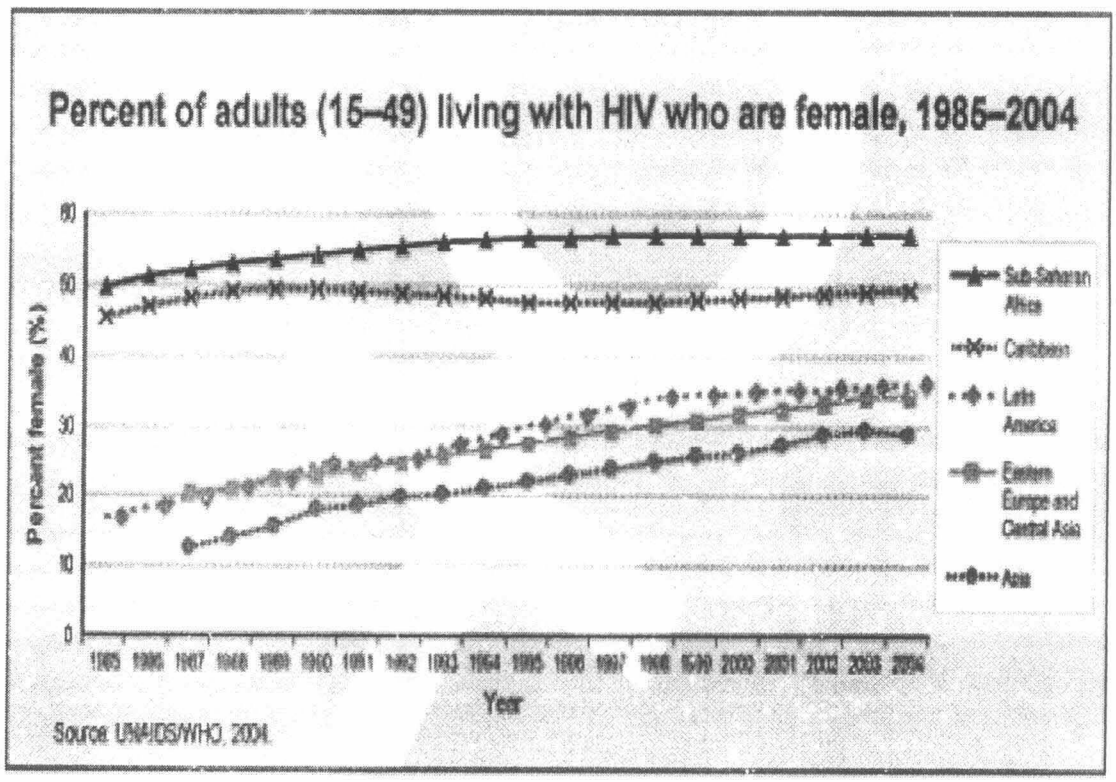

Figure 1

[30] Bennett l, 1983
[31] Ibid

It is equally important that women are more closely involved in designing and guiding programmes that are meant to serve them. This applies particularly to women living with HIV, who can contribute in unique ways to strengthening responses to the epidemic. In addition, the nurturing of strong civil society organizations, particularly women's and youth groups can improve the reach, accountability and effectiveness of AIDS programmes.

For many women in developing countries, the "ABC" prevention approach (Abstinence, Being faithful and reducing number of sexual partners, and Condom use) is insufficient. "Strategies to address gender inequalities are urgently needed if we want a realistic chance at turning back the epidemic," said Dr Piot. "Concrete action is necessary to prevent violence against women, and ensure access to property and inheritance rights, basic education and employment opportunities for women and girls."

Millions of young people are becoming sexually active each day with no access to prevention services. In sub-Saharan Africa, three quarters of all 15-24 year olds living with HIV are female. Young women are three times more vulnerable to HIV infection than their male counterparts. In addition to being biologically more vulnerable to infection, many women and girls, particularly in Southern Africa, find themselves using sex as a commodity in exchange for goods, services, money, or basic necessities – often with older men. This "transactional sex" is mainly driven by poverty and the desire for a better life.[32]

[32] ibid, p.65

Women in Nepal

Women comprised 50.1% of the total population of Nepal in 2001. Patriarchy pervades most of the country's castes and ethnic groups; Nepal has one of the highest indices of son preference in the world. Boys not only pass on the family name, but also represent "insurance" for parents in their old age and can carry out important rituals when parents die. Girls generally work at home and in the fields, considered too unimportant – and risky -- to educate, given the high value attributed to virginity and the dangers that schooling in the company of boys and men outside the household might pose to virginity. By contrast, early marriage constitutes a kind of virginity insurance.

Nepalese society was closed to foreigners till 1950. Therefore, during the Rana rule, Nepalese society changed very little. After the political transformation of 1950, Western donors began to provide foreign aid to Nepal as a part of the modernization/Westernization project. Women also began to raise women's right issues since then. Although biology is not and should not be the destiny but in practice the male centered process of socialization such as conditioning, ugly relationships between men and women that make belief that biology is the destiny of Nepal. In brief, such a male centered process of socialization results in the homo-social reproduction of existing discriminatory and exploitative relationship between man and women. It is no wonder that in the global and the South Asian Regional context gender inequality has shown its most ugly heads in Nepal than anywhere else in the world.[33]

Gender issues, including women's rights are very significant because women comprise of little over half of the total population. Nepalese women suffer from domination, exploitation, suppression, oppression, subordination and discrimination by their men.

[33] Bhattachan, 2001

Women bear triple work responsibilities in Nepal; ***Reproduction; Household work; and Employment.*** Given traditional gender divisions of labour, women concentrate more on their ascribed reproductive roles and responsibilities while men focus on "productive", income-earning roles. As in most households worldwide in both developed and developing countries, reproduction is not regarded as work and household work is not considered productive. However, the work burden of women in Nepal (16 hours) is much higher than the global average for three reasons; ***First,*** reproductive work is much more intense because the home continues to be the centre of nurture and socialization, ***Second,*** maintaining household is highly work-intensive, particularly during the peak agricultural season, ***Third,*** participation of women in Nepal in "productive" activities is one of the highest in the world. Now due to the Maoist problems, most men of the rural Nepal are either killed or have fled to India for their safety, leaving the women of the house with the added burden. The boundaries of all these activities undertaken by women are influenced by factors such as household composition i.e. extended/ joint, nuclear and female-headed families, household stratification by economic status – wealthy, poor or landless – the migration of male family members, education, knowledge and health status. Women are also confined to "culturally prescribed" and "socially acceptable" occupations. However, data on many Nepalese socio-cultural practices that discriminate against women are inadequate to date, in large measure because of the sensitivity of the subject,[34]

Early marriage and high fertility characterize women's lot and 40% of currently married before the legal age of 16 and a small but significant number 97%) before the age of ten. In Nepal 40% of the women have their first child between the ages of 15 and 19 years with at least one miscarriage experiences by a high proportion. Maternal mortality is extremely high and is estimated by the Family planning and Maternal Child Health Project to be 8.5 per 1000 livebirths. Abortion is illegal and clandestine resource to

[34] Bhadra C, 2001

abortion is suspected to account for a hemorrhage and infections account for the highest proportion of maternal deaths. [35]

According to the National Centre for AIDS and STD Control (NCASC), HIV has affected two categories of Nepali women- 'housewives' and 'commercial sex workers'. If a housewife is the product of high caste Hindu expectations of virginal marriage and life long female fidelity, then any woman who has ha sex with more than one man is, effectively, a sex worker. This distinction is enshrined in the categories NCASC uses to track the incidence of HIV infection in Nepal.[36]

Being female and poor may not directly cause HIV; however, in some contexts it does increase the probability of HIV infection[37]. A poor, female sex worker has less capacity than a wealthy female sex worker to ensure condom usage by her clients and this increases her risk of contracting HIV[38]. Since the mid to late 1980's, the third period of HIV prevention, research has been conducted on the social dimensions of HIV particularly in contextually grounded, vulnerability analyses[39]. From context to context, the social factors that shape the epidemic will vary[40]; however, the general vulnerabilities of poverty, gender, racial, ethnic, or sexual marginalisation and injecting drug use characterise the spectrum of vulnerabilities likely to be identified[41].

As in many other countries, women's low social and economic status in Nepal, combined with greater biological susceptibility to HIV, put them at increased risk of infection. Poor economic conditions, which make it difficult for women to access health and social services, compound this vulnerability. Eighty-six percent of Nepal's women are illiterate. At the end of 1997, an estimated 10,000 women (ages 15-49) were living with HIV/AIDS. According to the 1996 Family Health Survey, only 30 percent of females 24 to 49 could cite at least two acceptable ways of protection from HIV infection, and only

[35] ibid
[36] NCASC.
[37] Ackermann, et al.2002
[38] Chan, & Reidpath, 2003
[39] Mann, 1999
[40] Barnett, 1998
[41] Ashraf, & Godwin, 1998

6.2 percent of women ages 15 to 49 had ever used a condom. In 1993, HIV prevalence among sex workers was estimated at 1.3 percent outside major urban areas and 0.9 percent in major urban areas.

An estimated 100,000-200,000 Nepalese women have been sent or sold to brothels in India,[42] and the complicity of police and local authorities in some of this trafficking has been reported. Women are recruited from villages or urban areas of Nepal where they have come to work in the carpet and garment industries. Some women are sold by their families, whereas others are deceived by false marriages and promises of economic opportunities. Once a sex worker is found to be HIV positive, she is sent back to Nepal where she is often rejected by her family and may be forced to remain in the sex industry as a means of survival.

Women are particularly vulnerable within this context for several reasons. ***Firstly,*** evidence in Africa and Asia reveals that if they disclose their HIV status or become ill, their relationship may break up, leaving them without access to the resources provided by their male partner. ***Secondly,*** if the husband or male partner becomes ill first (which has been the pattern of the epidemic in African countries), women divert household resources to care for them, often at expense of their own income producing work, food and school fees for the children. Children are taken out of school because of lack of funds or to o assist in care. Girls are more likely to be taken out of school first, thus damaging their life chances. ***Thirdly,*** once the spouse dies, many women living under customary or religious law have no independent legal right to resources through inheritance. Widows may be abandoned by their husband's family (especially if known to be HIV positive) and will find it difficult to remarry to gain access to resources through another man. Many women therefore face an uncertain and impoverished future, pushed even further down the socio-economic ladder to an even more fragile economic existence (and greater vulnerability to HIV infection) such as selling food or beer or engaging in migrant labour or sex work..[43]

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[42] UNFPA, 1997
[43] ibid, p. 75

In Nepal, women are marginalized from birth by socio-cultural pressures. Rural families, especially women and girls, experience great difficulty in sustaining themselves because of a limited resource-base and the social constraints that women face in household decision making about existing resources. Deteriorating conditions and soaring inflation affect everyone. However, it is the women who, in the final analysis, suffer most from these socio-structural problems.

The extended family unit, the backbone of society in many developing countries will come under increased pressure from the impact of AIDS. As AIDS affects those age groups that are most economically active, these families will lose breadwinners. In the absence of comprehensive public health care, most people with AIDS will return to the care of their families and communities. As the death of breadwinners and the burden of care take their toll on the family unit and relatives, resources are drained and living standards decline, together with the family's ability to provide the social safety net of society. A family's ability to withstand this is directly related to its access to food, water, shelter, work and basic health and social services AIDS impacts most severely on vulnerable families, which in many countries tend to be rural and women-headed households.

Women's Greater Vulnerability To HIV Infection

Why is HIV infection rates in young women escalating worldwide, particularly in high prevalence countries? The reasons are numerous and based in biological, social and economic realities.

Biological makeup

HIV has been called a "biologically sexist" virus by the scientists, because women are in much greater danger of contracting the disease during sexual intercourse than a man.[44] Biological, cultural, and socioeconomic conditions contribute to women's greater vulnerability to HIV/ AIDS. During unprotected vaginal intercourse, a woman's risk of becoming infected is up to four times higher than that of a man. The vagina's greater area of susceptible tissue (compared with the male urethra) and microtrauma during intercourse make women more physiologically vulnerable to HIV. In addition, HIV infected semen typically contains a higher viral concentration than do vaginal secretions.

A final biological factor that makes women more vulnerable to HIV involves the synergy between HIV and other sexually transmitted infections (STIs). Research shows that an untreated STI in either partner can increase the risk of HIV transmission as much as 10-fold. This is especially significant for women because most STI cases in women are untreated. Women's symptoms are often latent or difficult to see, and many women who have been diagnosed with STIs have no access to medical treatment.

In the case of Nepal, due to the fact that women don't have much power to make the decision, they cannot say no to sex with her husband, sometimes knowing that they have HIV/AIDS. In the other cases, husbands don't tell their wives of their illness. In the rural areas it is also not possible for everyone to get the proper medical help even if they have knowledge about AIDS.

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[44] Vallaeys, 2002

Social and Cultural Norms

Women are not only at a biological disadvantage, but also a social disadvantage as well. "The second class status of women in economic, social and civic life has fueled the pandemic in much of the world."[45] Socioeconomic factors, including women's lack of access to education or personal income, perpetuate women's lower status and create even greater vulnerability to HIV infection. Many women fear that they will be abandoned by their husbands or supporting partners if they try to exert control over how and when they have sex and whether their partner uses a condom. Moreover, widespread poverty drives some women into the sex industry, where sexual trafficking and worker rotations promote continued exposure of new sex workers (and their clients) to HIV. Furthermore, men control the main tool for reducing the risk of sexual transmission of HIV: the male condom.

Cultural traditions such as forced marriage, older men's preference for young women, and female genital cutting contribute to women's lack of power. Throughout the world, prevailing views about masculinity encourage men to undertake risky sexual behaviors-multiple sex partners, alcohol consumption prior to intercourse, and sexual violence-that make women more vulnerable to HIV and other STIs. Young girls are at even greater risk of sexual coercion because of their social vulnerability and because some men assume that young girls are virgins and free of infection. A cultural myth in South Africa holds that sexual intercourse with a virgin can free a man from HIV infection. This belief has led to child rapes and to men seeking sex with very young girls.

Women are not expected to discuss or make decisions about sexuality. "Good" women are expected to be virgins before marriage and are expected to be "ignorant" or uninformed of any matters relating to sex, including their own sexuality. If women refuse sex or request condom use, they risk abuse. Violence against women (especially domestic violence) leads to forced sex (thus increasing microlesions). Marital rape is not recognized as a crime in many countries (and in no countries in South East Asia), so marriage condones non-consensual sex between a man and his wife at any time.

[45] Human Rights Watch, 2001

In Nepal too, lack of education and the women's vulnerable situation in front of their husband and families puts them in the disadvantage position. For men, multiple partners and sex outside marriage are widely culturally accepted. Women are expected to have relations with or marry older men, who are more sexually experienced, and more likely to be infected. Arranged marriages, particularly among relatives, without the bride or groom getting to know one another first, are a norm in rural Nepal. Marriage is strongly associated with reproduction and creating a family, and there is strong pressure on young, newly married women to have children. A woman's status greatly improves if she becomes a mother. The majority of non-literate people in Asia are women. This limits women's ability to access information for HIV/AIDS prevention, care or treatment.

Nutritional status

Women suffer from nutritional deficiencies due to unequal food distribution within the household. They receive less breast-feeding and are fed last and less nutritious food than their brothers.

Adequate nutrition, a fundamental cornerstone of any individual's health, is especially critical for women because inadequate nutrition wreaks havoc not only on women's own health but also on the health of their children. HIV-infected mothers who are malnourished may be more likely to transmit the virus to their infants and to experience a more rapid transition from HIV to full-blown AIDS. Malnutrition undermines women's productivity, capacity to generate income, and ability to care for their families. Women are more likely to suffer from nutritional deficiencies than men are, for reasons including women's reproductive biology, low social status, poverty, and lack of education. Sociocultural traditions and disparities in household work patterns can also increase women's chances of being malnourished. Globally, 50 percent of all pregnant women are anemic, and at least 120 million women in less developed countries are underweight.[46]

[46] ibid

Research shows that being underweight hinders women's productivity and can lead to increased rates of illness and mortality. In some regions, the majority of women are underweight: In South Asia, for example, an estimated 60 percent of women are underweight.

Many women who are underweight are also stunted, or below the median height for their age. Stunting is a known risk factor for obstetric complications such as obstructed labor and the need for skilled intervention during delivery, leading to injury or death for mothers and their newborns. It also is associated with reduced work capacity.[47]

Adolescent girls are particularly vulnerable to malnutrition because they are growing faster than at any time after their first year of life. They need protein, iron, and other micronutrients to support the adolescent growth spurt and meet the body's increased demand for iron during menstruation. Adolescents who become pregnant are at greater risk of various complications since they may not yet have finished growing. Pregnant adolescents who are underweight or stunted are especially likely to experience obstructed labor and other obstetric complications. There is evidence that the bodies of the still-growing adolescent mother and her baby may compete for nutrients, raising the infant's risk of low birth weight (defined as a birth weight of less than 2,500 grams) and early death.

In Nepal gender disparities show up in many different forms, including unequal distribution of food and nutrition within the household, and where young girls are married off at an early age to fulfill their societal obligation to procreate as early as their young bodies will take, it is small wonder that a very large number of women tend to suffer from serious nutrition deficiencies. [48]

Major nutritional deficiencies found in Nepalese women are iron-deficiency related anemia and low levels of Vitamin A. as it happens both these nutritional deficiencies play role in increasing the risk of contracting HIV/AIDS. Women with anemia are more likely

[47] Asian Development Bank, 2001
[48] Atlas of South Asian women and Children; UNICEF; 1996

to require blood transfusions, especially after delivery, raising the probability of infection through transfusion. Vitamin A plays a vital role in upholding the immune system and in keeping mucous membranes in function. Thus absence of adequate levels of iron and Vitamin A translate into higher risks of being infected.[49]

Economic Growth

This is defined as an increase in a country's national income or per capita national income. Growth is fundamental to development and thus the advancement of human welfare. Some argue that an expanding economy can coexist with problems of income inequality and poverty. They point out that economic growth does not always lead to improvements in health and education, and conversely that improvements in health and education are not necessarily dependent on economic growth.

The relationship between economic growth and health has been the focus of the Commission on Macroeconomics and Health. The Commission argues that infectious diseases such as malaria and HIV/AIDS act as a massive societal brake, slowing both economic growth and human development. Good health is linked to economic growth through higher labour productivity, demographic changes and higher educational attainment. In the same way, poor health undermines economic growth. For example, it is estimated that Africa's per capita growth rate of 0.4% in 1990-1997 was three times lower than it would have been had HIV/AIDS not existed.

In Nepal, women are less educated than males, more overworked and underpaid. Women are expected to work in the home and are often discouraged from going out to work, so they are more financially dependent on men. Women have few opportunities to engage in waged labour and so have limited financial survival skills if the primary breadwinner is sick. If women work outside the home, many are forced to become transient workers. Many women have to exchange sex for material favours for daily survival. Women are

[49] ibid

often not permitted to own property or to legally inherit ancestral properties or possessions.

Pro-poor policies put the poor at the centre of development policy and are seen as one way that neo-liberal economic growth approaches can be made to address poverty issues. Pro-poor policies require accurate information on the living conditions and livelihood strategies of different kinds of poor people: rural, urban, female, jobless. Such information can help to ensure that social sector spending reflects the nature of poverty in a particular country.

Men's Vulnerability

Unequal power suppresses women and girls- but also oppresses men and boys and makes sex vulnerable in different ways to HIV infection. In fact, men pay significant costs within patriarchies; enormous health disadvantages include occupational health and safety costs since men predominate in dangerous works. They are more likely to be subject to alcoholism, sexually transmitted diseases, homicidal violence and imprisonment. In the formal economy, there is lots of pressure on men to spend longer hours at the work place.[50]

In some occupational groups this result in a life practically consumed by work. The negative side to poor 'work/family life balance' is that there is very little time for them to share with their partners and children, the bulk of unpaid work in the home falls on the shoulders of women, it is difficult to be a good father in any ways except as an economic provider.

[50] ibid, p. 76

Rigid gender roles and expectations also narrow men's cultural experience. In education, men predominate in technical courses and natural science while they are under-represented in humanities, social sciences and human services.[51] Power oriented masculinities are often associated with ethnocentrism, rejection of other cultures and inflexible and rigid barriers to change.

In every country, and on average, men generally have higher reported rates of partner change than women, and the social acceptance and condoning of this pattern often begin during adolescence. Prevailing norms of masculinity expect men to be more informed and experienced in sexual matters, which in turn prevents them from seeking information or admitting lack of knowledge; this ignorance results in unsafe, sexual experimentation to prove manhood, particularly in their youth.[52]

Men are also less likely to pay attention to the sexual health and safety, and are more likely to inject drugs, risking infection from needles and syringes contaminated with HIV. IDU who are mostly male can transmit HIV to both their drug partners and sexual partners with unsafe drug related practices and unsafe sex.

Employment related migration often by men disrupts marital and family ties and is known to contribute to unsafe sexual behavior, which adds to men's vulnerability to infection.

Over the years a stronger focus has developed on the positive role men and boys can and do play in promoting women's empowerment in the home, the community, the labor market and the workplace. A better understanding of gender roles and relations at work and at home can make policy measures and actions for overcoming equalities more effective. [53]

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[51] ILO Meeting Brazil, 2003
[52] Gupta R, 2000
[53] ibid

Gender and power, sexual negotiations and sexual decision-making

The socialization process teaches girls to be subservient since childhood. The female child begins to be discriminated against even before she is born. The power imbalance that defines gender relations and sexual interactions also affects women's access to use of services and treatments. For example, the Tanzanian study conducted by Maman, Mbwambo and colleagues (1999) found that there were gender differences in the decision-making that led to the use of HIV voluntary counseling and testing services. While men made the decision to seek the counseling and testing, women felt compelled to discuss with their partners before accessing the service.

Power differentials and differences in social norms regarding girls and women affect young women's ability to control sexual situations (when and with whom they engage in sexual activities), thus making them vulnerable to gender-based violence and coerced sex.

Education

In many countries with high HIV/AIDS prevalence rates, large numbers of teachers, administrators and other educational employees are becoming infected, with substantial impacts on the supply and quality of education. In addition, the consequences for the planning, administration and management of education are expected to be profound and strategies for the organization of the sector will require substantial re-thinking.

HIV/AIDS is threatening recent positive gains in basic education, and disproportionately affecting girls' primary school enrolments. An investigation by the Girls' Education Monitoring System found that children's participation in formal schooling is decreasing in African countries with the highest prevalence of HIV (11 percent or greater). Within these high prevalence countries, girls are most affected and their enrolment has decreased in the past decade. This is in contrast to countries with lower HIV incidence, where enrolments have increased. The researchers warn that, "if projections of HIV/AIDS

infection rates over the next decade are borne out, current positive gains [in education] in most countries of Sub-Saharan Africa, and perhaps other geographic regions, are likely to be wiped out."

Education is one of our key defences against the spread and impact of AIDS. The evidence for this is growing: in countries with severe epidemics, young people with higher levels of education are more likely to use condoms and less likely to engage in casual sex than their peers with less education. However, just as HIV targets the body's defence system, the HIV/AIDS pandemic is disabling the education sector's core functions and protective value. Achieving Education for all will require making HIV/AIDS the highest priority in the most affected countries. Only by managing the impact of HIV/AIDS on children, young people and the education system itself can education realize its potential to decrease vulnerability to HIV/AIDS and reduce the risk of further infections

It is important for the women to be well educated to look after her family. This lack of proper education in Nepal too plays a key role in teaching them about HIV/AIDS. The education system of Nepal is not properly reaching the people all over the country. Due to the difficult to reach rural (hilly, mountains) areas, it becomes impossible to get the education even though wanted by the people. Poverty also is the main cause as to why Nepalese people are unable to educate themselves. All the members of the family have to work since morning' till night to earn their livings. It is however, the responsibility of the government to make sure that the people get the education as well we they are knowledgeable about HIV/AIDS.

Victims Profiles: Case Studies

It is hard to imagine the agony and the suffering of scored of HIV/AIDS affected individuals and their families who are shunned by the community and turned away even today by the public authorities. Despite recent media based advocacy attempts, these individuals and their families continue to be subjected to every form of social discrimination, stigma, abuse and blame.

The case studies have been taken from the various reports from the various NGOs. Further, no interviews have been conducted for writing these case studies

"Maya"

"Maya" is from a small village in Nuwakot district. She is twenty-three, but looks much older. She has dark circles under her eyes; her skin is dry and lined. Maya said she first left her village when she was eighteen and returned to her village in July 1993, after spending three years in an Indian brothel.

Maya was married to a man from a nearby village when she was around thirteen. Soon after, her husband began seeing someone else. He moved out when Maya was sixteen, married a second wife and took her to Kathmandu. Maya had lived alone for two years when her father-in-law told her she should follow her husband to Kathmandu. He took her there. At her husband's house she was beaten and treated very badly.

In 1990 a fellow villager began visiting the house. The second time he came to visit, he brought another man along. They invited Maya and her husband to come out to see a movie. Maya's husband told her to go ahead without him. The three of them boarded a bus, which Maya said kept going farther and farther from Kathmandu. Eventually, they went through the border at Kakarbhitta. They were never stopped or questioned by the police.

After two days traveling by bus, they reached Bombay and the men left Maya at a house and told her they would pick her up the next day. They never came back. Maya realized she was in a brothel when she saw that the house was occupied by about twenty-five women, all but three of whom were from Nepal. Two or three were girls she had known from her own village. The brothel where Maya worked was called a "pillow house," lowest in the brothel hierarchy where most new girls start out. After a year, the owner told Maya that the broker had been paid for her and that she was responsible for paying back her purchase price, but she was never told how much she owed. The owner told her she could go home only after she paid off her debt. Maya noted that another brothel inmate, a woman from Trisuli, had worked there for thirteen years and had never managed to pay off her debt.

Maya was beaten severely for the first four or five days she was held in the brothel because she refused to have sex with customers. They continued to beat her until she submitted. Later on, she was beaten with bottles and thick sticks because she was not earning enough. She said that all the brothel inmates were beaten if they did not earn enough. Her customers included Indians and foreigners -- Germans, Singaporeans, Filipinos and Saudi Arabians. The customers would select the women they wanted, and the women could not refuse, or they would be beaten.

In the three years Maya was held in the brothel, she never received any form of contraception. Girls who became pregnant would be given abortions. The brothel did not provide condoms, but occasionally customers brought their own. Maya said that she never asked clients to use condoms because she did not know they could prevent AIDS. She said she had heard about AIDS, but did not know anything about it. Because she stayed in the brothel only a short time, she did not know the symptoms.

After one year in Bombay, Maya began to get sick. She developed a high fever and was taken to the doctor who gave her an injection, but she did not know what it was.

After working for three years in a brothel, I got HIV from clients. Then I was rejected by the brothel owner and came back to my home. But I am rejected by my stepfather and the people from my village. After that, I used to sleep in the public toilets and I suffered from many sicknesses. Now I am taking treatment for tuberculosis and getting support from WATCH.

"Santhi"

"Santhi", age twenty-nine, told that after she was tricked into going to India by traffickers who offered her work in a carpet factory, she spent more than ten years in Bombay brothels before finally making her way back to Nepal. In Bombay, she contracted HIV.

Santhi, who returned to Nepal in 1991 after more than ten years in a series of brothels in Bombay, had ran away from her home in Sindhupalchowk when she was a teenager. She went to Kathmandu where she first found work as a domestic servant. A male cousin came to Kathmandu to visit her and offered to help her get a job in a carpet factory in Birganj, a town on the Indian border. He told her that if she worked in the factory for two months she would begin earning a salary. Santhi left the house where she had been working and went with him. They travelled by bus, and then by train and then by taxi, going from Kathmandu to Birganj to Bombay. Midway, they were joined by an older man whom Santhi did not know.

When they reached Bombay they stopped in a park. Santhi was told to wait with her cousin. The older man left them in the park, and returned with a woman he introduced as his sister and said that they should go with her. They all got in a taxi and went to a house. Santhi was put in one room and the men were given another. That was the last time she saw them. Santhi found out later that a month after she arrived in Bombay, her cousin

took her sister from their village and brought her to Bombay as well. Her sister and she were bought by the same person, but were kept in different brothels.

When Santhi returned to Nepal, she was afraid to go directly home – worried her family would not accept her -- so she sent a message from Pokhara saying she had returned. It was the time of the Teej festival, when married daughters return to their home villages to visit their families. Everyone in the village came to the place where she was staying and hugged her and cried. Santhi lives in her parents' home. She says her family treats her well, because they know she had gone to India in order to find a better work. Her brothers are however, less welcoming, and Santhi thinks that she might face problems when her elderly parents die.

"Radha"

I was sold by my neighbors to Bombay before I was 15 years old. When I came back after eleven years of trafficking, I tried to get support from police and the local authority to punish the trafficker, but I never got the support. Yet, my husband, who rescued me and married me, was arrested because he filed the case. We have been threatened by the local political leaders many times.

"Sita"

"Sita", twenty-five, is a high-caste Hindu from a small village in Tanahu District, near Pokhara. Sita was married when she was fourteen. After two years of marriage, she became pregnant and her husband went to India in search of work. Her in-laws mistreated her so Sita returned to her parents' home. When five years later her husband came back from India, she and her son went back to live with him.

Six months after his return. His health began to deteriorate. He started loosing weight and suffered from diarrhea, high fevers and stomachaches. He was treated with traditional medicine and feels that he has been cured, although he remains very tired and weak and

cannot work. Sita has knowledge about HIV/AIDS and has also been to the hospital where she was told about her HIV positive status. She knows that she has been infected by her husband. More than herself and her husband she is worried about her son. She knows that once the villagers comes to know about their health it will be difficult for them to live in the village, because she has seen how people treats the sick.

These are the voices of the women in a National Public Hearing Programme organized by WATCH (Women Acting Together for Change). Article 20 of the Nepali constitution, adopted in 1990, prohibits trafficking in human beings, slavery, and forced labor in any form. Any contravention is punishable. However, manipulation of this law by politicians and other powerful people creates a positive environment for pimp and sex trade agents. Prevailing patriarchal law and those customary norms, which negate women's perspectives, will never offer justice to the victimized female members of our society.

The above four case studies tells us the different stories of the vulnerability of the women. In the case of Maya, she was the victim of child marriage and was later ignored by her husband and tortured by her in-laws. When she came back from the brothel, nobody is prepared to take her back. Without any fault of her, she was rejected by the society at large because of the stigma attached with the disease.

The second case study is about Santhi, who was taken to the brothel luring her to provide with the job. In her case however, her parents support her though she has HIV/AIDS but her brothers have a different perception regarding her disease.

Radha's case is somewhat different, here we don't know if she is infected with the virus. Though she says that she was involved in the prostitution for eleven years she doubts that she has HIV/AIDS. Her husband (who rescued her from the brothel) stands by her and it is the law and justice system of the country that is not supporting her case.

The last case study about Sita, who was infected by her husband, ignores her health and is hesitant to talk about it, because of the stigma and discrimination, she and her family has to face.

Women are marginalized from birth by socio-cultural pressures. In Nepal, once a woman has been wittingly or unwittingly forced into prostitution, there is no going home. Once she has been trafficked, a family's moral code means that even a daughter or wife is rejected, and it does not matter if she is sick or without a place to live. Prevailing patriarchal law and those customary norms which negate women's perspectives will never offer justice to the victimized female members of our society.

CHAPTER III

GLOBALIZATION AND HIV/AIDS: COMPARATIVE LITERATURE IN SOUTH ASIA

HIV/AIDS and Globalization

To quote Paul Kennedy, globalization is ***"the inter-connectedness of capital, production, ideas and cultures at an increasing pace."*** [1]

According to The Blackwell Dictionary of Sociology (Johnson 1995:122), *"Globalization is a process in which social life within societies is increasingly affected by international influences based on everything from political and trade ties to shared music, clothing styles and mass media."*

Disease epidemics have been related as both cause and effect to increasing integration of human economies, societies and cultures throughout history. It is well known that infectious disease is not equally distributed between different societies and different sections of the same society. This is clear on a global scale where disparities in exposure to infection and access to public health provision and health care are acute.

William McNeill (1977) was among the first to draw our attention to the role of epidemic disease in human history. Many subsequent authors have noted its importance, and most recently, Jared Diamond (1998) has informatively discussed its role in the increasing integration of human society and economy over the past 13,000 years (which may be another way of talking of "**globalization**). Scott and Duncan (2001), argued that the Black Death" in medieval Europe and other plague events must be understood as events affecting "metapopulations", a term used by ecologists to describe "populations of populations" (Scott and Duncan, 2001, 13).

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[1] Kennedy, 1996

They noted that the term is not usually applied to human populations but that it is appropriate in relation to studies of spatial heterogeneity of disease "where individuals can be either infected or uninfected, an example of the interaction between demography and disease"(Scott and Duncan, 2001, 13).

As early as 1988 the political scientist A.J. Fortin discussed the relations among AIDS order, writing of: "The use-value the epidemic possesses for an expansionary development establishment, as well as for the international power relations between the West and Third world that this sector has traditionally mediated through its development programme.[2] Perhaps the first attempt to relate HIV/AIDS explicitly to globalization came in a 1990 paper by John O'Neill, who referred to AIDS as *"a potential globalizing panic"* on two fronts namely,

- A crisis of legitimation at the level of global unisexual culture and
- A crisis of opportunity in the therapeutic apparatus of the welfare state and international medical order [3]

He used the term, 'a global unisexual culture' to mean a 'same-sex culture whose technological infrastructure is indifferent, benign or emancipated with respect to its male and female protagonists'

It is argued that the rapid spread of HIV/AIDS is linked with globalization, which makes it easier for people to travel and may promote some risk behaviors. HIV/AIDS is also undermining the benefits of globalization for many countries. Between 1960 and 1990, life expectancy in Africa increased by a very substantial nine years. The impact was to add between 1.7% and 2.7% a year to the growth rate of per capita gross domestic product (GDP). The HIV/AIDS epidemic, however, is reversing these gains. According to a World Bank report, HIV/AIDS may subtract an additional 1% a year from GDP economic growth in some sub-Saharan African countries, owing to the continuing loss of skilled and unskilled workers in the prime of life. In South Africa HIV/AIDS may depress GDP by as much as 17% over the next decade.

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[2] A.J.Fortin.1988
[3] J.O'Neill, 1990

The first significant international response to the new epidemic came in 1986 when the WHO established the Global Program on AIDS (GPA), based in its Geneva headquarters. GPA had three clear achievements:

- The establishment oh an international discourse around HIV/AIDS that stresses the language of empowerment and participation;
- Technical support for a number of developing countries in a range of policy and program areas;
- The mobilization of donor countries to support a multilateral response to the epidemic.[4]

Building on the strength of local and national community organizing around AIDS, GPA encouraged the formation of networks such as the Global Network of People Living with AIDS (GNP Plus), the International Council of AIDS Service Organizations (ICASO) and the International Community of Women Living with HIV/AIDS (ICW).

HIV/AIDS is a global pandemic affecting the ultimate metapopulation – the entire human community. Its distribution is unequal: ***spatially***, in terms of countries and parts of countries; ***socially***, in terms of social and cultural groups; and ***economically***, in terms of income and wealth classes.

Globalization impacts upon sexuality in all three ways:

- Economic changes mean that sexuality is increasingly commodified, whether through advertising or prostitution, which as I the nineteenth century is closely linked to economic dislocation and change
- Cultural changes mean that certain ideas about behavior and identity are widely dispersed, so that new ways of understanding oneself become available that often conflict bitterly with traditional mores
- Political realm will determine what forms are available for sexual expression[5]

[4] Mann and Kay, 1986
[5] Altman D, 1994

AIDS is the first epidemic of globalization. It has spread rapidly because of the massive acceleration of communication, the rapidity with which desire is reconstructed and marketed globally and the flagrant inequality that exists within and between societies. There are two key factors that have been critical to the global spread of the disease and are of particular relevance to business. One is ignorance and denial the other is increase in mobility and industrialization.[6]

HIV/AIDS has succeeded in joining the people around the world in a common consciousness about its threats and implications. It is the only disease to have a dedicated United Nations Organization-UNAIDS- charged with the single aim of confronting it. It is the first epidemic where the long-term implications could be recognized as they happen. Global Climate change has taught that human action has long-term consequences. This provides a better appreciation of the nature of risk and its social, spatial and temporal distribution. We recognize that risk is distributed unequally between the poor and rich, between one place and another, and that actions by few may create risks and hazards for the many. HIV/AIDS has struck at a time when we are able to perceive such events within very long-term scientific perspectives without taking refuge in millennial or apocalyptic responses.

The growing internationalization of trade in both sex and drugs has played a major role in the diffusion of HIV, and its rapid spread into almost every corner of the world. It has been argued, "patterns of use of illicit drugs are becoming globalized and standardized."[7] HIV/AIDS also creates much higher costs of health care for governments and may undermine health insurance schemes, as premiums become unaffordably high in countries with high prevalence rates.

[6] Singh, 2004
[7] Asian Harm Reduction Network Newsletter, 1998

For the past 20 years a few academics and policy makers have debates whether or not HIV/AIDS have social and economic impacts and what they might be. Most have preferred to ignore and deny the problem. It is surprising how few senior policy makers and even fewer politicians have been prepared to consider the potential consequences of the epidemic and what should be done about them. In part, this has been the result of the glacial pace at which governments and international organizations are able to move and change. But this is not the whole story. There has been full measure of denial. Some perhaps the majority, seeing no way in which to engage with what has appeared to be and has become an over term impact of the epidemic. Others fear the disease stigma may besmirch their professional lives.[8]

As globalization increases the number and reach of global health policies and initiatives, the data and statistics that inform policies and decision-making become increasingly important. Today, data collected in one context may affect policies that are implemented in others. The need for accurate data and informed analysis is therefore paramount.

Accurate data can be hard to find. Population health measures can suffer from limitations in collection and reporting mechanisms, or be skewed - upward or downwards - to meet political needs. For example, advocates bidding for scarce resources may exaggerate estimates of the numbers affected by a particular condition. Alternatively, disease-prevalence figures may be revised down for fear that they will discourage tourism or investment. Other difficulties include: Data may be partial and fragmented. In many countries, even basic data on the number of deaths from particular causes each year are not available. Morbidity data, which look at the impact on population health of non-fatal disease and injury, such as dementia or blindness, are even more rare. Health-adjusted life expectancy (HALE) is a summary measure for population health that helps to mitigate this problem by adjusting life expectancy at birth for time spent in poor health.

[8] Barnett T and Whiteside A, 2003

Policy-makers may not be able to compare the relative cost-effectiveness of different interventions. At a time when people's expectations of health services are growing and funds are tightly constrained, such information is essential to aid the rational allocation of resources. WHO's work on the cost-effectiveness of essential interventions aims to fill this gap.

In the past, HIV/AIDS data have been particularly vulnerable to distortions owing to fear, denial, or lack of capacity to report. This was particularly so in Africa, where data collection systems are weak. Recognition of this problem, and increasing international interest in and commitment to HIV/AIDS, now mean that HIV/AIDS data collection and analysis can attract more resources and technical support than similar work on other diseases.

There is a need to disaggregate data for the rich and poor within countries, and for men and women, to show differences in health risk and access to health services. It is also important to disaggregate global statistics and data to highlight experiences in the developing world. For example, at the conclusion of the 1994 Uruguay Round it was forecast that the Round would lead to an extra US$200-500 billion in global income over the first seven years; however, it was predicted that sub-Saharan Africa would lose US$1.2 billion. Similarly, while the world is on target to meet some of the Millennium Development Goals, regions such as sub-Saharan Africa are not.[9]

Gender-related distortions are of particular concern. Much of women's work is informal and is not reflected in gross national product statistics. As a result, women's contributions to development, as well as the impacts that policies have on them, are often ignored.

[9] Uruguay Round, 1994

Most statistics relate only to the formal sector - that part of the economy that is regulated and overseen by the government. However, the formal sector frequently represents less than 50% of a country's "real" economy. The informal sector is the part of the economy that escapes regulation by government authorities and therefore cannot be monitored. In developing countries, this sector is thought to be enormous. As a result, figures for labour, production and even trade are frequently extremely inaccurate. In health, differences between government and nongovernment health provision are captured through population-based surveys, which are used to complement data reported by state services.

Richard Parker has written: "In little more than a decade the rapid spread of the international AIDS pandemic has profoundly changed the ways in which we live and understand the world. Never has a common, global problem so clearly drawn attention to the important differences that shape the experience of diverse cultures and societies. And nowhere is this more true than in relation to our understanding of human sexuality."[10]

HIV/AIDS, Globalization and Gender

Gender is a dynamic concept, which looks at the interrelationship between men and women in the context of their society and roles in that society. Gender roles are defined as the social and cultural traits that different societies assign to males and females. Such gender roles are the patterns of behaviour, rights and obligations defined by a society as appropriate for each sex. A gender perspective is a way of looking at situations and issues taking into account the respective roles and contributions of men and women in society.

[10].Parker, 1994

In practically all cultures, women have a lower status than men. The differences between women and men in terms of enjoyment of rights, responsibilities, decision-making and access to food and other resources needs to be understood if efforts to improve health and nutrition are to succeed. It is recognized that a gender analysis of such inequalities and their consequences can result in more effective approaches to health, nutrition, water and sanitation promotion, disease prevention, health care and services, and research.

Women's economic, educational and health status is fundamental to human survival. Women are the main conduits for health knowledge, the main providers of health care and the primary carers of children. The consequences of woman's ill-health for her family and society are often severely underestimated. This is in part because women are statistically "invisible" in data and, as a result, priority-setting approaches can easily ignore women, in particular poor women and female children. It is increasingly recognized that development policies, including health policies, may fail or have very different outcomes than planned if gender is not considered.

Because women have so many roles in society, most of which are "hidden" from standard economic analysis, it is argued that women are often the "shock absorbers" for the neo-liberal economic policies most usually associated with globalization. For example, it is well known that when school fees or health fees are raised as part of efforts to reduce public spending, women and girls are the first to stop receiving education or health services. In addition, the movement from hospital-based to community care is placing an increasing burden on women, who traditionally care for the ill.

There is a debate about whether globalization has a different impact on men and women. It is argued, for example, that 90% of jobs created by FDI in export processing zones are given to women. This may then mean that women are lifted out of absolute poverty, or it may mean that wages and conditions are poorer than those otherwise offered to men.

It is also argued that the health consequences of globalization are more likely to affect poor women than poor men. For example:

- Pregnant women account for many of the deaths from malaria.
- TB is more prevalent among poor women than men as they have worse nutrition and are more likely to be confined to the home and less likely to receive treatment during their illness.

HIV/AIDS is increasingly affecting women: of the 4.2 million new HIV infections that occurred in 2002, 2 million or 48% were in women and over time the incidence of HIV infections is rising faster for women than men. Women also bear the further burden of caring for sick relatives and have far less opportunity to control their own sexual health, making them more vulnerable to HIV infection.

Traditionally trade policies have been considered to be "gender neutral" However, evidence is emerging that women economic globalization (including trade expansion) has a worse economic impact for women than for men. The effect of globalization on women is magnified as a result of existing patterns of inequality between women and men, including:

Distribution of the labor force by sector.

In most countries, women and men are distributed differently across manufacturing sectors, between the formal and informal sectors, and within agriculture. The uneven impact of globalization by sector therefore has gender-based effects, including increased female employment in labour-intensive manufacturing and increased male unemployment in formerly protected industrial sectors.

Areas of comparative advantage

For many developing countries, an area of comparative advantage is low-wage, labor-intensive employment, such as garment manufacturing (in which women predominate in the workforce). An export strategy based on low-wage female labor may increase the proportion of women in the labor force but may also increase the overall wage gap between women and men and decrease the prospects for closing this gap.

Distribution of productive assets

The ability to benefit from new opportunities is related to access to productive assets - including education, skills, property, credit - to which women traditionally have less access than men.

Distribution of unpaid household labor between women and men

Women continue to carry out a larger share of the work necessary to maintain families than men do. This necessary but unpaid work is generally not considered in trade policy debates.

Cultural Dimension of Globalization

There are many debates about whether globalization increases or reduces cultural diversity or homogenization. For many, the influences of Western culture through TV, cinema advertising, radio, etc. are substituting for and competing with local and minority cultures.

This process is often blamed for increasing risk behaviours such as smoking and alcohol consumption, increasing social conflict, loss of identity, dislocation and dissatisfaction. Others argue that greater cultural exchange is likely to increase tolerance and understanding, while more access to information can create lifestyle and social changes with health benefits, such as gender equality, greater respect for human rights, less stigmatization of people living with HIV/AIDS.

For many, the result of global communications is the global village, a term referring to the increased contact between cultures, identities and views across national boundaries that results from the application of modern communications. This represents a positive view of globalization in which societies come closer together and develop shared values and interests.

Global communications play an extremely important role in the cultural dimensions of globalization. The term refers to the use of new information communication technologies such as the Internet, mobile phones, e-mail, and satellite TV. These technologies are becoming cheaper and more widely available. The increasing ease and speed of global communication has both direct and indirect influences on health. For example, global advertising campaigns may increase levels of tobacco use but, on the positive side, the Internet democratizes access to information, making it easier for health professionals to access and share knowledge, information, and ideas on health.

Despite advances in global communications, a massive "information gap" remains between developed and developing countries. Over 70% of Africans will not make a

telephone call in their lifetime, nor use the Internet. However, radio broadcasts are thought to reach 70% of all Africans. Ownership and influence over the content of communications is important. It should also be noted that, while culture is affected by TV and cinema, a society's culture could be expressed and influenced in many different ways. All that can be said with any certainty is that the integration of global markets and communication channels leads to a much higher level of interaction. Whether this increases or decreases homogenization and risk behaviour remains to be seen.

Globalization in Nepal

Nepalese society which is characterized by diversity in caste/ethnicity, language, religion and culture has a very long unrecorded history mostly preserved through oral history and cultural practices, including myths and legends, such as Mundhum of the Limbus of eastern Nepal, handed down from one generation to the next. The written history is less than two thousand years old. The various indigenous people of Nepal developed their own social, cultural and economic system within specific geographical boundaries. Each groups developed its own system of rituals from birth to death; each group has its own system of marriage, family, kinship, religion, magic, maw, politics and distinctive language.[11]

Until 1950, there was hardly any external cultural invasion in Nepal because the autocratic Rana rulers had closed the country for the outside world. With the establishment of democracy in 1950, Nepal was opened to the outside world and the saga of external cultural invasion has been unfolding since then. In Nepal, External cultural invasion has penetrated through various subtle and gentle but powerful media, following Jurgen Habermas, money and power. Both money and power are translated into foreign aid, Western technology, television programs, radio, newspapers, magazines, CD Rom, Internet, books, motion pictures, missionaries and education. All these means invaded underdeveloped countries like Nepal as part of the process of neo-imperialism. This

[11] Bhattachan. B. K, 1999

process is often represented by terms such as modernization, globalization, market economy, privatization, democracy, Westernization and human rights.[12]

The overall picture is foreign investment in Nepal is very small even after globalization because of intrinsic constraints such as landlocked geography, lack of skilled and trained personnel, poor infrastructure and power, macro-economic instability, policy fluctuation and political instability.

Impact of Globalization

Positive impact of globalization, such as the benefits of modern science and technology, including better health care, transportation and communication, education and foreign consumer products can be seen in Nepal, but such benefits are the exclusive privilege of the elite class. The overwhelming majority of Nepalese people are actually experiencing all possible kinds of negative impacts.[13]

The negative impacts of Multinational Corporations on less developed countries in the areas of balance of payments, local business, employment-creation, technology transfers and general economic appear to be true in Nepal as well.[14] The major benefits of multinational corporations, such as capital, technology, managerial skills, access to foreign markets, low cost products, enhanced competition increased government revenues and capability, change in traditional value systems social attitudes and behavior patterns appear to be inapplicable to in Nepal.[15]

The main ***socio-cultural impacts*** of the process of globalization on Nepalese society are the development of "West is the best" psyche, passification, increasing rich –poor divide, sandwiched indigenous institutions and culture, rising individualism, marginalization of women and children, exploitation of biodiversity, loss of sovereignty and criminalization

[12] ibid
[13] Cohen and Frieden, 1981
[14] Biersteker J.T, 1982

[15] ibid

of politics, cargo-cult view of "about to arrive development", and guerrilla warfare and insurgency: a ray of hope?

AIDS epidemic in South Asia

South Asia is the region symbolizing unity and diversity. A common culture and ethos binds the peoples together as belonging to one great heritage. The land mass of South Asian countries which have embraced the idea of regional cooperation under SAARC-Bangladesh, Nepal, India, Pakistan, Bhutan, Maldives and Srilanka is 4.38 million sq. Km or about one tenths of Asia's total of 44.3 million sq. Km and the population of 1073.5 million is about a third of Asia's total of 300 million. South Asia constitutes only 303 percent of the world's land surface but about a quarter of its population.[16]

Except for Nepal, the countries of the region have inherited a common administrative structure developed by the British government; the colonial relationship hindered their economic development in general and their industrialization in particular. Despite resing trends of industrialization and urbanization, the region primarily remains agrarian defined by traditional, sex segregated ethos that adversely affects women's access to development inputs in decisive ways.

Even in the midst of growing levels of modernization and advancement these countries adhere to an orthodox Asian culture ambience (patriarchal structure) of which deference to the old by the young and to the male by the female is a distant feature. This generates another often –highlighted Asian trait of a strong culture preference for the male child who alone is to carry forward the family lineage.[17]

Another common feature of this South Asian Region is deep-rooted religiosity. Even though at least three major religions are practiced in the region (Hinduism, Islam and Buddhism) the populace is equally conservation and religious in outlook. Complementary

[16] Dr. Mathur D, 2001
[17] Ibid

to religiosity are strong kinship ties and a fairly rigid family structure, which has remained fairly resistant to change. The caste system though a part of the Hindu social structure, has influenced the societies of the entire sub continent including those practicing other religions like Islam, Buddhism and Sikhism.[18]

South Asia is the only country in the world in which exist such countries like Bangladesh, Maldives and Nepal, where female life expectancy is shorter than male life expectancy. About 80% of pregnant women suffer from anemia-the chances of survival and quality of life are projected significantly in the barriers they face in education, labor force participation, health care, civic life and many others. The socialization patterns have effectively constructed a low self-image and self- esteem, with women ranking themselves at least significant and as being least deserving. As a consequence they remain consistently distances from positions of power.[19]

Epidemiology

HIV/AIDS in Asia was first detected in the early to mid-1980s. Initial AIDS cases were detected among MSM in several Asia Pacific countries such as Australia, Japan, Malaysia, New Zealand, Singapore, and Hong Kong during the early 1980s. A relatively extensive spread of HIV occurred in MSM sex networks in these Asia Pacific countries and such transmission probably peaked during the mid-to-late 1980s.

By the mid-to-late 1980s, it became evident that transmission of HIV was also increasing among other major HIV-risk behaviour groups in Asia. High HIV prevalence (up to 50% or more) was documented among female sex workers (FSW) in Thailand and in parts of India, notably Mumbai (Bombay), during the mid-to-late 1980s. In addition, intense focal HIV epidemics were documented in Thailand, parts of northeast India, and the "golden

[18] ibid
[19] ibid

triangle" area (where the borders of China, Myanmar and Thailand meet) in IDU populations beginning around the mid-to-late 1980s.

During the 1990s, in several south and south-east Asian countries (Cambodia, parts of India, Myanmar and Thailand), significant heterosexual transmission of HIV continued or was first noted, primarily from FSW to their male clients, and then from those infected males to their regular sex partners. An explosive spread of HIV within IDU populations, which can lead to infection levels of over 50% within a year or two, continued to occur in several provinces of China, north-east India, Malaysia, Myanmar, Pakistan, Thailand and Viet Nam, and most recently, in the late 1990s, in Indonesia and Nepal. Although HIV can spread rapidly among IDUs who share contaminated injecting equipment, and from them to their sex partners, these epidemics have, so far, resulted only in limited spread of HIV to the heterosexual population at large. The highest HIV prevalence rate reached in a few Asian countries with extensive heterosexual HIV transmission has only been about one tenth of the highest prevalence rates found in some sub-Saharan African countries.

UNAIDS reports that in 2003, over one million people were newly infected with HIV in Asia and the Pacific, bringing the total number of people living with HIV/AIDS in the region to 7.4 million.

Social forces are at the root of Asia's HIV/AIDS epidemic. The economic upheaval of the past two decades has resulted in increased population mobility and environmental degradation that encourages people to move to cities in search of better opportunities. Sexual transmission of HIV is exacerbated by this mobility, with migrant workers spending long periods of time away from home and frequently visiting commercial sex workers-then returning home to infect their spouses, who in turn pass the virus to their newborns. Throughout the region, HIV is spreading along trucking routes, among traveling salesmen, sailors, soldiers, fishermen, and migrant workers, and within the sex industry, which is itself fueled by economic disparity.

Growing poverty among those who have not benefited from Asia's inclusion in the global economy is also driving increased injection drug use, and few countries have mounted an effective response to the drug-related HIV epidemic through either peer education or syringe exchange programs. There has been little political will to combat HIV among IDUs in the region as the epidemic has often been falsely perceived to be self-contained in this highly marginalized community. Another important factor to consider, in countries like Cambodia and Myanmar, is that war and prolonged civil unrest have destroyed much of the public health infrastructure and have encouraged increased commercial sex and drug use.

The potential for a large scale HIV/AIDS epidemic in South Asia and its devastating impact on the lives of children, women and their families cannot be underestimated. The AIDS epidemic claimed an estimated 3 million lives in 2003, and an estimated 5 million people acquired the human immunodeficiency virus (HIV) in 2003 - bringing to 40 million the estimated number of people globally living with the virus. These are the latest estimates published in the recently released UNAIDS/WHO annual report "AIDS epidemic update 2003".

As the world enters the third decade of the AIDS epidemic, the evidence of its impact is undeniable. Wherever the epidemic has spread unchecked, it is robbing countries of the resources and capacities on which human security and development depend. In some regions, HIV/AIDS, in combination with other crises, is driving ever-larger parts of nations towards destitution. The scale of the AIDS crisis now outstrips even the worst-case scenarios of a decade ago. Dozens of countries are already in the grip of serious HIV/AIDS epidemics, and many more are on the brink. Around the world, an estimated 5 million people became infected in 2003, 700 000 of them children. Over the next decade, without effective treatment and care, they will join the ranks of the more-than-20 million people who have died of AIDS since the first clinical evidence of HIV/AIDS was reported in 1981. It is equally clear that the vast majority of people (including those living in countries with high national HIV prevalence) have not yet acquired the virus. Enabling them to protect themselves against HIV, and providing adequate and affordable

treatment and care to people living with the virus, represent two of the biggest challenges facing humankind today.

The AIDS picture in South Asia remains dominated by the epidemic in India. Latest estimates show that about 5.1 million [2.5–8.5 million] people were living with HIV in India in 2003. Serious epidemics are underway in several states. In Tamil Nadu, HIV prevalence of 50% has been found among sex workers, while in each of Andhra Pradesh, Karnataka, Maharashtra and Nagaland, HIV prevalence has crossed the 1% mark among pregnant women. In Manipur, meanwhile, an epidemic driven by injecting drug use has been in full swing for more than a decade and has acquired a firm presence in the wider population.

HIV/AIDS is not the first global epidemic and it certainly wont be the last: it is a disease that is changing the human history. HIV/AIDS shows the global inequalities. It will alter the history of many of the world's poorest societies.

CONCLUSION

CONCLUSION

As Kofi Annan pointed out in his speech to the UN General Assembly Special Session on HIV/AIDS:

> *"The battle against HIV/AIDS can only be won if women are fully educated and enjoy their full rights, including devising society's collective response. It has been said that "girl power is Africa's own vaccine against HIV/AIDS" and that should be true for the whole world.' Empowering women and young girls is therefore central to any intervention strategy against HIV/AIDS, but there should be attention for the phenomena a full say in of masculinity as well. Men are also responsible in matters of reproductive health and more insight in male attitudes and behavior could be helpful for devising male-focused behavior interventions".*

Thus, HIV/AIDS among women cannot be eradicated by simply treating it as a health issue. It is essential to link this debate on HIV with broader social issues, with specific focus on gender relations. It is important to understand the social and structural context within which women are placed. The issues that address the unequal relations between men and women, and passive role of women in decision-making processes need to be emphasized. These debates not only point towards the vulnerability of women to HIV/AIDS, but also focus on the need to evolve basic strategies to aware, educate and empower women.

A long-term process that challenges the patriarchal structure of our society in which men and women are asymmetrically situated and where women are not allowed to make any sexual choices need to be initiated. Along with this, short-term programmes such as awareness plans, plans that propagate use of precautionary methods should be implemented.

Since HIV/AIDS-related social issues will vary from country to country they will need to be addressed within their specific sociocultural context. Understanding contextual factors is crucial not only for HIV prevention through behavior change interventions but also for the delivery of new biomedical innovations such as antiretroviral drugs to treat HIV-infected people and female-controlled protection methods (microbicides).

It is not a matter of simply transferring global knowledge from one situation to another; on the contrary, such knowledge has to be adapted to specific local circumstances, conditions and culture. In underdeveloped countries like Nepal where strong patriarchal social order prevails, women are not allowed to make important decisions within the community or even family. The lower social and economic status of women in these countries deprives them of any right to express their sexual choices. However, there is no such strongly defined sex taboo on men in Nepal due to which a large number of men may have multiple sex-partners. There is large possibility of these men getting affected by HIV, which in turn makes their wives and children vulnerable to this disease.

As stated in earlier chapters that a large number of men migrate from Nepal to countries like India in search of jobs. This section of population is more susceptible to sexual diseases. Similar is the case with a huge number of transport workers in this region who may establish sexual relations with several partners. In the process they carry this infection to their spouse in Nepal.

While men need to be convinced and enticed into using their freedom to protect themselves from the virus, women need to be given the freedom that they now lack. Girls need to be educated and women need economic independence and security. In the words of the World Health Organization: "they must be empowered so that they are able to control their lives and in particular their sexual relations." This will require a profound shift in social and economic power relations between men and women, through increased educational and employment opportunities for girls and women, as well as public education campaigns on the harmful effects of unequal gender relations. Awareness of the risks and transmission of the virus is a necessary first step, but the pandemic is unlikely to be brought under control

unless the underlying cultural an economic factors that put both men and women at risk are changed as well.

Women's needs are different from men's and policy makers have to take this into consideration. Women should be offered appropriate information and education so that they can make informed choices. This should take into account their particular social and economic circumstances, as information is not enough if women are not in position to have control over their own lives and bodies. We know that AIDS does not have medical treatment so only awareness regarding AIDS is only the solution. What is needed now is massive mobilization of both government and civil society to end discrimination against girls and women and abuses of their human rights.

In the contemporary era where processes like globalization and commercialization have come to dominate the social and cultural scenario of our society, it is essential to grasp how these processes affect the health conditions of women, with specific reference to HIV. These processes have provided opportunity to people from different parts of the world to connect together. This has resulted in increasing awareness among people regarding various dreaded diseases like HIV. This can be regarded a positive step towards reducing the risk of these diseases. However, there are many negative affects of globalization process.

For, instance it increases the gap between rich and poor, thus making it difficult for the poor to afford the treatment for such dreaded diseases. Also this process has increased the incidence of poverty among women due to which they become more prone towards HIV/AIDS as a result of unprotected sex. Furthermore the process of globalization and materialistic way of living among the youth legitimizes the patriarchal social order. The consumerists approach among youth devoid them of their capacity to critically analyze the exploiting social relations prevailing in our society.

Also it is important to understand that AIDS should be seen as any other serious disease. However, the attitude of people in our society towards those who are infected by this virus

is socially constructed. This implies that the stigma that society attaches towards this disease makes it difficult for the infected people to cope with it. Hence, there is a need to use agencies like mass media and press-media to educate people about this disease. These agencies can help creating an inclusive society where infected people are not socially boycotted but are instead taken care of.

AIDS is an extraordinary kind of crisis; it is both an emergency *and* a long-term development issue. Despite increased funding, political commitment and progress in expanding access to HIV treatment, the AIDS epidemic continues to outpace the global response. No region of the world has been spared. The epidemic remains extremely dynamic, growing and changing character as the virus exploits new opportunities for transmission.

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Acronyms and Abbreviations

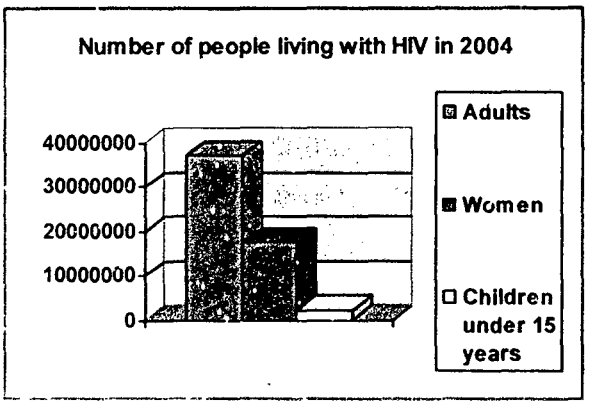
AIDS	Acquired Immunodeficiency Syndrome
ARV	Antiretroviral.
BBC	British Broadcasting Company
CBO	Community Based Organisation
CBS	Central Bureau of Statistic
CWIN	Child Workers in Nepal
DDC	District Development Committee
DNA	Dioxiribose Nitric Acid
DoH	Department of Health
FHI	Family Health International
FPAN	Family Planning Association of Nepal
FSW	Female sex Worker
GAD	Gender and Development
GDP	Gross Domestic Product
GNP	Global Network of People Living with AIDS
GO	Government Organization
GPA	Global Program on AIDS
GRID	Gay Related Immunodeficiency Syndrome
HAART	Highly Active Antiretroviral Therapy
HALE	Health-Adjusted Life Expectancy
HB	Hepatitis B

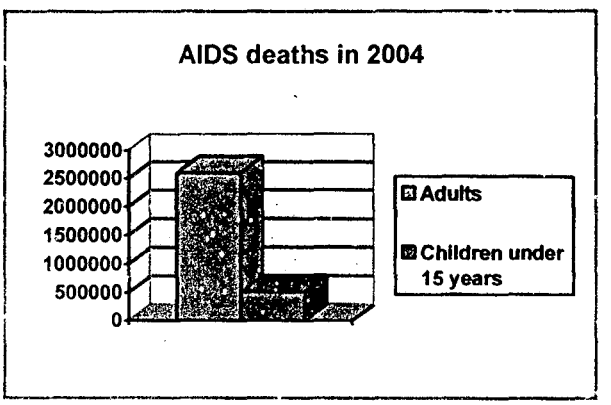
HD	Human Development
HDI	Human Development Indicator
HDR	Human Development Report
HIV	Human Immunodeficiency Virus
HTLV	Human T-Cell Leukemia Virus
ICASO	International Council of AIDS Service Organizations
ICW	International Community of Women
HMG/N	His Majesty The Government of Nepal
IDU	Injecting Drug Users
ILO	International Labour Organization
INGO	International Non-Governmental Organization
MMWR	Morbidity and Mortality Weekly Report
MOH	Ministry of Health
NCASC	National Center for STDS and AIDS Control
NGO	Non-Governmental Organization
SIV	Simian Immunodeficiency Virus
SLC	School Leaving Certificate
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNICEF	United Nations International Children's Emergency Fund

US	United States
VCT	Voluntary Counseling and Testing
WAD	Women and Development
WATCH	Women Acting Together for Change
WHO	World Health Organization
WID	Women in Development

Table I

Global Summary of the AIDS Epidemic December 2004





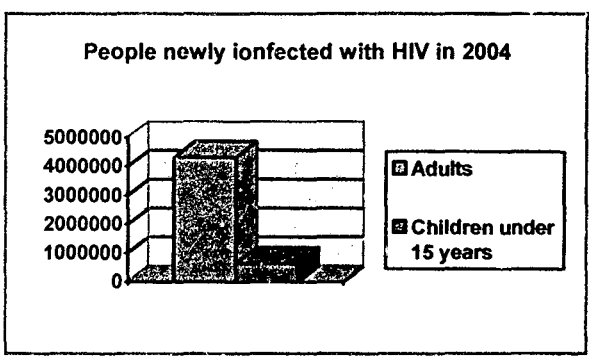


Table II

Year wise detection of HIV/AIDS in Nepal

1988-2003

Year	Sample	HIV+			AIDS		
		Male	Female	Total	Male	Female	Total
1988	9016	3	1	4	1	1	2
1989	5180	0	2	2	0	0	0
1990	8619	2	3	5	0	2	2
1991	17000	12	14	26	2	3	5
1992	33995	39	38	77	1	4	5
1993	38228	41	40	81	4	6	10
1994	16523	18	22	40	2	9	11
1995	21867	71	39	110	12	4	16
1996	10457	50	86	135	13	18	31
1997	9475	394	95	489	76	24	100
1998	3611	166	54	220	38	16	54
1999	5170	174	48	222	35	19	54
2000	3039	301	95	396	117	48	165
2001	1470	264	60	324	62	23	85
2002	5596	360	107	467	70	14	84
2003	2179	505	209	714	61	19	80
TOTAL	191425	2400	912	3312	494	210	704

---Source NCASC

Table III

Ministry of Health
National Center for AIDS and STD Control
Teku, Kathmandu

Cumulative HIV/AIDS Situation of Nepal
As of May 31, 2005

Condition	Male	Female	Total	New Cases in May 2005
HIV Positives (Including AIDS)	3636	1357	4993	89
AIDS (out of total HIV)	638	250	888*	12

Cumulative HIV infection by sub-group and sex

Sub-groups	Male	Female	Total	New Cases in May 2005
Sex Workers(SW)		580	580	2
Clients of SWs/STD	2599	73	2672	37
Housewives		646	646	15
Blood or organ recipients	7	2	9	
Injecting Drug User	961	15	976*	27
Children	69	41	110	8
total	3636	1357	4993	89

Cumulative HIV infection by age group

Age group	**Male**	**Female**	**Total**	**New Cases in May 2005**
0-4 years	35	22	57	3
5-9 years	27	19	46	5
10-14 years	18	7	25	
15-19 years	173	173	346	
20-24 years	701	331	1032	10
25-29 years	928	351	1279	16
30-39 years	1360	349	1709	41
40-49 years	332	91	423	13
50 above	62	14	76	1
Total	**3636**	**1357**	**4993**	**89**

* Death – 249 (New death cases in May 2005 – 3)

** Mode of Transmission – IDU or Sexual

(Data include reports from sentinel surveillance sites and voluntary confidential testing centers.)

Source of May 2005 data: National Public Health Laboratory, Teku; Teku Hospital, Teku; National Center for AIDS & STD Control; AMDA STI, Hetauda; Youth Vision VCT, Putalisadak; N-SARC VCT/DVD-Bheri Zonal Hospital, Nepalgunj; SACTS VCT, Thapathali, INF Paluwa, Pokhara