HIV/AIDS IN NEPAL: THE MAKING OF A CULTURAL MODEL

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Introduction

HIV/AIDS has become a prominent problem in the tiny South Asian country of Nepal. Experts have stated that the number of AIDS cases has increased fifteen-fold over a three-year period (1990-93) and the numbers were expected to reach 100,000 cases by the year 2000 (Suvedi, Baker and Thapa 1994). Although the numeric impact of HIV/AIDS has not been as dramatic as anticipated,[1] it is expected that AIDS will grow at an alarming rate over the next few years. One author proclaims AIDS as a "coming crisis" for Nepal (Seddon 1995).

The way people make sense of illness is, in part, culturally determined. Existing beliefs and presuppositions shared by a community (cultural knowledge) regarding illness plays a significant role in shaping an understanding of newly emerging illnesses in any given culture. This cultural knowledge is organized as cultural models, which are utilized to "make meaning" of new situations such as the HIV/AIDS epidemic. These cultural constructions (cultural models) of illness can also contribute to the spread of the epidemic.

In this paper I examine the various factors involved in the creation and spread of a dominant cultural model of HIV/AIDS in Nepal. This process seems to be the result of a complex combination of factors, both cultural and biological. I will introduce the dominant cultural model of HIV/AIDS and examine the role that NGOs, doctors and policy makers, the media, and underlying biologically based schemata have all played in the making of a dominant cognitive model of HIV/AIDS in Nepal. The resultant model is a type of hybrid model based on the application of traditional ideas (underlying culturally-based illness schemata), the strong influence of an imported

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Western model of HIV/AIDS (especially the aspects of this model that are reinforced by pre-existing cultural schemata), and universal biology.

The findings of this paper are based on a larger study of HIV/AIDS in Nepal, which included 1) an ethnomedical study (cognitive anthropology) that examined cultural models of illness and the schema which underlie these cultural models, explicitly focusing on villagers perceptions of the newly emerging phenomena of HIV/AIDS, 2) a discourse analysis (linguistic anthropoloy) study of 30 narratives of persons living with AIDS (PWAs), in-depth interviews with multiple HIV/AIDS NGO staff, a knowledge, attitudes, practices (KAP) study conducted among Nepali doctors and a six month study of the Nepali media's presentation of HIV/AIDS. The data collected was presented as a doctoral dissertation for the department of anthropology at Washington State University (Beine 2000b).

Cultural models of HIV/AIDS in Nepal

In my doctoral dissertation I explored various cultural models of HIV/AIDS that exist among different sub-groups in Nepal and examined the various schemata that inform these models. Based on the findings of my research I also proposed a dominant cultural model of HIV/AIDS that influences these various sub-group models. The three major components of this dominant model are fear, hate and blame. The research also demonstrated widely shared understandings of HIV/AIDS as a fatal, infectious, and sexually transmitted disease. The research also illuminated common themes regarding AIDS as a "bad person's" disease, AIDS as the result of bad *karma*, and the belief in a strong connection between worry and disease. Based on the data, I have proposed a dominant cultural model of AIDS in Nepal that encompasses these features as major elements (Figure 1). As can be seen in Figure 1, however, there are also slightly modified cognitive models held by different sub-groups (e.g. rural versus city PWAs, and urban female PWAs versus urban male PWAs). These sub-group models still encompass the major features of the wider model, but differ from one another in significant ways as well. Although these differences are of interest, I will focus here mainly on the creation of the dominant model. It is this model that is being disseminated widely and is having the greatest impact in shaping people's understandings of HIV/AIDS. It is, therefore, this model that I expect to have the most impact in the coming years. For a more complete explanation of the dominant cultural model, the various sub-group models and the various

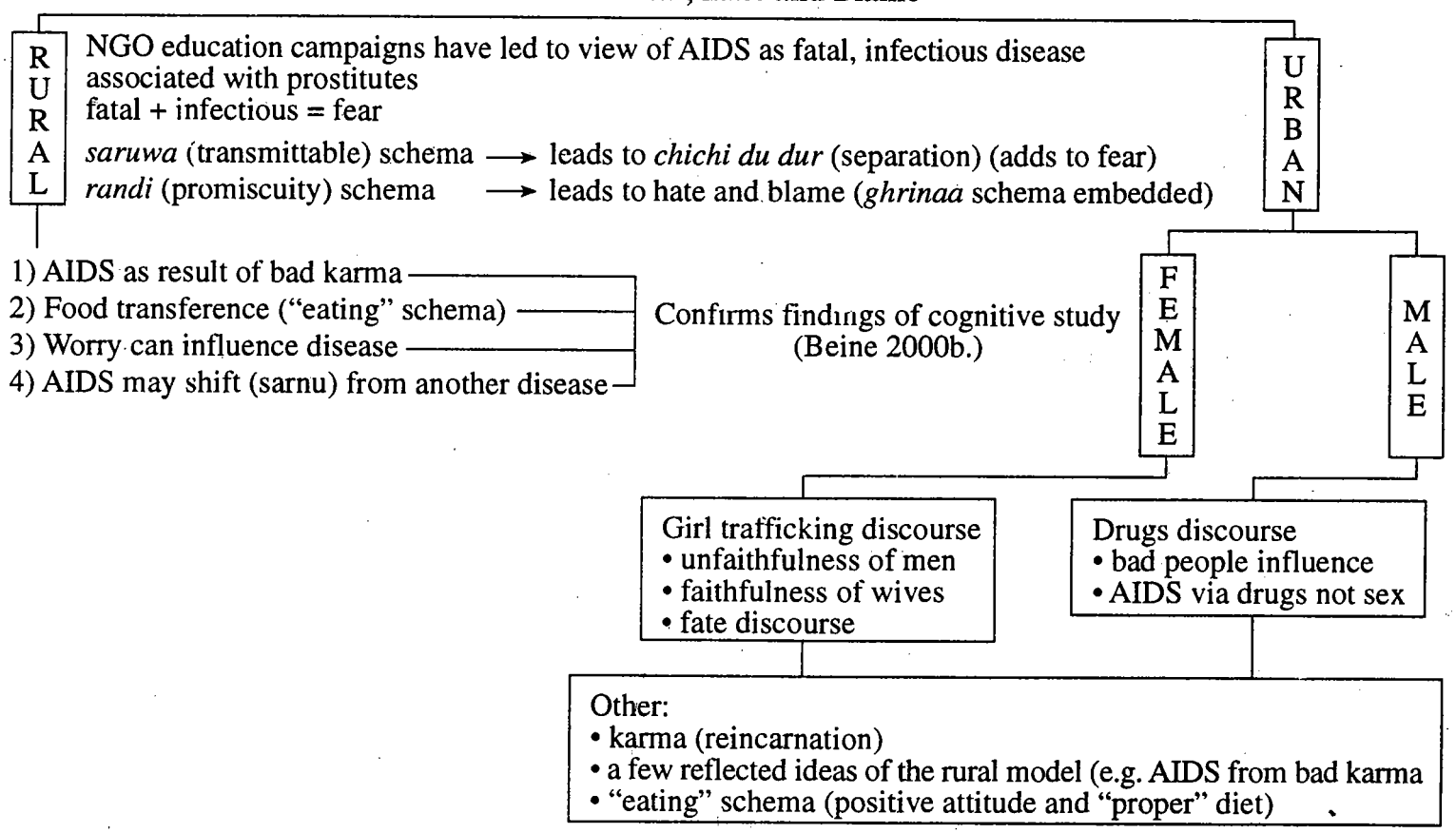

Figure 1 Cultural Model of HIV/AIDS in Nepal (including embedded schemata)

embedded cognitive schemata, the reader is encouraged to consult Beine (2000b).

The role of NGOs

Western NGOs (non-governmental organizations) have contributed greatly to the dominant cultural model of HIV/AIDS in Nepal. There are currently nearly 100 NGOs working in the area of AIDS education and prevention in Nepal.[2] The education and prevention models employed by these organizations are drawn from the National Center for AIDS and STD Control (National Center), an organization charged with coordinating all AIDS education and prevention throughout the country. And the education and prevention models promoted by the National Center are mainly borrowed from the West (Beine 2000b). Therefore, the strategies employed and materials distributed focus primarily on the issues these Western organizations (based on the findings of Western KAP/KAB studies) have recommended. Western models dominate the AIDS discourse in Nepal. The result is an emphasis on awareness building that portrays AIDS (even using Western illness schemata[3]) as a highly communicable and fatal disease associated most directly with prostitution and drug use. The findings of my research studies (Beine 2000b) would suggest that the awareness building campaign, led by the various NGOs, has been fairly successful at promoting these associations with AIDS across the country. The concepts of AIDS as fatal, infectious and sexually transmitted are, therefore, a direct result of the Western-style awareness building campaign.

The influence of bikas

In Nepal deference is often shown toward anything considered *bikasi* (developed). Implied in this is the assumption that traditional is bad (usually referred to as "backwardness") and *bikas* (development) is good, as demonstrated by Pigg (1996). Given this deference to Western development, it is no surprise that deference has also been displayed toward the ideas of Western experts in the domain of HIV/AIDS education and prevention. Deference toward Western models (even when their impact is questionable) is quite obvious. The Nepali director of the National Center recently displayed deference toward the continuation of current Western approaches despite evidence that they may not be very effective. Karki (1998) displayed an understanding of the "KAP gap" problem when he acknowledged that

"although awareness of sexually transmitted diseases (STDs) and HIV among commercial sex workers (CSWs) is generally high...there is a wide gap between knowledge and practice" and that "regardless of how much one knows, it is often not translated into action." Yet, "awareness building," the recommended strategy of the various NGOs involved, remains the major thrust of the prevention campaign. Although condoms are made available free to the population by the Nepali government, not many people use them. Karki (1998) freely admits, "It is irony that in spite of much effort to make condoms available to all sex workers and their clients, it is estimated that less than 50% of sex workers or clients use condoms." Even so, Karki (1998) concludes that, "Condom promotion and its use by a large number of clients should be the target for the future." Awareness building (stressing the fatal, infectious and sexually transmitted nature of AIDS) and condom promotion have been strongly promoted by Western organizations consulted by Nepali AIDS prevention planners. And despite an apparent understanding of the limitations of an emphasis on awareness building and condom distribution, deference has been displayed toward this Western (developed) approach.

Given the sexually conservative nature of Nepalese public life, I have been very surprised at the small amount of controversy that the emphasis on condoms in the pubic sphere has created. Although I have heard some criticism, there has generally been a wide acceptance of the saturation of the country with condom billboards. Again, this would seem to suggest that AIDS is understood as a Western disease, and the approaches to combat it (e.g. the media condom campaign) have been suggested by the West, therefore deference is displayed toward the public display of sexuality, even when it violates cultural norms. Given the history of development in Nepal it is not a surprise that the evolving AIDS prevention campaign would be a product of Western development paradigms.

The Development Industry of AIDS in Nepal

Closely related to the idea of *bikas* is the fact that Nepal, being a poorer country, has created a development industry. AIDS is no exception. Back in 1995 David Seddon expressed concern that,

> There is a real danger that the prospect of an epidemic will attract organizations and individuals whose interest lie more in the resources that are now being made increasingly available to NGOs for work on HIV-AIDS related issues and will not serve

> the interests of those directly and indirectly threatened by the disease. Already it seems that everyone in Kathmandu seems involved, everyone after money, that is (according to one expatriate commentator). (1995:9)

Likewise, a Nepali policy maker commenting on this trend said,

> Unfortunately, the disproportionate amount of money that has gone into HIV/AIDS prevention in Nepal compared to other less glamorous diseases like TB and malaria have spread the perception that AIDS is a donor-driven agenda in Nepal and that bigger killers do not get the same attention. This is to a certain extent true, and informal polls of journalists in Nepal show that most reporters and editors believe that AIDS is getting undue attention. Whatever the truth, AIDS organizations are also perceived by some journalists as 'dollar harvesters.' This has created some problems for organizations dealing with media sensitization, because some reporters seem to think that they are being "used." AIDS organizations and their media advisors need to look at this problem seriously and not underestimate their potential to damage their work. (Dixit 1998)

It seems that Seddon's predictions may have come true. Although the prevalence rate country-wide is less than 1% and various other diseases actually kill many times more people in Nepal than does AIDS, there are currently more NGOs working in the area of HIV/AIDS in Nepal than in these other areas, such as TB and malaria control. The fact is that development in Nepal, including health development, follows a donor driven agenda, and AIDS is currently a hot topic internationally.

The Impact of Traditional Schemata

Traditional ideas also are being reinforced by the NGOs working with HIV/AIDS. Unfortunately, many of these practices are further reinforcing the stigma associated with AIDS. For instance, a worker at one NGO that repatriates CSWs and works to give women other economic options, told me that this NGO was building a special home for the girls that tested HIV positive and for the girls with "other diseases." When I asked about who else,

besides the HIV positive girls, would be kept at the new home, I was told "those with tuberculosis and hepatitis B." I was told that since these diseases are "contagious" they want to keep those infected away from the other girls. The NGO director said "we don't want the other girls to be victimized." What is most unfortunate is that the HIV positive girls (not a risk to other girls unless sexually active with them) are very susceptible to other infections such as TB. Putting these girls together with TB carriers is like a death sentence for the persons with AIDS (PWAs).

Ideas about the possibility of non-sexual transference of the disease are also being applied to AIDS intervention work. One NGO director contended that even though there are many organizations working with HIV/AIDS in Nepal, their staff "won't live in the same houses, use the same kitchen or eat off the same plates" as the PWAs. She also gave an example of an international conference she attended in which she was the only female NGO director who was willing to share a room with female PWAs. The the traditional illness schemata of *sarawa* (transmittable) and *chichi durdur* (separation) although not mentioned by name, are clearly evident in these examples. Again, although various NGOs are working hard to bring HIV/AIDS to the forefront in Nepal, many are participating in practices that are unnecessarily perpetuating stigma and even hastening death.

I found that many of the wider illness schemata identified in my earlier studies[4] were also being applied by many of the NGO staff working with PWAs. For instance, in regards to treatments for AIDS, love, good diet and hygiene were the most common recommendations. One NGO director told me,

> If you are healthy (eat well and don't worry) you can stop the growth of that virus. If you are not healthy, then naturally, from both the sides—health-wise and disease-wise also, the virus will eat you up.[5]

Directors of three other AIDS related NGOs similarly told of the importance of 1) love, 2) good diet, and 3) keeping a positive attitude. These are all traditional ideas about illness that have been applied to HIV/AIDS as well.

The role of doctors and policy makers

Nepali doctors and policy makers have also been influential in creating and confirming elements of the wider cultural model. First, through deference to Western education and prevention models (as noted above), the doctors and policy makers have promoted the aforementioned elements (AIDS as fatal, infectious and sexually transmitted) of the major cultural model. Next, doctors and policy makers have been influential in perpetuating these ideas via the media as we will see in the next section. Finally, doctors have also sent powerful non-verbal messages through their actions that have confirmed many of the traditional schemata associated with AIDS in the minds of the general public. For instance, the common practice of doctors refusing to treat patients once they know they are HIV positive is well documented throughout the narratives of thirty PWAs (Beine 2000b).[6] This practice has also been well documented elsewhere (Dixit 1996; Karki 1998) and we will see further examples of it in the media in the next section. I personally encountered many experiences that further confirmed this practice. Besides the various stories told to me by PWAs, I was told directly by several doctors that they are aware of colleagues who will not treat PWAs. An incident of mistreatment of a PWA also occurred at Patan Hospital during my research that prompted a scolding letter from the hospital director (Figure 2).[7] Some members of the Emergency Room staff had refused to treat (or even touch) a patient once their HIV status was revealed. One NGO director told me of several incidences in which she had taken her HIV positive girls in for treatment, but they had been told to go to another place for treatment. After arriving to the recommended location they were also refused treatment by medical professionals. And another NGO director told me of her friend (a female medical doctor) who refused to touch her when the doctor discovered that a PWA had vomited on her. It seems that fear is prevalent amongst many in the medical community.

The findings of two different KAP studies done among doctors in Nepal (Bhattarai, Karki and Naing 1999; Beine 1999) suggested that the knowledge of the majority of the doctors surveyed was adequate in many areas of HIV transmission. Nevertheless, there were certain areas where a surprisingly large number of doctors seem to be following the Nepali cultural models of AIDS rather than biomedical knowledge as it relates to HIV/AIDS. For instance, in the first study 44.5% of the doctors agreed that it was necessary

to fumigate the bed and the room occupied after the discharge or death of any AIDS patient (Bhattarai, Karki and Naing 1999:6).[8]

Likewise two-thirds of the doctors agreed that gloves need to be worn while feeding an AIDS patient or wiping saliva from his/her mouth and only half responded that HIV positive patients can be kept in wards with other patients (Bhattarai, Karki and Naing 1999:7). Wearing gloves while feeding AIDS patients and keeping patients in separate wards are both medically unwarranted practices (Bhattarai, Karki and Naing 1999:22). Likewise, 56.7% of the doctors responded affirmatively or undecidedly when asked if AIDS is a problem of moral behavior (45.4% yes, 11.3% undecided) and 31.9% answered affirmative or undecided when asked whether they would feel uncomfortable inviting someone with HIV/AIDS into their home (Beine 1999). Although the questionairre was a "tick the box" type, one respondent even wrote in reply to this question, "I know I shouldn't, but still I hesitate."

I also asked questions regarding two popular rumors that were circulating around Nepal during the time of my research. The first had to do with a rumor that people were using HIV infected needles to "pump up" raw chickens with water before their sale in order to increase their profits. According to the rumor, people were eating the chickens and becoming infected with HIV. The second had to do with PWAs (the newspapers labeled these people "AIDS junkies") leaving "infected needles" hidden in the cushions of movie hall seats where an unsuspecting victim would later enter (in the dark) and sit on the needles, stabbing themselves, thus becoming infected with the HIV virus.[9] It must be noted that the HIV virus is generally very weak and would not likely survive cooking nor even being out of the body long enough to be put in a syringe and stabbed through cushions into another person. In fact, the odds of infection from blood transferred directly from body to body via needles (such as inadvertent medical needle sticks) is only one in two hundred and fifty (Bhattarai, Karki and Naing 1999:24). Suffice it to say, that the chicken rumor is virtually impossible and the movie hall rumor, although theoretically possible, is also extremely unlikely according to medical professionals. Yet it was surprising to me that seventeen percent of the medical doctors either expressed belief in, or the possibility of, transfer of AIDS via eating chicken (4.1%) or were uncertain about the possibility (13%) of this mode of transmission. One Western-trained medical school professor commenting on the question volunteered, "We have been teaching this as a possibility in our environmental health course, but the evidence is not conclusive." Likewise, 59.3% expressed belief

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G. P. O. Box 252
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To: Patient Hospital Doctors, Health Assistants, and Nurses
From: Dr. Mark Zimmerman, MD
Date: 8 October 1998

Concerning: **The care of HIV positive patients**

Dear Colleagues,

HIV positive patients pose a number of clinical, social and emotional problems. From time to time, we all need to be reminded about their appropriate care. Recent incidents with two such patients lead me to write to you at this time.

- Examination and referral of HIV positive patients

At Patan Hospital, we expect that all doctors, health assistants, and nurses will provide the same excellent care to HIV patients as they do to all patients. Because of the extremely low likelihood of a medical care giver ever getting HIV from a patient, and because protective equipment is available to all who work in this hospital, there is no excuse for anyone to refuse to see a patient who is HIV positive or to limit the care given.

- Writing and speaking about the "HIV" status of the patient

Universal precautions mean that all blood and body fluids should be treated as if it were positive for HIV. Because more than 90% of the HIV in a community is likely to be unrecognized, it is essential that you take appropriate protective measures for all patients whose body fluid may come into contact with you.

The policy of Patan Hospital and its Infection Control Committee is that we DO NOT label specimens, patient charts or lab slips as being "HIV", "HBV", or even "high risk". If we take special precautions with these few patients, it leads to carelessness with other patients (some of whom will be positive, but unrecognized.)

You should take measures to assure confidentiality about the patient's disease. DO NOT write boldly "HIV" on places where this might be seen by non-staff. It may be best on rounds to speak of a patient's "immunodeficiency virus" rather than saying "HIV" in front of visitors. As with all diseases, a particular patient's HIV status should not discussed outside the treating team.
Thanks for your help in this challenging area.

Sincerely,
Mark

Mark D. Zimmerman, MD

Figure 2 Hospital Director's letter to address mistreatment of PWAs at Patan Hospital.

in, or were undecided about, the possibility of contracting HIV through a needle stick at a movie hall (36.4% yes, 22.9% undecided). It seems that a surprising number of medical doctors are acting, in part, on the cultural model of AIDS as it relates to *sarawa rogs* (transmittable disease including the concept of *chichi durdur [separation]*) rather than trusting the biomedical knowledge on the subject.

I should make the point that the figures above suggest that the majority of Nepali doctors do not share these opinions and seem to be treating AIDS patients appropriately. I should also point out that these types of irrational beliefs (medically speaking) are not restricted to Nepali doctors or even to doctors working in the developing world. A KAP study conducted among primary care physicians in New York State in 1988 demonstrated that eleven percent of the medical doctors surveyed believed that it was either very likely or somewhat likely that a person could contract the HIV virus by being coughed on or sneezed on by a PWA (Gemson et al. 1991).

Although it is clear from the figures above that the number of medical doctors who hold these opinions comprise a minority, the impact of this minority's beliefs and actions upon the wider cultural models of AIDS is great. Many stories about doctors refusing service to AIDS patients have been published in the media. A doctor treating an AIDS patient is not "news" while one who refuses to treat a PWA is "news." The result is that only stories about doctors not treating or mistreating PWAs are published, thus generating a perception among the general public that normalizes the practices of the minority. And since they are doctors, the general public, not being privy to the majority view, defers to the understanding of their "developed" countrymen. Thus, some doctors further perpetuate a cultural model (based on the application of traditional schemata). I will talk more about the role of the media in the creation of a cultural model in the next section.

Doctors' refusals to touch and treat PWAs also have had an impact in the creation of a cultural model in the village area. In a discussion regarding the modes of transmission, one villager told me "even city doctors are not touching people with AIDS. We read about it in the paper. They are educated people! What do we know? We are simple villagers. They are the developed (*bikasi*) ones." His response was in reply to my question of why he believed that AIDS could be spread through touch. Here we see that the doctors' actions have been used to confirm the application of traditional ideas regarding *sarawa rogs* to AIDS. And as can be seen by the figures above, the

doctors' beliefs about the separation of AIDS patients from others also confirms the traditional concept of *chichi durdur* (separation). We also see, again the impact of the deference displayed toward those considered more *bikasi.*

Medical doctors also have contributed to the element of blame in the wider cultural model. First of all, in response to the question about which groups of people in Nepal are most greatly affected by AIDS, prostitutes and drug addicts were the two most frequent responses. Although these two groups are, in fact, the two most affected groups, they are also traditionally considered "bad people" as has been previously noted. The association of AIDS with these groups, therefore, has inadvertently created the image of AIDS as a "bad people's" disease, thus warranting blame. And a little less inadvertently, a surprising number of doctors (as noted above) considered AIDS a problem of immoral behavior. This certainly perpetuates the idea that AIDS is a "bad people's" disease, which creates societal blame and hate and further stigmatizes those with the disease.

It is clear that some of the doctors are employing a cultural model of AIDS that is a product of both imported Western ideas (fatal, infectious and sexually transmitted) and the activation of traditional schemata (*sarawa* and *chichi durdur*). The view of these doctors is then spread (via the media) and deference is shown to their opinion by lay people who use the actions of these doctors to construct and confirm a cultural model that includes the above mentioned traditional schemata. Thus we see how doctors are contributing to a wider cultural model of AIDS that displays fear, hate and blame as major components.

When investigating why this "irrational fear" exists among some Nepali doctors it was suggested that the fatal nature of the disease is the key. For example, one NGO director who had many doctors turn her PWAs away told me,

> The doctors say one thing, but do another because they don't want to die. I think that even though they read about how AIDS can and cannot transfer in their medical books, they are just not sure. They passed their exams by reading the books, but they are just not certain. AIDS is fatal. They don't know if they can trust the books. They don't want to die.

Another doctor, when asked why doctors would be acting against their medical knowledge, replied, "because death is the final trump card." It seems that fear of death is, indeed, a powerful force that is influencing the cultural model of AIDS in Nepal creating much fear. The biological basis for this will be discussed later in this paper.

The role of the media

Various authors have examined the role that the media has played in the construction of a social understanding (cultural model) of HIV/AIDS in various countries (Albert 1986; Baker 1986; Herzlich 1989; Lyttleton 1996). As in other countries, the media has been instrumental in the creation and confirmation of the widely held cultural model of HIV/AIDS in Nepal. In this section I will examine several phases the media have passed through in their representation of HIV/AIDS to the general public and I will discuss the role the media have played in the creation of a cultural model of AIDS.

First of all, it is notable that the doctors and policy makers early on identified and targeted the media as a valuable vehicle for the creation of public awareness about HIV/AIDS (Karuna 1998). Therefore, the early information going out to the general public about AIDS via the media were those ideas (e.g. fatal, infectious, sexually transmitted) passed along to the media by the policy planners, who had developed these messages under the influence of Western models. The use of the media as a vehicle for creating awareness regarding AIDS has been very successful to date. Various studies (including the rural study presented in chapter six of my dissertation) have confirmed that the media (mainly Radio Nepal) has been the major source of AIDS information (Karmic Society et al. 1998; New Era 1997; Maharjan et al. 1994).

The first phase of the media presentation of HIV/AIDS focused on the issues mentioned above. Because of the association with sexual transmission, the dialogue on HIV/AIDS quickly became subsumed under the girl trafficking discourse. Early articles focused on the association between AIDS and commercial sex work, and CSWs (all women) began to be blamed for the advent of AIDS in Nepal. For instance, in 1991 a leading Nepali magazine published an article that featured the story (including picture, name and village) of a woman named Geeta (Figure 3). In the article she was identified as a prostitute returning home from Bombay and carrying AIDS (Janmanch 1991:12). Later that same year the director of the NGO where Geeta had been

living in Kathmandu returned with her to Geeta's home village. About this visit she wrote:

> When we stepped down from our jeep in Melamchi, people surrounded us and stared at Geeta. We soon felt that they were silently blaming her for her condition as they held out their copies of Janmanch magazine. Geeta was thirsty and weak from the trip, but when she attempted to get drinking water from a shop, she was refused. This was her first experience of contempt and segregation in her own community, but not her last. As we walked to her father's house, a large crowd followed us over the bridge and up the narrow path.
>
> We soon met Geeta's father along the track, but he stood expressionless before his daughter. We tried to talk to him about his daughter's health and needs, but he turned from us. Further up the hill, we met Geeta's mother. She asked us to take Geeta back to Kathmandu: she told us she did not want her home. Only then did Geeta cry out in anger and humiliation. (ABC Nepal 1996:56)

Later in the article, the NGO director describes a second visit to Geeta's village after Geeta had reluctantly been allowed to live there again:

> They [Geeta's family] believed that the disease could be contracted through casual contact... Geeta's relatives were reluctant to accept responsibility for her...They still feared that casual contact of almost any kind would transmit the virus.
>
> The community was still very wary and hostile toward Geeta. She had been restricted from using the road or going to the bazaar. In other words, she was effectively quarantined. At home, her family still believed that casual contact with Geeta could make them sick. She was forced to use a separate comb for her hair, a separate plate and glass, and she was not allowed to touch or hold her younger brothers or sisters. In her small world, she was kept apart by fear, and there were no avenues for simple expressions of love and affection. Geeta was frustrated and hurt by how she was being treated and she wanted to leave the village.

एड्समा मौलाएका गैर सरकारी संस्था

तारानाथ दाहाल

नुवाकोट, सिन्धुपाल्चौक र काठमाडौंको उत्तरी क्षेत्रका गाउँहरूमा त्यस्ता एउटा गाउँ पनि छैन, जहाँ गैर सरकारी संस्थाका समाजसेवीहरू

गीता दनुवार जो अहिले भेलाभरीमा मृत्यु भेटिनेकी छिन्

नपुगेका हुन् र सामुदायिक विकास एवं एड्सको कुरा नगरेका हुन्।

सिन्धुपाल्चोक जिल्ला र नुवाकोट जिल्ला चेलीबेटी बेचबिखनको निम्ति कुख्तिएको नै छ। छोरी, बहिनी, बुहारी, स्वास्नी, भाञ्जी र भतिजी बेचेर पनि टिनका छाना लगाएका घरहरू काठमाडौंको उत्तरपूर्वी पहाडी क्षेत्रमा प्रशस्त पाइन्छन्। चेलीबेटीको बिक्री गर्ने प्रथाले सामाजिक मान्यता पाइसकेको छ र प्रशासनले पनि कानूनी छूट जस्तै दिएको छ। यी ठाउँहरू राजधानीमा बसेर समाजसेवाको पगरी गुथ्नेहरूका निम्ति सम्बन्दा उपयुक्त ठाउँ हुन पुगेका छन्।

ए हजुर! सदनमा समेत छाप्रो जिल्लाको बदनाम गर्‍यौं रे एउटा कार्यसत्रले, छोरी बेच्ने ठाउँ भनेर भन्थे रे, त्यस्तालाई छाप्रो अर्जुन नरसिंहले पनि केही गरेनछ, म भए त त्यही ठीक गर्थें नुवाकोट धुवाकोटीका वीरबहादुर घल्यान आफ्नो गाउँ-ठाउँबाट छोरीचेली बेचिएकोमा कैन् आफ्नो गाउँको नाम लिएकोमा यसरी कुद्ध भएका छन्। उनी भन्छन्- कसलाई पो थाल छैन र? बम्बईमा बेच्छ, त्यहाँ रण्डी काम गर्नुपर्छ भनेर। तर जान्छन् भने कसले रोक्ने। चेलीबेटीहरूलाई बेच्ने कामलाई रोक्नु पर्दैन? भनेर सभाउँदा वीरबहादुरले उक्त प्रतिक्रिया व्यक्त गरे। सिन्धुपाल्चोकका हेनुहाका किसनसिंह एड्स एड्स!! भनेर प्रचार गर्नेदेखि झेक्किदै भन्छन्- 'वस्तु चराउने, घाँसदाउरा काट्ने शिवपुरीको डाँडोलाई चाहिं घेर्ने, टाउरा र घाँसकाट्न नदिने, सिपाहीहरू राख्ने, डर्क नै हड्पने पनि विकास रे! केटीहरू लाहुर जान हुँदैन भन्ने कुरा पनि विकास रे! यस्तो पनि हुन्छ विकास? किसनसिंहलाई कांग्रेसले शासन चलाए यता पटकै मन पर्देको छैन। 'पहिला पहिला त ब्राह्मिहरू आए पनि, बाबुसाहेब आए पनि केटी, बेच्न हुँदैन पनि भन्दैनथ्यो, शिवपुरीमा घाँस काट्न हुँदैनथ्यो पनि भन्दैनथ्यो'- उनी भन्छन्।

सिन्धुपाल्चोक र नुवाकोटमा यस वर्ष भन्दा बढी केटीहरू बिदेशिएका छन्। सिन्धुपाल्चोक दुबचौरका सामाजिक कार्यकर्ता केशव सुवेदी जनआन्दोलनपछि प्रशासन यन्त्र कमजोर भएको महसूस गर्नुहुन्छ। उहाँका अनुसार धुपे सामाजिक संस्थाहरूले चेतना वृद्धि गर्ने कार्यक्रम संचालन गरे पनि केटीहरू बेचिने क्रममा झन् वृद्धि भएको छ। यस्तै अनुभव नुवाकोट लिसुखोलाका शैलेन्द्र फुयालको पनि छ।

विगत केही वर्षदेखि सिन्धुपाल्चोक जिल्लालाई आफ्नो कार्यक्षेत्र बनाएको एजी.सी. नेपाल कृषि, वन, आधारभूत स्वास्थ्य र सहकारी नेपाल का निर्देशिका दुर्गा घिमिरेले केही दिन अगाडि मसंग भन्नुभएको थियो- 'यदि चेलीबेटी बेचबिखनलाई रोक्ने हो भने, यहाँबेखा एउटा त एड्सको प्रचार गर्नुपर्दछ र यो महामारीबाट बच्न चेलीबेटी नबेच्नुस् भन्नुपर्छ। अर्को वैकल्पिक आर्थिक आयको व्यवस्था गर्नुपर्छ।' घिमिरेको एजी.सी. नेपालले एड्सको प्रकोपका बारेमा त्यस क्षेत्रमा धुपे पटक गोष्ठी र सेमिनारको आयोजना पनि नगरेको होइन। महिला पुनर्स्थापना आयोजना र बाल बचत सरोकार केन्द्र जस्ता संस्था लगायत स्थानीय रेडक्रस, एड्स प्रिभेन्सन कन्ट्रोल प्रोग्राम र स्थानीय जनस्वास्थ्य शाखाले पनि केही न केही गरेकै छन् तर यी प्रयासहरूको कुनै सकारात्मक लक्षण नुवाकोट र सिन्धुपाल्चोकका गाउँहरूमा देख्न सकिदैन।

यी ठाउँमा यहाँसम्म सुन्नु पर्‍यो कि- ही क्षेत्रमा कार्यरत संस्थाहरूकै कर्मचारीहरूले समेत चेलीबेटी बेच्ने गरेका छन् भनेर। उनीहरूलाई प्रौढ कक्षा, प्रशिक्षण भत्ता र स्वास्थ्य शिविरहरूदेखि त झन् बढी नै एलर्जी भएको छ। सिन्धुपाल्चोक भोटेचौरका एक शिक्षकले त्यहं क्षेत्रमा कार्यरत एकजना एड, नेपालकै कर्मचारी समेत बेचिएको दृष्टान्त सुनाए।

एड्स प्रिभेन्सन कन्ट्रोल प्रोग्रामका नामसा श्री ५ को सरकारले करौडौं रूपैयाँको व्यय गरेर एड्स रोगको महामारी रोक्न प्रचार अभियान गरिरहेछ। तर यी कार्यक्रम झन् प्रत्युत्पादक भएको छ- गाउँघरमा। एक विश्वस्त सूत्रले जनाए अनुसार केन्द्रीय रक्त परीक्षण केन्द्रमा रक्त परीक्षण गरेर फेला परेका ४९ एड्स रोगीमध्ये २ जना (गीता दनुवार लगायत) सिन्धुपाल्चोकका र ७ जना नुवाकोटका रहेका छन्, जसको बारेमा जनमञ्चले पहिल्यै लेखिसकेको छ। तिमध्ये ७५ प्रतिशत बेचिएर फर्किएका चेलिबेटीहरू हुन र २५ प्रतिशत तिनजाट फैलिएको व्यक्तिहरूको रगतमा देखा परेको हो। तर यो कुरा एड्स प्रिभेन्सन कन्ट्रोल आयोजनाका अधिकृत स्वीकार्दैनन् र यो बताउन नमिल्ने कुरा भन्छन्। लगभग ३०० जनाको रक्त परीक्षणबाट ९ जनामा एच.आइ.भी. पोजेटिभ्स देखा पर्नु निश्चय पनि चिन्ताजनक अवस्था हो र यस समाचारले सिन्धुपाल्चोकमा त्रासको वातावरण सिर्जना गरेको छ।

एड्सका कीटाणु भएका व्यक्तिहरू जहिले पनि सभाजमा अपरिचित रूपमा नै रहनुले गर्दा रोक्न कसरी भट्टन गाह्रो भनी सोच्दा एड्स नियन्त्रण आयोजनाका अधिकृतले रोगीको पुनर्स्थापनाको समस्या एकातिर हुने र अर्कोतिर विश्वव्यापी प्रचलनमा पनि एड्सका कीटाणु फैला परेका व्यक्तिलाई समाजमा परिचित

Figure 3 Geeta's story, featured in Janmanch magazine (Janmanch 1991:12), showed her picture, gave her real name and the name of her village, and prompted much ostricization by her family and other villagers.

> I organized another meeting with Geeta's family members to discuss these problems. The family explained their actions. They said that the community would outcast them if they allowed Geeta to remain with them. But their own beliefs, I knew, would have propelled them to treat Geeta like this even without community sanctions. (ABC Nepal 1996:58)

From this example we can see the impact of 1) an association of AIDS as fatal, infectious, and sexually transmitted as promoted by the media, and 2) the application of the traditional *sarawa* (transmittable disease and the embedded *chichi durdur* [separation] schemata) and *randi* (promiscuity--including blame and *grena* [disdain]) schemata. Unfortunately, this sad scenario was played out in village after village as CSWs returned from India with AIDS.

In 1996 one major media event further supported the association of HIV/AIDS with the girl trafficking discourse. One hundred and twenty-eight Nepali girls were repatriated to Nepal from the brothels of Bombay (Ghimire 1997). The underage girls had been rescued from the brothels during police raids and held in various rehabilitation centers while the Indian Government discussed repatriation of the girls to Nepal. At first, the Nepal government was not responsive, but after much pressure they agreed to repatriation (Ghimire 1997). Regarding this incident, Ghimire writes,

> We did not receive favorable coverage from the media. The media has started to publicize the issue, but in many cases some media only want to publish the victims' names and photographs which creates a negative impact in the society. One of the rescued girls from Bombay was working in a destitute home for widows and displaced women. One day she was interviewed on a radio program. Immediately after the broadcast other destitute women living in the center recognized her voice and came to know about her story. Immediately she was forced by the other members to leave the center. They told her that she would continue the same business (prostitution) and defame those working in the center... sometimes the publicity of the victim creates a lot of problems for the rehabilitation of the rescued girls as well as HIV positive cases. (Ghimire 1997:18)

This repatriation made major headlines in various Nepali mediums and the association of AIDS with commercial sex work was further solidified in the minds of the general public. And again, the elements of fear, hate and blame are clearly evident in this example. It is also evident that the application of the *randi* (promiscuity) schema results in the labeling of those with AIDS (due to the strong association with commercial sex) as "bad people."

During the second phase of the media's development of AIDS, the cultural model grew to include other "bad people" (drug users) as carriers of AIDS. Again, when the findings of the early AIDS studies in Nepal began to confirm that many injecting drug users (IDUs) were contracting AIDS, the policy makers began to channel messages to the media that made a strong association between drugs and AIDS. The media in turn passed the information along and more stories about AIDS and drugs joined the stories about prostitution. The association of AIDS with another group traditionally branded as "bad people" further stigmatized the disease.

The findings of a recent six month media study (Beine 2000a) confirm that stories that promote fear, hate and blame (the major elements of the widely-held cultural model) are still being widely circulated via the media. Table 1 displays the findings of the media study. Over a six-month period, the leading English daily newspaper published, on average, two and a half stories weekly about HIV/AIDS. Sixty-six percent of the articles were related principally to AIDS in Nepal and were published in the "local" section of the newspaper.[10] The other 34% of articles related to AIDS internationally and appeared in the "international" section. The articles in both sections can be grouped by focus. Forty-four percent of the "local" articles centered primarily on sensationalizing the AIDS epidemic in Nepal. Twenty six percent of the articles would be considered more or less "educational" stories. Nine percent focused primarily on condom use. Nine percent focused primarily on drug use. Seven percent focused primarily on girl trafficking or commercial sex work issues. And five percent focused on political economic issues associated with AIDS. Of the international stories 73% were sensationalizing articles, twenty-three percent were primarily educational stories, and four percent focused on a trafficking discourse about AIDS.

The largest numbers of articles in both the local and international groupings were sensationalizing (54% of the total). The sensationalizing stories create fear that consequently spawns blame and hate toward PWAs.

Table 1: AIDS related articles from a six-month analysis of the Kathmamdu Post.

Local Articles:

Association made between AIDS and:

Article focus	fatal	infec-tious	sex	drugs	other
A. Sensationalizing Article titles:					
1. Over 25,000 Nepalis HIV+	X	X	X		condoms, western anti HIV drugs
2. Big Dilemma as AIDS Cases Increase		X	X	X	condoms
3. Tainted Blood Supply	X				
4. HIV Scourge in Morang	X				
5. TB Snowballing Into Serious Threat	X	X			
6. Man Tricked Into Marrying AIDS Victim					"dreaded disease"
7. Rude Shock for Bridegroom With HIV	X	X			"killer disease"
8. Health Workers Unknowledgeable about AIDS	X				
9. Nepal Will Have 50,000 AIDS Cases By 2000	X	X	X		
10. AIDS Claims Seven	X				those who go to foreign countries
11. Health For All By 2000: A Distant Dream	X	X			
12. Children Suffer From AIDS Due to Parents Mistake	X	X	X	X	tied to "flesh traders"
13. HIV/AIDS Alarming in Developing World	X	X			

14. AIDS And Tuberculosis: A Bloody Tie	X				food: "but if the food and atmosphere are good, they may live longer." preference to attribute death to TB rather than AIDS
15. Blood Screening on the Agenda Due to HIV	X	X	X		transfusion
16. HIV To Orphan 40M By 2020	X	X	X		
17. As Ill Luck Would Have It, She Came Back With AIDS Virus	X	X		X	transfusion
18. HIV Tainted Needle Attacks—Rumor or Reality?	X	X	X	X	
19. Hospitals Facing Blood Shortage		X			blood related

Table 1: AIDS related articles from a six-month analysis of the Kathmamdu Post.

Local Articles: (continued)

Article focus	fatal	infec-tious	sex	drugs	other
B. Educational focus Article titles:					
1. Only Way To Arrest March of AIDS	X	X	X	X	condoms
2. Talk on HIV/AIDS	X	X			
3. Workshop on HIV/AIDS Ends	X				
4. Collective Efforts to Combat AIDS Stressed		X			
5. Awareness About Aids Vital		X			
6 Children's Move Against AIDS	X				
7. AIDS Training Ends			X		
8. AIDS Awareness Workshop in Heteauda		X	X		
9. Awareness on AIDS Vital				X	"dreaded disease"
10. In Aid of AIDS (Quiz)	X	X	X	X	foreign origin
11. Workshop on HIV/AIDS Concludes		X	X		
C. Girl Trafficking/CSW focus					
1. The Development Journey		X	X		
2. Sex For Sale		X	X	X	
3. They Went to the Land of Dreams to Seek Fortune But Found Only...	X	X	X		foreign tie

D. Condom focus					
1. Condom Users on the Rise		X	X		
2. NGOs Promote Condom Use	X	X	X		
3. Condom Day for Community Mobilization		X	X		
4. Thanks to Condom		X	X		
E. Drug focus					
1. 50 Percent Pushers Are HIV Positive				X	"AIDS junkies"
2. Needle Exchange Helps Worsen HIV/AIDS Menace	X	X	X	X	expresses compassion toward drug users tied to foreigners
3. Drug Addicts Contract AIDS Due to Syringe Sharing	X	X		X	compassion expressed "ruined"
F. Political Economy focus					
1. All's Well At AIDS Meet But Grass Roots Voices Ignored		X	X		girl trafficking/csw discourse development discourse
2. 1 out of 5 HIV Patients in Asia	X				new drug therapies economic issues of AIDS

Table 1 AIDS related articles from a six-month analysis of the Kathmamdu Post.

International articles:

Article focus	fatal	infec-tious	sex	drugs	other
A. Sensationalizing Article titles:					
1. Man Charged For Not Informing of AIDS	X	X	X		
2. Children Innocent Victims of Africa's AIDS Epidemic	X	X			
3. Doctor Accused of Trying to Kill Mistress With AIDS Injection	X	X	X		
4. HIV Cases rose 10% in 1998: WHO		X			
5. South Africa Has Fastest Growing HIV Epidemic	X	X			
6. HIV Infected Mother Hangs Disabled Son					
7. AIDS, Poverty Destroy African Respect for Dead	X	X			
8. US Govt. Urged to Collect HIV Positive People's Names		X	X		tied to gays
9. Homosexuals Have Highest Percent of AIDS Infections			X	X	tied to gays
10. Death Takes a Holiday in the Gay Community	X	X	X	X	tied to gays new drug therapies
11. AIDS: The Big Health Crisis Facing Nigeria's New Rulers	X	X	X		

12. AIDS Day Observed Amid Alarm in Developing World	X	X	X		isolation new drug therapies
13. 820,000 Asians Contracted HIV in 1998: UN		X	X	X	
14. Urban Poor Women Face High Risk of Acquiring AIDS		X	X	X	
15. AIDS Virus Affects 7000 A Day	X	X			breast feeding
16. Indian State Heading for AIDS Disaster		X	X	X	
B. Educational Focus					
1. Global Call to Action Against AIDS	X	X	X		economic issues condoms
2. Clinton Marks World AIDS Day	X	X			
3. Mandela Hits Out at Silence on AIDS		X			
4. Anti AIDS Substance in Urine Identified		X			
5. US Takes a Hard Look at Blacks, AIDS	X	X	X	X	tied to gays condoms
C. Trafficking Discourse					
1. AIDS, Poverty Spur Child Trafficking		X	X		economic tie

One exemplary article is titled "Big Dilemma for Nepal as AIDS Cases Increase." The article suggests:

> Nepal's health infrastructure may not be able to cope with the increasing number of HIV/AIDS patients who are certain to seek scarce hospital beds when they reach the stage of full-blown AIDS. In that case, people who need immediate medical attention, for example: appendicitis patients or patients with broken limbs will be the sufferers...If the number of people with full blown AIDS suddenly increases, a lot more people with HIV negative will also be sufferers. (Silwal 1998)

Such articles certainly play a role in the creation of fear, blame and hate towards PWAs in Nepal.

Although the articles are grouped by primary focus, it should be noted that associations between AIDS and various other topics were also made throughout the articles as is demonstrated in Table 1. The strongest associations throughout the articles were 1) AIDS is infectious (mentioned in 78% of the articles), 2) AIDS is fatal (mentioned in 57% of the articles), 3) AIDS is sexually transmitted (mentioned in 54% of the articles), and 4) AIDS is drug use related (mentioned in 25% of the articles). It is clear from these findings that the media is strongly promoting the major elements of the wider cultural model (e.g. AIDS as a fatal, infectious, sexually transmitted disease). It is also easy to understand how the media's association of AIDS with CSWs and IDUs has stigmatized AIDS as a "bad people's" disease. The association made between AIDS and gays (another "bad people" group in Nepal) in four articles further adds to the image of AIDS a "bad people's" disease. And, of course, societal blame and hate is traditionally warranted against "bad people" as a form of social control.

Besides these major thematic associations, several articles also made associations between AIDS and various issues we saw reflected in a few of the earlier narratives. For instance, in chapter seven I noted the belief expressed by one PWA that an HIV positive diagnosis could turn to negative. One article (Kathmandu Post 1998a.), commenting on the plight of children in South Africa, states that, "two-thirds of babies who test positive for the AIDS virus at birth later test negative." Likewise, several narrators from the narrative analysis project (Beine 2000b) commented on the possibility of new drug therapies to cure AIDS. As noted in Table 1, five articles included

comments regarding the availability of these new drug therapies in the West. Other themes familiar in the narratives, such as a foreign origin of AIDS (five articles) and the association between good diet, positive attitude and health (one article), are demonstrated in Table 1.

The theme of societal compassion for drug users, that was evident among the male urban PWAs in the findings of the narrative analysis project (Beine 2000), is also expressed in two different articles. For instance one article tells of an "unfortunate young lad who fell into the clutches of drug abuse" and claims that "the very society which could have rescued him from the horrors of drug abuse, was one way or the other, responsible for pushing him into the present misery" (Kathmandu Post 1998b.).

In an evaluation of the media's recent portrayal of HIV/AIDS and assessment of future use of the media in the fight against HIV/AIDS in Nepal, the director of the National Center has written:

> In the Nepali media today, we see a qualitative improvement in the coverage of HIV/AIDS. It is fairly rare to see newspapers and magazines publishing pictures of people living with HIV, or their names. The articles are factually more accurate, fairer, they address the root issues and not just the sensational elements of an HIV/AIDS story. Radio and television have also seen improvements, with the introduction of an adolescent sexuality hotline on FM radio as well as longer issue based coverage of the disease on community radio and Radio Nepal.
> But still, the lack of accurate and up-to-date information on the scientific, sociological, developmental or human rights aspects of the disease still hobbles the media's handling of HIV/AIDS coverage within Nepal. If the press and public relations firms are going to be used as vehicles for awareness creation, it is still necessary to sensitize mainstream media professionals regularly about HIV/AIDS. Media seminars on HIV/AIDS cannot be one shot affairs, they have to be regular and sustained. Otherwise, instead of awareness we're going to have more confusion in the Nepali public.
> Aside from the mainstream media, the tabloid press still by and large treats HIV/AIDS either as a titillating sensationalist news item to boost circulation or as an excuse to stereotype, stigmatize or victimize people living with HIV. This has only

> served to scare the public, alienate infected people, and perpetuate prevailing ignorance.
> Sensitizing media will check the negative side effects of inaccurate information and help move on to spreading mass awareness and ultimately bring about the behavior change that is needed to halt the epidemic. It is clear that if Nepal and other South Asian countries are to tackle a rapid spread of HIV there has to be a radically new approach to using communications for awareness building. Present efforts within Nepal for instance may be inadequate to meet the challenges of this looming crisis. (Karki 1998)

In this section we have seen the interplay that has existed between three unique groups (NGOs, doctors and policy makers, and the media) in the creation of a cultural model of HIV/AIDS in Nepal. AIDS has entered the public conscience of Nepal, in part, via the messages of these various groups. Because AIDS is a new disease, the formulation of a cultural model of HIV/AIDS has been strongly influenced by these preliminary messages about the disease. Once enough information existed, the disease was categorized (through the schematization process) and relevant associated cultural schemata were applied. The messages of "fatal," "infectious" and "sexually transmitted" communicated by the NGOs and doctors and policy makers via the media were enough to evoke associations of AIDS as a *sarawa rog* (requiring the practice of *chichi durdur*), and as a disease affecting primarily those who are *randi.* These various associations have produced a cultural model of AIDS in Nepal that has, in turn, created an atmosphere of fear, hate and blame exhibited toward PWAs in Nepal.

A comparison of Cultural models: Implications of Underlying Biological Schemata

The research presented in this paper affords good opportunity to compare the emerging cultural model of AIDS with other models around the world. For instance, Paul Farmer (1994:805) identifies the key elements of a village Haitian cultural model as shared understandings: 1) of AIDS as a new disease, 2) of AIDS as associated with skin infections, drying up, diarrhea, and most strongly with tuberculosis, 3) of AIDS as the result of a) sexual contact with a carrier, b) the result of voodoo, or c) both, 4) that whether the

result of sex or voodoo, it is caused by a microbe, 5) that AIDS is transmitted through contact with contaminated blood, and 6) that AIDS is closely associated with larger political-economic issues. Besides this list, Farmer identifies, but leaves unspecified, other key elements of rural Haitians' understandings about AIDS as fatal, which produces much "personal fear" (1994:805). Likewise, Herzlich (1989) has demonstrated how the media were influential in the construction of a cultural model of AIDS in France that socially constructed an understanding of AIDS as 1) fatal and infectious, producing great fear, and 2) sexually transmitted (but tied to a group considered deviant -- homosexuals), thus creating an atmosphere of moral judgement and blame. Albert (1986), studying the media's involvement in the creation of a cultural model of AIDS in America has demonstrated that fatal and infectious were two major elements (due mainly to the initial "unknown" nature of the disease) that produced much fear. And because of the "fear of contagion" and the association with the gay community, a major theme of the media was blame, usually in the form of considering AIDS as a punishment of God. And Lyttleton (1996) has demonstrated how AIDS in Thailand (via the media again) was associated with the much feared "other." Like in Nepal, the major association was with prostitutes and drug users (societal deviants).

Although many specifics differ between the Nepali, Haitian, French, American and Thai models, there are some striking similarities between the models (in form) as well. For instance, all of these models first associated AIDS with marginalized groups. In Haiti, America and France, it was homosexuals, while in Thailand and Nepal, it was prostitutes (including *randi*) and drug users, both classified as "bad people" groups who were marganilized by the wider society. Next, both models display the extension of traditional ideas to the new disease. In the case of Haiti, it is that AIDS can be contracted through voodoo. In Nepal, it is that AIDS, a *sarawa* illness, can be contracted through the same means as other *sarawa* illnesses (like TB[11] and leprosy). In France, it was pre-existing understandings of STDs (particularly genital herpes) that were influential in shaping a social understanding of HIV/AIDS. In America, it was ideas about the great plague of the Dark Ages (because "plague" had been popularly presented as an image schema for AIDS). And in Thailand, it was pre-existing understandings of the "feared other" with whom AIDS had become associated.

Blame is a common feature of all the models although the object of blame differs from culture to culture. For instance, in the case of the American, French, Thai and Nepali models it is marginalized groups, while in the case of Haiti, Farmer (1994) demonstrates that the blame is directed toward perceived agents of hegemony

The positing of dualistic explanations for the disease (although they can differ from culture to culture) is also common to various models. For instance, as noted earlier, *karma* (past actions) and drug use were both cited in Nepali texts as possible causes of AIDS. Likewise, Farmer notes the dualistic explanations of AIDS as the possible result of "germs" and "voodoo." Closely related to the idea of dualistic explanations for illness is the notion of multiple causes for disease. The understanding of AIDS being the result of a viral infection or a punishment for sin is common to the American (Giblin 1995:136) and French (Herzlich 1989:1237) models.[12] The notion of multiple causation of illness has also been noted in general models of illness in Brazil (Price 1987:328). In all of these cases we see multiple notions of disease causation that combine traditional beliefs regarding illness with modern understandings of Western biomedicine.

In all the models we see the common themes of fear, blame and hate (because of the association of AIDS with "bad people"). In many cases, the common themes have produced common responses. For instance, the early American model, chronicled by several other authors, shares many striking similarities with the Nepali model. For example, Giblin (1995) demonstrated various reactions of fear by the general public against PWAs: people didn't want to sit with PWAs or use utensils of PWAs, morticians refused to embalm the bodies of PWAs, and doctors began wearing masks to treat PWAs or refused to treat them altogether. All of these reactions have also been noted in Nepal.[13] Likewise, Flynn and Lound (1995) demonstrate how the early model in America (AIDS as a "gay" disease) was created by the media, and how those infected were branded as "bad people" (1995:14). Flynn and Lound also discuss the various rumors that PWAs were deliberately infecting others (1995:14), a product of the extreme fear associated with the disease. I have previously described similar events in Nepal.

Anyone familiar with AIDS research in any given country might recognize, in the findings of this research, themes common with those expressed elsewhere in the world. It seems that there are some universals associated with AIDS around the world. For instance, the association of

AIDS with "bad people" and blame. Regarding this association Sontag (1988:59) has written, "any important disease whose causality is murky, and for which treatment is ineffective, tends to be awash in significance...first the subjects of deepest dread (corruption, decay, pollution, weakness) are identified with the disease." And regarding blame Sontag (1988:101) suggests that "it seems that societies need to have one illness which becomes identified with evil, and attaches blame to its victims." Regarding the association between STDs and strange beliefs of contagion, Sontag (1988:112) has written, "Infectious disease to which sexual fault is attached always inspires fears of easy contagion and bizarre fantasies of transmission by non-venereal means in public places." Likewise, Sabatier (1989) has suggested that blame and prejudice are common associations made with STDs worldwide. He concluded that "the process of attributing blame does not always require evidence, and tends to focus on people who are not considered 'normal' by the majority, especially on minorities or foreigners" (1989:66).

Janet McGrath (1991) has proposed that all cultures exhibit universal responses to epidemic disease. She suggests that that if an epidemic is evaluated as acute, then direct actions such as flight or extraordinary preventative measures, such as quarantine and isolation, are implemented as common adaptive strategies. If an epidemic is perceived as non-acute, then indirect action such as ostracizing and scapegoating of those who are considered at risk or resignation toward the disease (fatalism) are displayed as common responses. McGrath suggests that these responses are common themes throughout the history of epidemic disease. Further, she suggests that these responses are mostly biologically adaptive.[14] Interestingly, in Nepal, both direct action (quarantine and isolation— i.e. *chichi durdur*) and indirect action (scapegoating— i.e. strong blame of prostitutes [those who are *randi*]) are common responses toward those with AIDS.

As an interesting sideline, although McGrath doesn't mention "schema" by name, she acknowledges that a process similar to the schematization process described in this dissertation underlies the production of these common responses to epidemic disease. For example, she suggests that the first response to epidemic disease "is based on a familiar response derived from previous experience" (1991:408). This is akin to the idea that schemata serve as a kind of template (created from past experience) that functions to make meaning of new events that are perceived to be similar. She suggests that "behavioral responses begin with 'normal practice.' That is, the earliest

responses to epidemics are those that have been used successfully in response to other crises" (1991:409). McGrath's proposal of the application of "familiar responses" (1991:412) in order to control epidemic disease implies the application of underlying biologically based schemata. This would certainly help to explain, at least in part, the *chichi durdur* (separation), *sarawa* (transmittable disease) and *randi* (promiscuity) schemata that have been so easily associated with AIDS in Nepal.

The striking similarity between various cultural models of HIV/AIDS might be, in part, a result of the application of various universal schemata that produce the universal similarities noted. These universal schemata, in turn, play a part in the social construction of meaning associated with HIV/AIDS as they are embedded as fundamental elements of particular cultural models of HIV/AIDS. For instance, I propose that in Nepal, biologically based schemata are embedded in higher level schemata, such as the *sarawa* schema, and these schemata are, in turn, embedded in higher level schemata (cultural models).

Other such universal schemata might be 1) a "sexually transmitted disease" schema that posits the possibility for strange methods of transference as noted above, and 2) a "survival" schema. It seems that some sort of basic survival schema exists that causes us, when a disease is understood as fatal and infectious, to act in a way that would assure maximal safety. This would explain in part, the "fatal trump card" idea spoken of earlier as well as the doctors' preferences to act on the conclusions of their cultural model rather than their biomedical knowledge. According to Flynn and Lound (1995:55), many irrational fears and actions of people toward AIDS are a result of the fear of AIDS, which in turn, is a result of the fatal nature of the disease.

In regards to the process of application of schemata in the making of meaning associated with HIV/AIDS in France, Herzlich and Pierret (1989:1241) have written:

> As an instance of this, let us examine the likening of AIDS to cancer, the plague, syphilis, and leprosy. Such comparisons give rise to what can be called a system of second degree metaphors. AIDS was associated successfully or simultaneously, with all of these diseases, each of which had served as a metaphor at a certain epoch. Although AIDS condensed all of these into a single metaphor, it would during

> its construction, tend to be most likened to the oldest of them, the disease most distant from and strangest to us. Although the first articles in 1981-1982 mainly compared it to cancer, the prototype of 'modern' illnesses, it would then be likened to diseases—usually the plague—that have vanished in the West. In fact, the comparison was more frequently made with the plague than syphilis, a disease more like it and closer to us... AIDS, as stated, has been the subject of a discourse about the 'other,' who is as far as possible from ourselves, as foreign and strange as possible. This discourse works by repeatedly making a cleavage between one's self and others. This is not new: foreigners have always been accused of bringing epidemics.

Although based in the specifics of the French cultural model, we see the explanation for the application of various schemata associated with AIDS. We see other illnesses used schematically as a prototype to understand AIDS, and we see, in part, the explanation behind the application of AIDS as a foreign disease and its association with marginalized groups (e.g. those we consider strangest). Although my proposal, that underlying biological schemata inform higher level schemata and, therefore, ultimately cultural models, does not answer all of the questions, I hope that it does shed some light on the connection between cultural and biological phenomenon in the creation of a cultural model of HIV/AIDS in Nepal.

Notes

1. The National AIDS and STD Control Centre reports that although the number of Nepal's HIV/AIDS infected remains "low" (1,807) it could be much higher given the poor testing facilities. The Centre warns that although only 142 people are known to have succumbed to HIV/AIDS so far in Nepal, there is every possibility that the problem could be worse since there is no way of knowing how far the infection has penetrated the hinterland.
2. This information comes from a list titled "NGO list at working HIV/AIDS/STD" that I obtained from the HIV/AIDS Training Unit of the United Mission to Nepal.
3. The leading campaign slogan "condom *lagau* AIDS *bagau*" (lets wear condoms and chase away AIDS) employs a Western war schema (*bagau*

is what you do to enemies, thieves and dogs), a schema not usually associated with illness in Nepal. The war schema is employed heavily in western cognitive models of illness (e.g. *fighting* a cold, *battling* illness, my *defenses* are down, etc.).

4. Prior to interviews with doctors and NGO workers two different studies were conducted in tandem in order to discover the various meanings attributed to HIV/AIDS by various groups in Nepal. In the first study (using a cognitive anthropological approach), the research on HIV/AIDS was conducted within the larger context of a examination of cultural models of all illness and the schema which underlie these cultural models. Thus, many of the schemata identified within the HIV/AIDS context are wider illness schemata as well.
5. The "eating" schema is another foundational schemata identified during the research (see Beine 2000b).
6. The second study conducted was a narrative analysis project (discourse analysis) that studied the narratives of 30 PWAs living in Kathmandu (Beine 2000b).
7. In my estimation Patan Hospital offers the best care to PWAs available in the whole country. This was also the place of choice among PWAs to be seen. They felt more compassion is given to them at Patan Hospital. This was a rare incident at Patan, but I use it to illustrate that if this kind of practice is taking place at the best hospital, one can only imagine what is happening in other places.
8. HIV cannot be transmitted through exposure to anything (including feces, urine, sweat, etc.) that would be left behind by an AIDS patient, therefore, fumigation of a patient's bed or room would be medically unwarranted (Bhattarai 1999:22).
9. This story made the headlines in several magazines and newspapers as well as in the leading English daily newspaper. In a follow-up investigation, however, no basis was found for the rumors. Interestingly, the local movie hall owners accused the local video storeowners of instigating the rumor in order to increase their profits at the expense of the local movie hall owners.
10. The Valley/Nation section (local news) which is usually only one page, is filled with the numbers of fatalities from the latest cholera epidemic, various bus accident fatalities, and numbers of Maoist guerillas killed by the police in recent attacks. I affectionately refer to this page of the

newspaper as the "death" page. Again, it is no wonder that AIDS is perceived by the general public as fatal.

11. Interestingly, in both countries, AIDS is most closely linked with tuberculosis. Farmer quotes one informant as saying, "tuberculosis and SIDA (the local and French, term for AIDS) resemble each other greatly. They say that TB is SIDA's little brother, because you see them together." I also heard this same analogy used in Nepal. The common association is probably due to the fact that TB is the most common opportunistic infection that affects PWAs in these two countries.
12. It is also possible that the attribution of multiple causation to disease is universal. Sontag (1988) has demonstrated how disease in the Iliad and Odyssey is attributed both to supernatural punishment and natural causes.
13. One NGO director told me that when they have taken bodies to be cremated at the local temple, they are often refused or charged double once the priests learn that the person was a PWA. And one of the leading doctors treating PWAs in Nepal told me that once he discovers a person is HIV positive he will wear a mask or only speak through a glass window.
14. McGrath demonstrates that although these responses are believed to be biologically adaptive, under certain conditions they have led to social disintegration.

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