



FHI INTERVENTIONS:

Initiating Best Practices, Providing Comprehensive Services and Monitoring Impact in Nepal



January 1994–December 2004

The decade of prevention, care and mitigation of HIV/AIDS in Nepal has been made possible through financial support from the United States Agency for International Development to His Majesty's Government of Nepal, implemented through the Ministry of Health/ National Center for AIDS and STD Control and Family Health International.

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Foreward

Approaching a decade of work on HIV/AIDS in Nepal, it seemed appropriate to reflect back on what has been accomplished and learned and then look forward to future needs. There are numerous accomplishments and lessons learned that have been shared and could be recounted. Yet in the process of capturing the overall picture of FHI's contributions to the national HIV/AIDS program, there were recurring themes of FHI's work that repeatedly surfaced in conversations with staff and partners. FHI chose to highlight each of these themes:

- **Programming both responds to the changing HIV/AIDS epidemic and supports the national HIV/AIDS program.** Over the past 10 years, the epidemic has evolved as have national HIV/AIDS strategies. In support of His Majesty's Government of Nepal, FHI programs and strategies responded to emerging needs of new vulnerable groups and in wider geographic areas. These changes and overall accomplishments are described in the publication, *FHI Responds: Expanding Prevention, Care and Mitigation Programs during a Decade of Work in Nepal*
- **Technical assistance, innovation and leadership strengthen the quality and effectiveness of responses.** FHI in Nepal has both developed innovative interventions and applied international best practices over the years, particularly for HIV/STI prevention. All of FHI's technical and programmatic contributions to the national HIV/AIDS program for prevention, care and mitigation are highlighted in the publication, *FHI Interventions: Initiating Best Practices, Providing Comprehensive Services and Monitoring Impact*
- **Partnerships create synergies, better meet beneficiaries' needs and maximize available resources.** FHI's strength comes from its large network of implementing partners that are able to adapt to local needs and build community-based projects—each of FHI's previous and current implementing agencies is highlighted in the document, *Working in Partnerships: FHI's Implementing Agencies*.
- **Community-based responses best meet the needs of beneficiaries in diverse communities across Nepal.** FHI's combination of research, responsive programming, technical assistance and partners come together in the field where local organizations develop and provide services to those most at risk. The film *The Road Ahead* features FHI's longest running implementation strategy, Safe Highways, and highlights services, needs, beneficiaries and local realities along Nepal's busy transport routes where FHI and its partners implement HIV/AIDS prevention and care projects.

Special thanks for many years of support and partnership with His Majesty's Government of Nepal—especially the National Center for AIDS and STD Control—and the United States Agency for International Development for its continuing commitment to addressing HIV/AIDS in Nepal. Special thanks to our Implementing Partners for their long term commitment and dedication to work in this field, and to the people with whom we work closely in the field and are most affected by this epidemic. FHI looks forward to continuing to support a national comprehensive response to the HIV/AIDS epidemic in Nepal.



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Range of FHI Interventions: Prevention, Care and Mitigation

Since Family Health International began its work in Nepal, a range of interventions for HIV/AIDS prevention and control were developed and implemented. Over time, as the HIV/AIDS epidemic has changed and programs have expanded, FHI's range of interventions also has changed and expanded. By 2004, FHI's collective experience over a decade covers 11 different interventions that promote prevention, provide care and support His Majesty's Government of Nepal to Mitigate the impact of the epidemic.

FHI and its implementing partners recognize the importance of a comprehensive approach that responds to local needs and realities. Depending on the needs of the target audience, FHI continues to advocate and support strategies to best meet the needs of vulnerable groups for HIV/AIDS prevention, care and mitigation services.

FHI in Nepal provides technical assistance and support to HIV/AIDS prevention, care and mitigation activities. Specifically, FHI offers:

- **Prevention** including a combination of interpersonal behavior change interventions (BCI), mass media communications, condom social marketing (CSM) and distribution, risk reduction and STI management;
- **Care** for those infected and affected by HIV/AIDS with voluntary counseling and testing (VCT), care and support services (including treatment) and activities to reduce HIV/AIDS-related stigma and discrimination; and
- **Mitigation** of the epidemic through research and surveillance (including epidemiological estimations and research ethics), capacity development in HIV programming and policy support.



Prevention

Behavior Change Interventions (BCI)

What is BCI?

Behavior Change Interventions (BCI) have been a key component in all of FHI's HIV/AIDS programs. BCI is a combination of activities designed and tailored to the needs of a specific group. BCI can help reduce risk behaviors and vulnerability to HIV and STIs, create awareness and demand for available services and create an enabling environment for individual and collective change. Components include:

- Local advocacy;
- Behavior change communication;
- Community mobilization; and
- Links to accessible, appropriate health services and commodities

Why Is BCI Important? Why Is It Needed For HIV/AIDS Programs?

To promote safer behaviors and encourage use of available services, communication that speaks effectively, persuasively and directly is key. For this reason, BCI is the foundation of FHI's HIV/AIDS prevention and care programs. Internationally, it is best practice to use BCI for HIV/STI prevention, such as promoting the ABCs of abstinence, being faithful and consistently using condoms.

Increasingly BCI is helping raise awareness about and generate demand for VCT, care and treatment services. BCI approaches were designed to ensure that relevant behavior change messages are directed to the appropriate target populations to achieve a positive health impact.

What are FHI's Main BCI ?

In Nepal, FHI has used a variety of different BCI approaches and channels to promote safer behaviors and increase use of available services. A combination of peer education, outreach education, drop-in centers (DICs), street theater, trainings, group interactions, community events and communication materials have become the cornerstone of BCI for HIV/STI prevention. FHI originally adapted its work in Africa and Thailand to the local needs in Nepal. Over the past decade, FHI innovated several interventions that later were recognized as international best practices.

HELPING SAATHI (FRIENDS) STAY SAFE: A PEER EDUCATOR SHARES HOW THIS WORK HAS POSITIVELY AFFECTED HER LIFE AND COMMUNITY

Years ago as a young woman, Jagamaya Bhattarai ran away with a man who promised to marry her. The relationship soon ended, and alone she struggled financially. Soon she started working as a FSW to survive. With regular clients, she was able to earn a steady income.

About four years ago, an FHI partner organization invited her to volunteer as a peer educator and talk to others about how to prevent STIs and HIV. In this new role, she developed a courageous attitude and became active in her local community.

After opening a DIC, many in her community thought she was encouraging sexual activities by talking about STIs and HIV/AIDS. Jagamaya was determined to prove her detractors wrong, and slowly things improved.

Every day, 12-15 people visit the DIC for information, some come regularly. Many of her DIC visitors are FSWs or their clients. After talking, some ask for condoms or where they can go for an STI checkup. A lot of people tell her that they appreciate her determination and hard work.

Jagamaya shares, "As they say in Nepali society, sometimes it is the boy that goes wayward and sometimes it is the girl that goes the same way. But I feel that by giving such diverse services as condom distribution and STI referrals, my prestige in the local society has increased. At the moment, I have been receiving the most encouragement from the local community. It seems a lot of people are interested in getting more knowledge on HIV and AIDS. I feel that I have saved many lives from contracting HIV/AIDS and other STIs."



In Nepal, FHI uses three main activities for BCI: peer education; outreach education; and DICs. **Peer education** is an international best practice adopted by FHI in Nepal in 1998. FHI's partner organizations recruit from the target group and select people who are articulate, enthusiastic, confident, committed and respected by their peers. These volunteers are then trained on HIV/AIDS, STIs, correct condom use and interpersonal communication techniques.

Peer educators (PEs) work a few hours a day interacting with friends from their target group. They distribute communications materials, demonstrate correct condom use and give out free condoms, make referrals to STI and VCT services and talk about the realities of changing behaviors. PEs usually work at assigned locations (such as DICs), in designated areas or at events. Different projects have mobilized PEs differently, such as occasionally volunteering to help at large events or more regular educational and reporting requirements for a small monthly stipend. PEs are invaluable in promoting and sustaining behavior change. They are liaisons between their friends and the information and support being offered by outreach educators (OREs) and FHI implementing agencies (IAs).

Ten years ago, FHI had not yet mobilized PEs. By the end of 2004, FHI had mobilized and supported over 900 PEs—many of whom have been FHI PEs for many years.

Outreach education supports and complements peer education. FHI supports teams of OREs who are FHI IAs staff with more advanced training and more responsibilities. On average, a full-time ORE supports five to seven PEs. An ORE conducts outreach education directly with individuals they identify or those referred by a PE. They discuss a range of issues or make referrals to upcoming STI clinics. An ORE spends

time in the field to support and supervise PEs, collects data from PEs and resupplies materials and condoms. OREs usually are the same gender as the PEs they support and sometimes are former PEs themselves.

Outreach teams were small at the beginning of HIV prevention work in 1994. By 2004, FHI supported over 130 OREs throughout its program area.

Complementing FHI's human resources, **drop-in centers** (DICs) are an innovation developed in Nepal. In 2001, the first DICs were created in Southeastern Nepal along the highways as a way to offer mobile target groups of FSWs and their clients a safe place to gather, collect free condoms and bring their questions and

concerns. Over the years, FHI has adapted DICs to the needs of the specific group and the location. Examples of DICs include:

- A small tea stall along the highway that functions as an community-based information point (CIP);
- A large room at a bus park where drivers and their helpers can watch videos, play games, pick up free condoms, bring along their friends and discuss their concerns;
- A petrol pump where truckers can pick up brochures on HIV/AIDS and free condoms;
- A wooden booth with a microphone to attract passersby to stop and receive communications materials about HIV/STI prevention at the border to India;
- A room within a VCT center for information on HIV testing as well as for support group meetings of people living with and affected by HIV/AIDS (PLHA) and
- A space within an FHI IA's office for hosting educational events, STI and VCT services several times a month, and monthly PE meetings.

In contrast to 1994, when FHI had no DICs, by 2004 FHI supported over 150 DICs throughout Nepal.

In addition to human resources to contact and connect with people at risk, FHI also uses large-scale events such as World AIDS Day and National Condom Day celebrations, entertainment (such as video shows, street theater and magic shows) and a variety of communications materials to offer other sources and opportunities for information. For example, in 2001 FHI produced two video films called *Jeevan ko Geet* (Song of Life) and *Jeevan ko Upahar* (Gift of Life) that told stories about young men to highlight prevention messages for youth.

How Has BCI Changed within FHI Programs Over the Past 10 Years?

At first, few Nepali knew about HIV/AIDS, so the focus was broad community education and awareness raising about prevention. To raise awareness about HIV/AIDS and to destigmatize condoms, FHI supported street theaters and large-scale public events and distributed communications materials to audiences. The materials contained general information about HIV/AIDS for all audiences. Over time, as public knowledge of HIV/AIDS rose, FHI focused more effort on reaching those most at risk and promoting and sustaining their behavior change through many channels of interpersonal communication. Materials also became very focused to specific audiences' needs for information and in a format and style that most appeals to that group. For example, comic books were developed as an entertaining way to reach transport workers with HIV/STI prevention messages.

From the beginning, FHI used outreach education to motivate FSWs and their clients use condoms, reduce numbers of partners and seek appropriate treatment for STIs. For example, in 1994 FHI mobilized five teams of OREs, community health nurses and supervisors that provided direct interpersonal STI and HIV/AIDS communication to these target groups. In 1998,



Community Events and Street Dramas Raise Awareness about HIV/AIDS and Related Issues

FHI's approach broadened to include peer education, based on effective projects in India. Quickly peer education became a major community-based, interpersonal BCI for HIV prevention. With hundreds of PEs, it was now possible for FHI to meet, educate and interact with the same person several times. Despite the difficulties reconnecting with such mobile populations, repeated interaction became a focus of BCI.

Repeated contact through different BCI also was important. To provide additional ways to interact and educate, DICs were added and then expanded. FHI also expanded its BCI to address a wider range of behaviors. Additionally, FHI now uses BCI not only to promote HIV prevention but also to promote service-seeking behaviors for STI and VCT and to reduce HIV/AIDS-related stigma and discrimination in communities.

OFFERING THE ABCs WITH A CUP OF TEA OR TIRE REPAIRS AT COMMUNITY-BASED INFORMATION POINTS

Along Nepal's East West Mahendra Highway, hundreds of trucks and buses stop for a meal, repairs and some rest. Next to a favorite picnic spot, one of many small tea stalls is distinguished by a signboard outside, announcing it as a Community-based Information Point (CIP) for health education. The tea stall owner also works as a PE for FHI and provides STI and HIV/AIDS information and condoms to the men who stop here.

CIPs are non-traditional venues for health communication, operated by PEs from their homes or places of work. The first CIPs were located in the *bhatti pasals* (liquor shops) and tea stalls. The women owners agreed to take on volunteer PE activities. Similar centers later were established at repair shops frequented by long distance drivers, at bus parks and at other locations regularly visited by men who could be clients of FSWs.

Most CIPs depend heavily on the networks of contacts and friends of the individual PEs. The PEs distribute free condoms and demonstrate correct condom use. They also motivate visitors to attend the FHI-supported STI clinics for diagnosis and treatment.

The messages communicated at these CIPs reach the large number of people visiting for other reasons—to have a cup of tea, buy liquor or even fix their rickshaw or vehicle. Many people drop in for information and/or condoms. These centers have been highly effective in reaching target groups. In 2004, FHI supported 94 CIPs.



Also in the process of trying new approaches for different audiences and as their needs changed over time, FHI has developed different BCI models and tools to help better communicate among its implementing partners and with beneficiaries. For example, mobility mapping has been used to identify ways to improve its BCI interventions, by shifting the location of the DIC and changing PE and ORE locations to reach larger numbers of those at risk.

What Has FHI Accomplished?

FHI credits BCI for HIV prevention for increasing knowledge and safer behaviors among target groups. Through BCI, over 95% of FSWs, transport workers and male laborers surveyed in 2001 in FHI's project districts knew that the using condoms could prevent HIV transmission. More importantly, behaviors also have changed: in the same 2001 survey, FSW condom use at the last sex act had risen to 87% and consistent use of condoms to 45%. Similar changes were seen in behaviors among FSW client groups. Clearly, behaviors are influenced by a variety of factors, and many including FHI's prevention activities contributed to these positive changes. FHI-supported PEs and OREs have played an important role in promoting and sustaining behavior change of groups vulnerable to HIV and STIs.

Another positive outcome of BCI is that peer educators—often marginalized or semi-literate—feel empowered by their ability to protect themselves, help others and work with a respected non-governmental organization (NGO). FSW PEs look for other ways to support themselves and their families, such as starting small income generating projects. Some have even progressed to become full-time OREs.

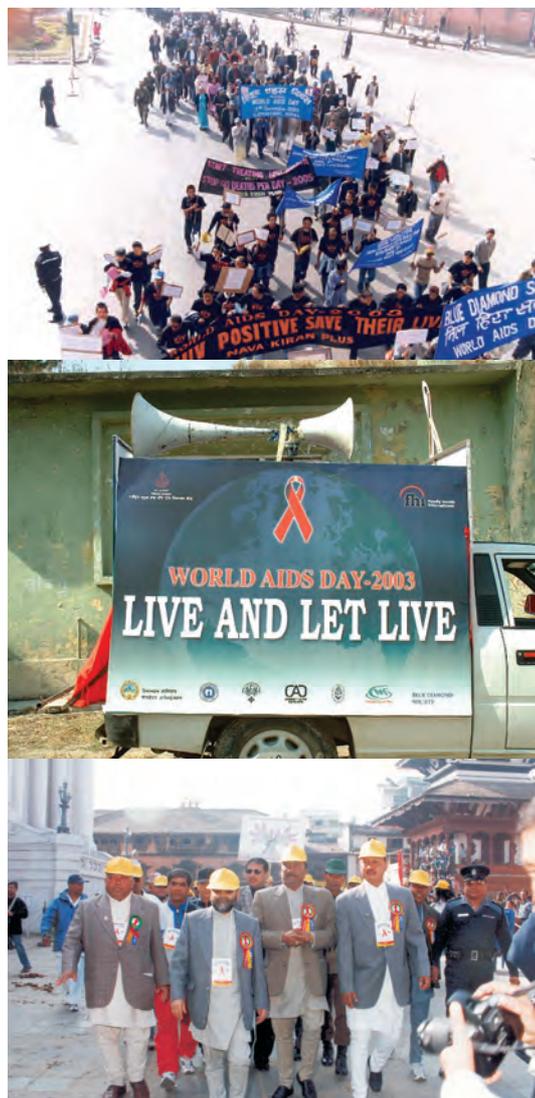
In support of PEs, FHI's partner organizations have developed various types of PEs and supporting materials, such as PE training manuals, flipcharts and communications materials. In 2004, FHI with partner organizations and PEs began to develop a comprehensive prevention to care, module-based PE training package to give PEs a broader range of tools to use and information to share.

How Has BCI Contributed to HMG/N's National HIV/AIDS Program?

FHI's work in BCI for HIV/STI prevention has contributed significantly to national HIV/AIDS strategies and objectives. Since HMG/N's first plan in 1993, FHI has worked collaboratively to design and implement prevention and control programs that reach target groups and promote sustained behavior change. For example, the current *National HIV/AIDS Strategy (2002–2006)* focuses on prevention among vulnerable groups, and FHI supports BCI for HIV prevention among these identified groups. FHI supports government in many other ways, such as producing materials for World AIDS Day and developing national BCI strategies. In these ways, FHI directly contributes to HMG/N's progress.

FHI's BCI projects have been used as models in other HIV/AIDS prevention projects in Nepal. FHI shares its materials, research findings and strategies with other organizations. Additionally, FHI IAs have leveraged their HIV prevention expertise to expand activities with other funding. Some of FHI's partner organizations also are strong advocates for HIV prevention at the policy level with government.

Even at the local district level, FHI and its IAs has worked with local governments through the District AIDS Coordination Committees (DACCs) to coordinate activities, promote collaboration and develop annual workplans for HIV prevention activities.



FHI Joined HMG/N and Others for World AIDS Day Events in December 2003

Mass Media Communications

What Are Mass Media Communications?

Mass media is a communication channel that uses radio, newspaper, print media, cinema halls and television to reach large audiences, usually among the general population. In Nepal, FHI uses mass media communications campaigns to broadly promote condom use to prevent HIV/AIDS, address issues of stigma and discrimination, and reach migrant men in Mumbai, India and also their families in their home villages in Nepal.

Why Are They Important in HIV/AIDS Programs?

Mass media communications are important because they can reach large audiences and promote key public health messages. FHI's first mass media campaign reached millions of Nepali. Mass media is a cost-effective way to reach large numbers of people. For example, the *Jhilkey Dai* campaign was estimated to have reached 13 million people a month through national radio alone. The wide reach of campaigns can include important secondary audiences, such as spouses of those most at risk and youth. Mass media communications campaigns sometimes address sensitive issues and therefore help to promote discussion and acceptance in society. FHI campaigns have helped destigmatize condoms, injecting drug use and HIV/AIDS.

What Are FHI's Mass Media Communications for HIV/AIDS?

FHI has developed five different mass media communications campaigns since 1995:

- **Condom Lagaun, AIDS Bhagaun** or **Use a Condom, Drive Away AIDS** Campaign (1995–1997) used print, radio and local informational events with a logo of a cartoon condom called *Dhaaley Dai* (brother condom) to reach millions of people. It promoted condom use for HIV and STI prevention. The campaign promoted purchasing or obtaining condoms from the private and public sectors, including community-based non-traditional outlets. One of the main achievements of this campaign was changing the perception that condoms were for family planning and raising awareness about their role in protecting against HIV/AIDS¹.
- **Condom Bata Suraksha—Youn Swastha Ko Raksha** or **Use A Condom To Protect Your Sexual Health** Campaign (2000–2002) adapted and modernized the cartoon condom in front of a Bollywood style backdrop as *Jhilkey Dai* (stylish brother condom). The campaign slogan also was revised to more broadly promote condoms for sexual and reproductive health. This second campaign also expanded its reach by: using targeted radio spots in five local languages; adding a 30-second cartoon aired on TV and in cinema halls; posting almost 150 billboards along the highways; and producing dozens of different merchandising materials. This campaign had an estimated monthly reach of 13 million radio listeners and 5.8 million television viewers.
- **HIV/AIDS Bare Aajai Dekhi Kura Garaun** or **Let's Start Talking About AIDS Today** was developed and conducted in 2002 in close collaboration with the National Center for AIDS and STD Control (NCASC) of HMG/N. It used striking a black and white motif of nine Nepalese celebrities, athletes and personalities to encourage youth to protect themselves from HIV. Film stars, athletes and PLHA all appeared on billboards,



Jhilkey Dai Makes His Television Debut in 2002

¹ Qualitative Study on the Efficacy of Dhaaley Campaign Slogan and Logo, Nepali Technical Assistance Group (NTAG), July 1998

posters, on radio and on television. The campaign was launched during the first football match of the 2002 World Cup. In the first three months, the campaign reached over three million people through TV, 2.5 million through print and three million through radio.

- ***Desh paradesh* or *My Country and Our Neighbor*** is the Safe Migration radio program. Developed in 2004 and broadcast beginning in 2005, it uses innovative means of participatory AM/FM broadcasting and satellite radio to link workers in India with their families in remote Farwestern districts of Nepal. This 26-episode program is a serial drama about two cousins traveling to and working in Mumbai as they encounter health, financial and social problems. It also includes a magazine show with news about Nepal, interviews and discussions.
- Stigma and discrimination reduction radio serial drama **called *Ek Aapash Ka Kura* or *Talking to Each Other*** was developed in 2004. This serial drama follows Sweetie and her boyfriend Jeevan in daily life. In each weekly 30-minute episode, they deal with situations with HIV/AIDS-related stigma and discrimination. The drama will be broadcast on Radio Nepal and four regional FM stations throughout Nepal for a year beginning in 2005. It is estimated over five million listeners will be reached per episode.

All of the campaigns were developed in coordination with HMG/N, based on formative research and were pretested. Some were developed closely with FHI IAs, target audience members, NCASC officials and local community members.

How Has FHI Mass Media Communications Changed Since 1994?

FHI's use of mass media has changed over 10 years as the media mix in Nepal has changed. In 1994, radio was very popular and the only way to reach the majority of Nepali who lived in rural areas. TV was available only in Kathmandu and on the Indian border. So mass media communications campaigns were designed to maximize radio and print media and to bring entertaining events to communities through street dramas and video vans to promote the campaign messages. For example, the *Dhaaley Dai* campaign in 1995 was broadcast on the only national TV channel, Nepal TV, mainly for Kathmandu audiences and on Radio Nepal to reach rural communities.

DHAALEY DAI: BROTHER CONDOM INFORMS NEPALI THAT CONDOMS PROTECT AGAINST HIV/AIDS

Before *Dhaaley Dai* arrived in Nepal, most Nepali did not think they could be at risk for STIs or HIV. People were shy when talking condoms or sex-related issues. Condoms were available as a family planning method, but not well known for STI/HIV prevention.

In 1995, FHI supported the first national mass media campaign in Nepal aimed at sexually active men under 30 to get their attention, make them aware and motivate them to action. The campaign used the catchy slogan and jingle *Use a Condom, Drive Away AIDS* with a simple cartoon condom logo. The campaign used TV, radio, billboards, print media, video film, street drama and a variety of special events.

FHI produced a range of communication materials, such as stickers, signboards, hats, informational brochures and calendars. *The Dhaaley Top Ten* cassette of popular songs and campaign spots was very popular among truckers. FHI later added other messages about being compassionate and kind to PLHA to address fears about people with HIV/AIDS.



At the time, the most effective means of reaching people particularly in rural areas was through radio. Uniquely, the campaign was closely linked to condom social marketing activities and outlets to help increase access and demand for condoms. This campaign reached millions and increased condom sales. Not only did the campaign promote safer sex messages, it also created awareness and acceptance of condoms.

At first, some felt the campaign was controversial, but the condom character and jingles proved very popular. Brother Condom is credited with destigmatizing condoms and raising awareness of their role in HIV/STI prevention in conservative Nepali society. In the campaign evaluation in 1998, all respondents liked and remembered the cartoon character. Even four years later, many respondents in a HIV/AIDS media recall survey for another campaign still spontaneously remembered the *Dhaaley* slogan.

WELL KNOWN NEPALESE PERSONALITIES “START TALKING ABOUT HIV/AIDS” IN

In 2002, NCASC wanted to capitalize on the excitement in Nepal about the 2002 World Cup and raise awareness about HIV/AIDS among the millions of youth who would be watching the football matches. The campaign aimed to further break down inhibitions about talking about HIV/AIDS and create compassion for PLHA. It was hoped that such discussion could promote healthier behaviors especially among youth and lessen the stigma for people living with HIV/AIDS.

FHI was one of NCASC’s main partners in the development of this national mass media campaign. It featured nine people speaking openly about different key messages. Media personalities, film stars, sports figures and a PLHA appeared.



For example, the national football coach shared:

In football one person’s mistake can lead to the team’s defeat. Similarly, in life, one careless mistake can lead to HIV/AIDS. The best way to protect yourself is to use a condom every time you have sexual intercourse.

The campaign used national television, radio, newspaper advertisements, billboards and special advocacy activities over six months. Over 1,200 TV spots and 20,000 radio spots were aired, with an estimated reach of 85% of youth in Kathmandu. When the campaign as evaluated at the end of 2002, people exposed to the campaign were more likely to know correct information than those not exposed. For example, campaign audiences knew:

- Using condom safeguards against HIV/AIDS/STIs (97% compared to 64%)
- A person can not get HIV by sharing a meal with someone who is infected (80% compared to 34%)
- A healthy-looking person could have HIV (80% versus 52%)

Campaign audiences overwhelming felt that a person infected with HIV/AIDS should continue to live at home with family or in the community at 81% versus only 32% of those not exposed to this campaign.

By 2002, regional and FM radio stations had flourished throughout Nepal, cable TV brought dozens of channels, and TV access and ownership had risen all over Nepal. In a 2002 national media recall survey, over 50% of rural respondents watched TV. The *Let’s Start Talking about AIDS Today* campaign heavily used television, and 69% of respondents in its evaluation had seen the spots on television.

In 2004, FHI added another channel of communication: digital radio. FHI has begun innovative programming using satellite radio and live broadcasts to reach migrant men in Mumbai and also their families in their home communities of Nepal.

Mass media channels changed, but also the content of messages also changed. In the beginning, condom use and knowledge about HIV/AIDS were low so FHI focused on educating all Nepali by talking openly and publicly about condoms and AIDS. After several years, condom promotion messages evolved from a focus on HIV prevention to a broader message about protecting health. FHI also added messages about treating PLHA with compassion and care in several of its campaigns.

What Has FHI Accomplished?

Mass media communications is one area of HIV prevention where FHI has been very successful in promoting key public health messages related to HIV/AIDS. FHI’s first HIV prevention campaign was the first of its kind in Nepal and was incredibly effective. Public recall of the campaign slogan was nearly universal by its conclusion and left such an impression that years later in 2002, many people still spontaneously recalled the slogan when questioned about HIV/AIDS messages.

In Nepal, the first two condom promotion campaigns were the only mass media communications campaigns about condoms for HIV/STI prevention aired nationally in Nepal. Almost 80% of ever-married women in the 1996 Demographic and Health Survey (DHS) who had ever heard of AIDS had learned about it

from radio—attributable to FHI’s *Dhaaley Dai* campaign. FHI continued its HIV prevention campaigns through radio and by the next DHS, the percentage of ever-married women who had ever heard of AIDS had almost doubled to 50% in 2001².

² Nepal Demographic and Health Survey 1996, Nepal Demographic and Health Survey 2001, His Majesty’s Government of Nepal

Subsequent campaigns also were effective. Evaluations of two other media campaigns were conducted in 2002 and were sampled from the general population throughout Nepal. Both found awareness of HIV/AIDS around 90%, and prompted recognition of *Jhilke Dai* campaign slogan was 89%.

Because condom promotion campaigns were linked to increased CSM efforts, FHI and IAs saw stigma around carrying or buying condoms decrease dramatically, although there is still shyness to buy and carry condoms in Nepal.

FHI also has complemented HIV prevention messages with other related topics, such as HIV/AIDS related stigma and discrimination. Since its first campaign, FHI had added messages to reduce stigma and discrimination to the *Dhaaley Dai* campaign, featured a PLHA in the *Let's Start Talking about AIDS Today* campaign and created a year-long radio serial drama in 2004. In addition, FHI is pioneering a cross border satellite radio program with storylines and live broadcasting developed weekly on site in Mumbai, India and migrant-source communities in Nepal.

How Has Mass Media Communications Contributed to HMG/N's National HIV/AIDS Program?

All of FHI's campaigns have been developed in collaboration with HMG/N and are in support of its national HIV/AIDS-strategies' objectives. When the first campaign was developed, FHI formed a media advisory team that included a variety of government representatives to approve television and radio scripts. Nepal TV and Radio Nepal provided appropriate time slots on the nation's only electronic mass media channels.

When NCASC wanted to develop the *Let's Start Talking about AIDS Today* campaign, a small group that included government officials created the messages. This campaign directly responded to a NCASC need and contributed to its *Year of HIV/AIDS Awareness*. It also included a unifying logo developed to tie various government activities together. FHI's campaign for Nepali migrants and on HIV/AIDS-related stigma and discrimination are innovative and in direct support of priorities in the current *National HIV/AIDS Strategy* (2002–2006).



HMG/N, USAID and FHI Together Launch the *Jhilkey Dai* Campaign in 2000

Condom Social Marketing (CSM) and Distribution

What is CSM?

Social marketing applies marketing techniques to social challenges, such as HIV/AIDS prevention. It creates a demand for a desirable product or service through communication, often using both BCI and mass media communications. CSM focuses on both increasing the supply of condoms and the demand for this product. CSM offers condoms at a subsidized price so that they are more affordable to the target audience. Efficient distribution processes ensure appropriate goods or services are available for the intended consumers. CSM in Nepal began as a family planning activity over 25 years ago and began for HIV/STI prevention in 1994. For FHI, CSM best responded to the needs of the most vulnerable groups through a community-based model.

Why Is CSM Needed for HIV/AIDS Programs?

Consistent condom use is one of the ABCs of HIV prevention, so a sufficient supply of condoms is essential. While condoms are provided free through public sector services especially for those who cannot afford to buy them, many Nepali are able to afford high-quality condoms at a low cost. CSM complements other prevention interventions and increases the accessibility, demand and acceptance of condoms. CSM increases access to needed goods and uses marketing to meet public health priorities.

How Did FHI Provide CSM for HIV Prevention?

FHI's CSM activities began in 1994 with on going CSM for family planning. The community-based CSM evolved in the 1990's to bring condoms to those most at risk of HIV and STIs. This model was designed based experience from ongoing HIV prevention programs that reported condom accessibility and availability were barriers to consistent condom use among vulnerable groups. FHI began community-based CSM with an initial market assessment to identify potential condom outlets in non-traditional venues. In addition to distribution to traditional outlets such as pharmacies and medical shops, FHI wanted to expand distribution through non-traditional outlets. Non-traditional outlets include tea shops, *paan* (tobacco) shops, grocery shops, *bhatti pasals* (liquor shops), kiosks, bars, hotels, petrol pumps and PEs. Over 5,600 various types of condom outlets were created in 16 districts, plus Kathmandu and Pokhara. In addition to introducing new types of CSM outlets, FHI also expanded the choice of socially marketed condoms, offering 17 different brands of condoms to respond to consumers' demand for more choice. These varieties complemented the well-established CSM brands for family planning in Nepal.

CSM included distribution, recruitment of participating outlets, product placement, consumer and merchant education about condoms, and monitoring. The CSM representatives routinely visited outlets to restock, distributed promotional materials and updated sales records. FHI's CSM partners distributed display racks, condom posters, calendars, condom brochures, danglers, stickers and signs. Over 1,800 people were trained over two years, such as



CSM at a Small Kiosk, a Non-Traditional Outlet

FSWs, their clients, MSM, IDUs, retailers, PEs and NGO staff.

To create interest in socially marketed brands and condoms in general, FHI conducted dozens of types of public events, competitions, essay contests, rickshaw races and community activities. Especially early in FHI's work in Nepal, shyness about discussing, selling, buying and carrying condoms was pervasive throughout the country. These entertaining and educational events helped reduce some of the stigma around condoms.

From the consumer's perspective, condoms became more accessible. These non-traditional outlets were open longer hours and often located near places where FSWs, their clients and MSM socialize or work. For example, a truck driver who stopped for a rest along the East-West Mahendra highway could buy a range of condom brands at the small roadside kiosk.

How Did FHI's CSM Change from 1994 Through 2002?

From the beginning in 1994, FHI recognized CSM and related communications campaign promoting condom use were essential to its prevention program. FHI first worked with the existing family planning CSM program, adapting existing family planning social marketing systems and approaches to reach those populations most at risk for STIs/HIV. At this time, condom use was a very sensitive and taboo subject, and it was difficult to convince some retailers stock condoms.

From 1996, FHI began directly funding CSM projects and in 1999, refined its strategy to focus on community-based CSM to increase access to populations at risk. FHI teamed up with private contraceptive companies, pharmaceutical distributors and NGOs to create a condom distribution mechanism that made condoms affordable and easily accessible for target groups. FHI worked with its partners to make condoms available at non-traditional distribution outlets. Over 5,000 outlets were set up in areas where high-risk sexual activity was occurring.

Also by the mid-1990s, research showed price was not a major issue when marketing condoms. People were willing to pay more for a better quality product, and consumers wanted choice. In response, FHI CSM diversified product mix by adding a range of condoms to the existing well-established CSM brands for family planning.

By the end of 2002, FHI concluded its CSM activities. From 2003, Population Services International (PSI) is supporting CSM within their reproductive health social marketing strategy.



Rickshaw Races and Other Types of Events Generated Awareness about Condoms

LATE NIGHT PLACES TO FIND A CUP OF TEA, CIGARETTES AND CONDOMS: IN- CREASING ACCESS FOR THOSE MOST AT RISK THROUGH COMMUNITY-BASED CSM

In 2002, as FHI prepared to conclude its CSM activities, a review team spent a week in the field, traveling up and down the East-West Mahandra highway. Covering all 16 CSM project districts, they visited over 200 outlets, interviewed 35 outlet operators and observed both FSWs and their clients.

After returning to Kathmandu the team analyzed condom distribution data, stocking and sales patterns, and communication methods. Overall, it was concluded that FHI's CSM project offered "the right product mix, at the right price in the right mix of places and used the right mix of communications". Other noted accomplishments were:

- Substantial number of FSW and clients were protected.
- Condom stocks and resupply of most outlets were adequate.
- Good BCI systems for one-on-one counseling exist.
- Pack prices are appropriate for different user groups.

Useful lessons learned included:

- The community-based social marketing model works well for HIV prevention.
- Non-traditional outlets can be harnessed successfully.
- DICs are effective for educating about and promoting condom use.
- Converting high risk non-users into users requires substantial effort and time.



What Has FHI Accomplished?

CSM in Nepal was a unique intervention for FHI globally, but one that integrated well into its HIV prevention activities in Nepal. FHI recognized the importance of expanding supply through distribution systems while increasing demand through its ongoing communications campaigns. For this reason, mass media communication campaigns were closely linked to promote condom use and condom sales, with impressive results. Between 1993 and 1996, condom sales increased 189% in the 22 districts where CSM was implemented. The following three years, FHI sold over 16 million condoms in its program area.

When FHI shifted its strategy to be more community-based, its annual condom sales decreased. Its CSM activities were still considered very successful because a larger proportion of total sales were from outlets known to be in high risk areas accessible to vulnerable groups. Also, this targeted CSM project was complemented by the ongoing large-scale CSM program for family planning. Overall, national condom sales combined from these two sources increased significantly from 1997 to 2002. More condoms were sold in Nepal and hopefully used, which is a considerable achievement for reproductive health and HIV prevention programs.

An important accomplishment was the reduction of the stigma formerly associated with condoms. In 1994, condom use was a very sensitive and taboo subject. Even when retailers were convinced to stock condoms, within a few days they were not selling them or kept them out of view saying that customers were avoiding the stores due to condom visibility. Female retailers in particular were teased for selling condoms and were reluctant to participate in CSM. By 2002, condoms were visibly displayed in kiosks and chemist shops. Much of the shyness had been reduced.

How Did FHI's CSM Activities Contributed to HMG/N's National HIV/AIDS Program?

HIV prevention has consistently been the focus of government efforts to combat and contain HIV/AIDS in Nepal. FHI has contributed by supporting the first CSM program for HIV/STI prevention and improving distribution strategies to make condoms more accessible to the vulnerable groups identified in HMG/N's national policies.

FHI initiated CSM for HIV prevention in 1995 that complemented public sector condom distribution, private sector enterprise and the well-established CSM for family planning.

As a result of CSM activities and mass media campaigns promoting condom use, more people were seeking condoms, and more condoms were needed to ensure consistent use and dual protection. In fact, HMG/N reported an increased demand for free condoms from its health facilities intended primarily for family planning clients. CSM helps decrease the burden on HMG/N supplies by adding low cost options at conveniently-located outlets for those able to pay.

FHI's CSM helped generally promote condom use through the mass media communications campaigns. Condoms are not a popular family planning method, with just 3% of currently married women reporting using condoms in the 2001 Nepal Demographic and Health Survey. So the increases in condom sales recorded by CSM projects it would seem contribute mainly to HIV prevention.

STI Services

What are STI Services?

STI services provide quality counseling, diagnosis, treatment and management of sexually transmitted infections—such as syphilis, gonorrhea and chlamydia—for men and women. FHI's STI services are provided according to *National STI Case Management Guidelines* serve most at risk populations. Over the past 10 planning clinics, pharmacies, chemist shops, NGO-supported static clinics and mobile clinics.

Why Are STI Services Important? Why Are They Needed for HIV/AIDS Programs?

STI diagnosis and treatment is a core HIV prevention intervention because some STIs such as syphilis increase the risk of HIV transmission. Also, STIs and HIV are both transmitted through unsafe sex, making STI services an opportunity to promote HIV prevention and VCT.

How Does FHI Provide STI Services?

FHI STI services strategy is to provide quality services that are accessible and appropriate for vulnerable groups, particularly FSWs. Service delivery has been designed to best serve this population of highly mobile, marginalized women with little or no access to health care. Many of the women have never been examined by a doctor and are shy to talk openly about their risk behaviors or health problems. Clinics are promoted among other groups at risk, including MSM, migrant men and FSW clients. Often there are designated clinic days for referred male patients, such as a mobile STI clinic for MSM once a week in Kathmandu.

In coordination with ongoing BCI activities, OREs and PEs discuss STI risks and symptoms with all target groups and make referrals to STI clinics in their area.

STI services are provided by a team of a doctor, nurse and lab assistant. Each of the 12-20 patients every clinic day has their history taken by the nurse in a private room. The doctor then reviews the history, carefully examines the patient and collects samples for STI testing (including routine screening for syphilis). After the lab assistant takes a blood sample for syphilis testing, the patient waits for about an hour for the test results. Based on a combination of risk assessment, exam findings and test results, patients are diagnosed and if needed, treated. Some clinics offer subsidized priced drugs. For those who cannot afford to pay, treatment is free. Patients are given information about the 4 Cs: counseling; compliance to treatment; condom use; and contacting and referring partners. Condoms and informational brochures are available, and each patient receives a follow-up card and partner notification cards when needed.

"TUM KO HO GHAYA" ("YOU HAVE HAD IT"): A SYPHILIS PATIENT'S EXPERIENCE ILLUSTRATES THE IMPORTANCE OF GOOD COUNSELING AND CARE

A 20 year old single businessman came to an FHI-supported STI mobile clinic, after being referred by one of FHI's BCI partner organizations. He had had a non-itchy red rash all over his body for two weeks, plus genital swelling and scaly lesions on his palms and soles. He seemed depressed and complained of a dull headache. When he arrived, he said, "I know you can't help me because I have AIDS but I want to get rid of this skin problem".

Clinic staff took a history and examined him. A cautious probe into his sexual history revealed that he had unprotected sexual intercourse five months ago with a woman unfamiliar to him. He then had a small genital lesion that was painless and went away on its own after few weeks. Weeks after the ulcer disappeared, the current symptoms began. There was no history of fever, itching or urethral discharge.

Concerned about these unusual symptoms, he first went to a regional hospital for an examination and tests. When test results came back, the doctor told him "*tum ko ho ghaya*" ("you have had it") and was directed to a room "for the needful". As he left, he felt his "world crumbling to pieces". He felt "life isn't worth living". He "knew he had AIDS" and felt that "medical sciences cannot rescue him from the anguish of AIDS". He complained of hopelessness and a constant feeling of guilt.

After examination, an initial diagnosis of secondary syphilis was made. Tests conducted in the clinic lab confirmed he had syphilis. He was treated immediately that afternoon with penicillin, as recommended by HMG/N STI guidelines. A review of his hospital reports showed indeed he had tested positive for syphilis—but negative for HIV.

With this news, he exclaimed, "I am reborn. I have no HIV/AIDS. Thank you!" He left the room in a jubilant mood. He pledged to never indulge in unsafe sex and that he would "offer a goat at the sacrificial altar for the gods for having given him a new life".

He was advised repeat the HIV test at a nearby center and again tested negative. The young patient was counseled, encouraged to refer his sexual partners, scheduled to return for further treatment and given some free condoms. Three weeks later he returned and seemed well on his way to good health with an optimistic outlook on life.

Referrals are made to VCT, family planning services or other needs identified during the visit. Coordination with FHI BCI IAs is critical for making referrals, often accompanying patients, encouraging follow-up appointments and giving feedback to the STI clinics.

Over the years, FHI has offered STI services in different ways and through different venues. Currently, FHI offers STI services in two ways. First, FHI has established clinics at fixed locations where services are often on a regular schedule. This is the traditional health service delivery model, and one FHI has used since its first STI project static clinic in Chitwan in 1996. In the current model, static clinics offer service several times a week or month, depending on the size of populations to be served. For example, STI services are available five days a week at static clinics in Kathmandu, Nepalgunj and Hetauda. Other static clinics are located within BCI partner organizations' office or DICs in places such as Inarwa and Narayanghat and are open at least two days a month.



Health Along the Highways: A Static Clinic Offers STI Care at a Truck Park in Hetauda

FHI's second service delivery model both increases accessibility and use of human resources by sending static clinic staff on the road to run one-day mobile clinics several times a month. Usually, STI clinic teams along the highways travel 12-15 days a month to provide services at three to four static clinics and four to six mobile STI clinic sites at BCI IAs unit offices or DICs. FHI also schedules STI mobile clinics as requested by organizations working with these same vulnerable groups, such as HIV prevention projects for IDUs. These teams work long clinic days to set up mobile clinics and spend much time on the road. In addition to traveling several hundred kilometers a month, busy roads and frequent security checkpoints can make short distances take hours.

How Have FHI's STI Services Changed Over the Ten Years?

From the beginning, FHI has focused on reducing STIs as one of its main objectives. Initial strategies were to reach high risk women such as FSWs through family planning clinics and symptomatic men through medical shops and pharmacies. At the time, syndromic approach for STI diagnosis and treatment in resource-constrained settings was international best practice and was the core of both Nepal's national guidelines and FHI's protocols. FHI trained family planning clinic staff, chemists and druggists to provide quality STI care. The chemists training project was considered on the most innovative interventions of its time and was cited by UNAIDS as one of its recommended best practices for HIV/AIDS programs.

By 1998, both strategies were being refined. For men, FHI's highly regarded pharmacy-based STI activity was phased out due to difficulties finding cost effective ways to strengthen the chemists project. Further directing the change in strategies were new data in 1999 that syphilis was high among FSWs at 18% and truckers at 5.3% in the FHI program area. Because syphilis is a known risk factor for HIV transmission, focus shifted to an etiological approach that could test and treat syphilis. This change was supported also by growing international evidence that syndromic approach was missing the majority of women with STIs that experience no symptoms.

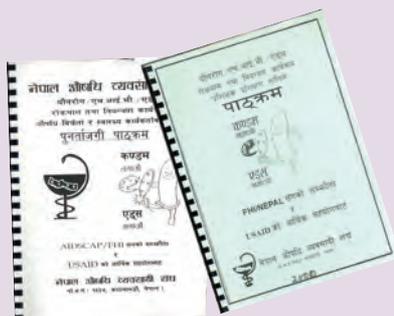
With syphilis at 18% and gonorrhoea and chlamydia at 9%, FHI also decided to shift from the broad service delivery platform of family planning clinics to better reach the smaller numbers of high risk women who had multiple partners. Mobile STI services were designed, and linkages with BCI prevention partners for referrals

IMPROVING STI PREVENTION AND TREATMENT WHERE NEPALI FIRST GO FOR CARE: CHEMIST SHOPS AND PHARMACIES

For many ailments, Nepali go first to the chemist's shop (pharmacy) for medicine to relieve their problem, including symptoms that could be STIs. After a qualitative study in 1994, FHI formally assessed the quality of STI services at these types of shops in 1995. Findings included the need for improved treatment advice, dispensing of medications, counseling for partner treatment and promotion of condoms.

FHI aimed to improve the quality of these STI services through training. FHI worked in 22 districts to train chemists and druggists on syndromic STI case management. A series of two-day trainings were conducted in Central Nepal, using a curriculum developed for this audience. Over two years, FHI trained 579 chemists, and over 20% were HMG/N health staff.

This innovative activity was cited as a UNAIDS Best Practice.



To evaluate the effectiveness of the training, a study was conducted in 1997, using simulated patients seeking advice for possible STIs. The study found that after the training:

- Four of every five chemists suggested medications to treat STIs in both the baseline and follow-up surveys.
- Nearly 45% of the chemists suggested the correct medications and dosages, up from just 0.8% at baseline.
- Chemists more correctly dispensed medications after training. Before training, few followed national guidelines: only 1% for gonorrhea and 2% for chlamydia. After training, over 50% were dispensing appropriately for both infections.
- More chemists suggested condom use after training, up from 14% at baseline to 23% at follow-up.
- Four times as many chemists encouraged patients to refer sexual partners after training (from only 5% to 21% at evaluation).

FHI also found that chemists' retention of the training content substantially decreased after three months following training.

were strengthened. By 2004, FHI provided STI care 170 clinic days a month through 14 static clinics and dozens of mobile clinics.

When FHI expanded its HIV prevention activities along the highways to Farwestern Nepal in 2002, 130 pharmacies and chemist shops in eight districts provided STI syndromic management. This support was phased out when static and mobile clinical services were established in key towns along the highways in 2004.

In 2004, FHI also added VCT services to some STI clinics. By the end of 2004, the majority of STI static clinics were already offering VCT as a pilot phase, with plans to add VCT to many others in 2005. All STI services have links to VCT centers in their area for referral.

What Has FHI Accomplished?

FHI has field tested and adapted several innovative approaches to providing STI services, such as pharmacy-based STI services and mobile services to reach those most at risk. FHI has also modeled an enhanced syndromic approach to STI diagnosis and treatment by adding basic laboratory testing to both static and mobile clinic services.

Over 32,000 people have been diagnosed and treated over the course of 10 years of FHI support for STI diagnosis and treatment. And most significantly, FHI's surveillance research found syphilis dropped among FSWs and truckers from 1999 to 2003 in its program area. STI services were redesigned based on the 1999 findings to specifically test and treat for syphilis, a known HIV risk factor. While these decreases are not attributable to FHI's work alone, nearly 100% of thousands of STI patients seen in FHI STI clinics in this area were screened (and treated if required) for syphilis since 2001.

Partnerships have been essential to reaching those in need of STI services and ensuring quality of care. FHI has worked with several national professional associations of doctors, chemists, druggists and family planning providers to train thousands of healthcare professionals throughout Nepal. FHI developed partnerships with transport associations to provide STI services to its members, such as during the cross border collabora-

tion with STI services in Raxaul, India and currently at a truck park in Hetauda. FHI linked STI services with its BCI projects to raise awareness about risks and symptoms of STIs and to make referrals to upcoming clinics. Other innovative partnerships are centered on making treatment affordable or free for those who can not pay. FHI partner organizations created revolving funds for this purpose. As caseloads increased and protocols required more expensive drugs, FHI developed a partnership in 2004 with the Japan International Cooperation Agency (JICA) and NCASC to supply donated STI drugs to FHI-supported clinics that serve those most vulnerable to HIV and STIs.

How Have FHI STI Services Contributed to the HMG/N National HIV/AIDS Program?

STI control has always been a part of HMG/N's HIV/AIDS strategies, and there are regional STD clinics at HMG/N hospitals throughout Nepal. These centers usually are stigmatized, and most people are reluctant to go. Vulnerable groups such as FSWs, MSM or IDUs are more comfortable with FHI STI services designed for them and offered in a convenient, discreet setting. FHI therefore helps to serve under-served populations following national standards of care and supports government in fulfilling its strategy. Patients diagnosed at an FHI clinic are more likely to receive treatment because drugs are often subsidized or provided at no cost, for those unable to pay.

In support of NCASC, FHI has participated in *National STI Case Management Guidelines* development. In 1994, HMG/N initiated the development of Nepal-specific national clinical guidelines for STI diagnosis and treatment. FHI provided technical assistance to develop, test and finalize them in 1995. FHI again participated in the process in 2001 and in 2004. In 2003, FHI supported some anti-microbial resistance research in some STI clinics to find out if gonorrhea was resistant to the most common treatment Ciprofloxacin—as is true in much of Asia. These findings and other FHI technical assistance were useful in the 2004 guidelines revision.

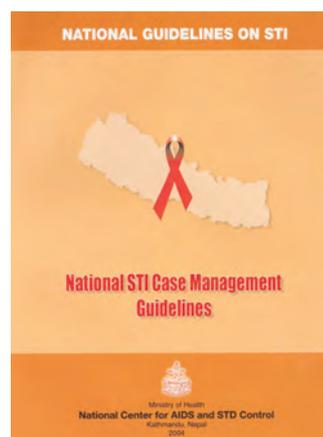
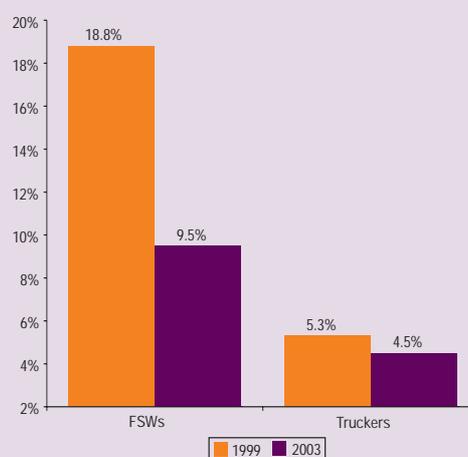
Based on national STI guidelines, FHI supported the development of a training curriculum to update doctors on the latest clinical information and the syndromic approach to STI care. In 1996, FHI produced and distributed a full training package for general practitioners, complete with overheads and color slides.

Over the decade of FHI's work in Nepal, it has contributed both STI technical assistance and services to HMG/N's national HIV/AIDS program.

FHI SERVICES HELP REDUCE SYPHILIS AMONG FSWS AND TRUCKERS

After a 1999 study found high rates of syphilis among FSWs and one of their client groups, truckers, FHI modified its STI strategy to better test and treat syphilis. Clinics were set up along the highways as mobile service vans able to bring a small lab and clinical staff to over 80 locations in 16 districts. A comprehensive STI service was offered and all patients were screened for syphilis.

By 2003, this targeted intervention paid off: syphilis was halved among FSWs and dropped by 20% among truckers.



FHI Helped HMG/N Develop National STI Guidelines in 1994 and Update Them in 2001 and 2004

Risk Reduction for IDUs

What Is Risk Reduction for IDUs?

Risk reduction for IDUs is an integrated set of activities that provide information, supplies and services to IDUs to help decrease their vulnerability to HIV. Realizing drug use may continue, activities reduce the harmful physical and social consequences. Activities can include needle and syringe exchange services, education of drug users, referrals to other services (such as STI or VCT services) and drug treatment and substitution programs. Effect programming recognizes that these behaviors are a result of various complex social, environmental, economic, cultural and personal factors.

Why Is Risk Reduction Important? Why Is It Needed for HIV/AIDS Programs?

IDUs can be very vulnerable to HIV/AIDS because of their unsafe needle and syringe sharing and injecting behaviors. Also because of addiction and illicit drug use, IDUs are a difficult group to reach and to support for sustained behavior change. In countries where injecting drug use is prevalent such as Nepal, risk reduction is an essential element of a comprehensive HIV prevention program—but often complicated by legal, social and cultural barriers. As long as people continue to spread HIV through drug injecting, risk reduction for IDUs will be needed to minimize the potential harm from HIV.

What Were FHI's Risk Reduction Activities?

When FHI began its risk reduction program under the Nepal Initiative in 2001, needle and syringe exchange and drug rehabilitation services had been available in Kathmandu already for 10 years. But these efforts were not sufficient to halt the spread of HIV and by 1999, IDU HIV prevalence in the capital had already soared to almost 50%. FHI then supported research in 2001 and found prevalence among male IDUs in Kathmandu had again increased to 68%.

For the duration of the Nepal Initiative, the expanded response introduced a range of services for risk reduction, referred to as a “minimum package”. It included: BCI; drugs and blood borne virus prevention education; needle and syringe exchange; condom distribution with safer sex education; safe injecting education and supplies; primary health care (PHC) services and abcess care; community advocacy; and counseling. Centers offering the minimum package developed links and referral networks with other services such as drug detoxification, rehabilitation, STI services, VCT centers and crisis counseling.

THE NEPAL INITIATIVE OFFERED HOPE, NEEDLE EXCHANGE AND BASIC HEALTH CARE SERVICES FOR IDUs THROUGHOUT NEPAL

In 2001, many of the young IDUs gathering in parks and other public places in Kathmandu knew they were at risk for HIV. Most knew someone who had died of AIDS, and many had heard that seven of 10 IDUs there had HIV. But few had access to the services and supplies needed to protect themselves and their friends. In fact, of the estimated 30,000 IDUs in Nepal at that time, fewer than 1,000 were receiving any type of services at the beginning of 2002.

Funded by a consortium of donors, The Nepal Initiative was created to rapidly implement an expanded response to provide a minimum package of services for this vulnerable group. FHI with a total 19 partners designed and implemented risk reduction activities in four “clusters” around a dozen major cities such as Kathmandu, Birgunj, Pokhara, Nepalgunj, Butwal and Biratnagar.

Services included the BCI for HIV prevention and the distribution of bleach, sterile water, condoms and communications materials—as well as needle and syringe exchange. Fifteen organizations provided these services in fixed DICs and during outreach. Four others provided PHC, counseling, dual diagnosis and advocacy. FHI also offered complementary services of referrals for VCT and crisis management, drug detoxification and rehabilitation, and STI services.

By the end of 2002, almost 6,000 IDUs were regularly receiving services. HMG/N had approved 26 centers that offered needle and syringe exchange. Monthly these centers were distributing over 23,000 condoms, providing almost 4,000 units of bleach and sterile water, and offering counseling and PHC to over 500 IDUs.



FHI and its partner organizations rapidly established a network of these risk reduction services in key areas of Nepal. The four areas of risk reduction programming were called “clusters” and included: Capital Cluster (Kathmandu, Lalitpur, Bhaktapur districts); West Cluster (Pokhara, Bhairahawa, Butwal); East Cluster (Biratnagar, Dharan, Damak, Kakarvitta); and Central Cluster (Hetauda, Birgunj). Some partners offered the minimum package of services while others provided the complementary services. In the Capital Cluster in Kathmandu Valley, the municipal governments in the three districts and partner organizations provided the minimum package. Other organizations offered capacity building, PHC, counseling, advocacy and STI services.

Another component of FHI’s risk reduction program was oral substitution therapy. At the beginning of the Nepal Initiative, there was only one such program in the country that reached 180–200 patients in Kathmandu. FHI worked with HMG/N to develop *Policy Guidelines For Oral Substitution Therapies in Nepal* and advocate for these services to be expanded to the other three clusters. Advocacy through exposure visits, guidelines development and events was important and helped create an enabling environment for more effective risk reduction programming. At the national level, advocacy for policymakers and parliamentarians helped bring awareness to a higher level within HMG/N, improved coordination between ministries and supported policy changes.

The combination of all of these risk reduction activities reached thousands of IDUs throughout Nepal who previously had little or no access to information and services that make them less vulnerable to HIV.

How Did FHI Risk Reduction Activities Change?

FHI worked on risk reduction for IDUs only in 2001 and 2002. Strategies and interventions rapidly scaled up nationally and expanded coverage. By the end of 2002, remarkable progress had been made in building national capacity, support and services for risk reduction. Controversial initiatives such as needle and syringe exchange and methadone substitution therapy however needed more political commitment, time and resources to be scaled up and sustained.

Also while FHI no longer directly supports risk reduction activities, other services for IDUs continue to be offered through ongoing BCI, STI and VCT programming. For example, VCT centers in Kathmandu and Pokhara have been set up within well-established organizations that work with IDUs to reduce their HIV risks. In the future, FHI will strengthen care, support and treatment services to better care for the over 8,400 IDUs estimated to be living with HIV/AIDS.

What Has FHI Accomplished?

Risk reduction is an area where HMG/N, FHI and its partner organizations together made great contributions to HIV prevention in Nepal. FHI managed the first large-scale risk reduction program and was able to offer a range of services in four regions of the country.

FHI helped set the standard for risk reduction for IDUs as the minimum package of services. As a result, 19 organizations now have the capacity and networks to provide quality risk reduction services—including some HMG/N facilities. By the end of 2002, 26 centers were approved for needle and syringe exchange. Besides the minimum package, complimentary components were initiated, such as social services, demand reduction, counseling training and sustainable human development (including vocational training, income generation and small/medium business enterprise).

FHI used peer-based approaches and built capacity for outreach, interpersonal BCI and counseling. These approaches complemented the integrated program design that looked collectively at progress in a geographic

area, rather than at each partner organization's contributions. Program design, mapping, training and monitoring were done together across all projects to minimize gaps and redundancies.

FHI conducted research among IDUs to better understand their needs, behaviors and networks. Ethnographic studies offered insight into sharing behaviors and networks, as well as gave this often marginalized group a voice through its findings. The findings were useful in raising awareness, mobilizing commitment and resources, strengthening services and developing communications materials.

Communication materials were developed by and for IDUs on topics such as abscess management, syringe cleaning, risk reduction and overdose management. Flip charts were developed to aid in outreach. Other print materials were produced to inform policymakers and stakeholders about the importance of risk reduction and the needs of IDUs. For example, fact sheets on different aspects of harm reduction also were developed.



Fact Sheets on Risk Reduction Helped Raise Awareness and Advocate for Needed Services

Most importantly, FHI through its risk reduction partners was able to exchange over 170,000 needles and syringes in just six months. By the end of 2002, almost 6300 IDUs were contacted—94% of whom received regular services.

How Has Risk Reduction Contributed to HMG/N's National HIV/AIDS Program?

HMG/N, FHI and the many other Nepal Initiative partners worked together to rapidly develop and implement risk reduction activities as an expanded response to the growing HIV/AIDS epidemic in Nepal. These were the first large-scale activities specifically for IDUs to reduce their vulnerability to HIV. Given the high HIV prevalence among IDUs and the potential for bridging into the general population, risk reduction for IDUs is critical. HMG/N Ownership of and commitment to the risk reduction program was strong.

Risk reduction raised and addressed some controversial issues, such as needle and syringe exchange and oral substitution therapy. HMG/N eventually approved a total of 26 government DICs to provide needle exchange service by the end of 2002.

On the policy level, HMG/N officials were exposed to regional and international best practices during exposure visits to methadone substitution projects and various conferences. Advocacy created an enabling environment for more effective risk reduction programming, improved coordination between ministries and affected positive policy changes. For example, *National Policy Guidelines for Oral Substitution Therapy* were developed and then endorsed by the National AIDS Council in October 2002.

Care

Voluntary Counseling and Testing (VCT)

What is VCT?

Voluntary HIV counseling and testing (VCT) is the process by which an individual undergoes counseling enabling him or her to make an informed choice about being tested for HIV. Only the individual can decide to be tested, and the process must be confidential. VCT also includes post-test counseling to support the individual to practice safer behaviors and receive appropriate referrals regardless of the result. VCT is more than just HIV testing because it includes professional counseling. VCT combines counseling and testing into a service that increases the benefits of both.

Why Is VCT Important? Why Is It Needed for HIV/AIDS Programs?

VCT is important for several reasons. First, it offers people who are concerned about their exposure to HIV a confidential way to be counseled, learn more about HIV/AIDS and if they choose, to find out their HIV status.

For those who decide to be tested and are negative, they can then protect themselves and stay HIV free. For those who are positive, they can begin to accept the results, protect their health, protect others from being exposed and seek available services to stay healthy. VCT services are an entry point to both prevention and care. For the majority of the estimated 60,000 PLHA in Nepal are not aware of their status, VCT that can help them learn their status and access care, support and treatment services earlier to preserve their health.

How Are FHI VCT Services Provided?

FHI VCT services in Nepal are offered through its IAs as a stand-alone service or integrated into other services such as STI clinics. VCT is a simple service to provide, but quality is critical to ensure accurate results and confidentiality to protect clients' rights.

To promote VCT services among those most at risk, OREs and PEs talk about VCT and sometimes accompany potential clients. At the clinic, staff ensure that the person receives counseling before and after the test and is undertaking testing voluntarily.

VCT SERVICES SUPPORT AND INSPIRE A FSW TO CHANGE HER LIFE



At just 14 years old, Kalpana (pseudonym) left her village to stay with relatives in Kathmandu to work and send money home. Sadly, her relatives forced her to earn money by becoming a FSW. To survive, she had no choice.

After a few years, she got married to a street peddler and happily gave up sex work. She believed things would be different. But when she was pregnant, her husband found out

about her past and deserted her. With no way to support a child, she returned to sex work.

Then, her life began to change by a chance encounter with a peer educator from one of FHI's VCT partner organizations. On the streets of Kathmandu, she learned about VCT and other support from this center. There, the counselor made a referral to a hospital and helped her get free treatment for a chest infection. Later, she came and talked about wanting to improve her life.

Kalpana now works part-time there, encouraging her peers to reduce their risky behaviors and use condoms consistently. She gives condom demonstrations, distributes free condoms and tells her old FSW friends about VCT services. She also found a part-time job at an income-generating project for PLHA, packing socially marketed condoms.

Kalpana has stopped sex work, is happy with her job and is raising her daughter well. Still scared of discrimination because of her past, she has changed her life for the better because of the inspiration and support she received from this VCT center.

A VCT client is first met by a trained counselor in a private room and receives pre-test counseling. They discuss behaviors to assess risk and when appropriate the VCT counselor recommends HIV testing. Testing is done by trained lab staff according to the *National Guidelines for Voluntary HIV/AIDS Counseling and Testing* using rapid HIV tests to be able to provide same day results. Post-test counseling is then conducted before the counselor shares test results confidentially with the client. For those who test positive, support groups' referrals and further counseling are available through the VCT centers. Regardless of results, clients are referred for other services and provided with informational brochures. Each clinic has developed a referral network and directory to improve referrals to other needed services, such as screening, diagnosis and treatment for tuberculosis and STIs.

How Have VCT Activities within the FHI Program Changed?

While HIV testing at government facilities has been available, VCT existed in only one center in Pokhara in 2002 when FHI initiated VCT planning. At this time, emphasis was first on establishing *National Guidelines for Voluntary HIV/AIDS Counseling and Testing* and supporting training courses to develop human resource capacity.

From 2003, FHI supported VCT services, first expanding VCT in Pokhara and then adding centers in Kathmandu. VCT services continued to be expanded in other FHI program areas in 2004. With just a few years of VCT programming, no major changes to the VCT strategy has been made yet. FHI remains focused on increasing access, demand and use of VCT among vulnerable groups.

What Has FHI Accomplished?

In the two years since FHI initiated its work on VCT services, FHI has worked closely with NCASC to produce a number of achievements. Technical assistance helped develop *National Guidelines for Voluntary HIV/AIDS Counseling and Testing*, train lab staff and VCT counselors, set up a quality control system and expand VCT services. As a result, several technical resources are available in Nepal to support the provision of VCT services.

MAKING A DIFFERENCE IN OTHER PEOPLE'S LIVES: ABIN KARKI'S LIFE CONTINUES TO INSPIRE

Twice a week, a room at a VCT center in Kathmandu fills with members of Vision Plus, a PLHA support group. As a member, Abin Karki encouraged others like him to live with HIV/AIDS positively and stay off drugs. With an estimated 4,000–5,000 IDUs in Kathmandu Valley, and an HIV prevalence rate of 68%, Abin was just one of the approximately 3000 young male IDUs living with HIV/AIDS in the capital.

From Kathmandu, Abin was a hardworking student until he started using drugs and eventually dropped out of school. He met some outreach workers from one of FHI's VCT centers, but did not want to hear about HIV or drug treatment. When his health deteriorated and his family threatened to kick him out of the house, he decided to enter rehabilitation.

Finally drug-free in March 2004, Abin decided to find out if he was also free from HIV/AIDS. He had long suspected that he was HIV positive because he had shared needles many times and had friends who had died from AIDS.

Unfortunately Abin was positive and depressed by this news. Once however he joined Vision Plus, he received support and counseling and his life changed for the better. Vision Plus helps its members empower each other, assess their own needs, share issues, plan activities and promote safer practices. Focus is on living day-to-day in a positive way both physically and mentally.

Abin wanted to help others like him who needed support and began to volunteer at Vision Plus. His friendly nature and capacity to motivate others helped him in his work. He felt Vision Plus gave him tremendous moral support and the enthusiasm to make a difference to others. He said, "I have a sense of purpose in life. Beyond supporting myself and remaining drug-free, Vision Plus gave me the opportunity to make a difference in other people's lives."

In April 2005, Abin died after a brief illness. His commitment and enthusiasm for making a difference however continues to be an inspiration.



VCT services have also been expanded in Nepal. Between August 2003 and December 2004, FHI has supported 15 VCT sites in 10 districts. Currently, this is the largest number of VCT centers supported by one program in Nepal. FHI has two VCT service delivery models: integrated into existing STI clinics for vulnerable groups, and stand-alone centers in selected urban areas, such as in Kathmandu, Nepalgunj and Pokhara. Up to 10 more centers will offer VCT in 2005, expanding services to an additional seven districts.

FHI has worked with these centers to strengthen the quality of services, create demand and build networks of referral services. FHI has been able to mobilize PEs, OREs, DICs and STI services to educate people from vulnerable groups about VCT. FHI has also developed materials to support quality VCT services, such as a counseling flipchart, training cue cards and pocketguide to aid in counseling. FHI also developed communications materials for VCT clients, clinic operational guidelines and various clinic forms.

FHI-supported services have provided over 2400 people with VCT—including pre-test counseling, HIV testing, post-test counseling and their results.

How Have FHI VCT Services Contributed to HMG/N's National HIV/AIDS Program?

FHI's expansion of VCT services has helped NCASC make considerable progress towards their objective of establishing 26 VCT sites. Equally importantly are the systems, guidelines and training curricula that were developed by NCASC with FHI support and that can be used throughout Nepal to ensure the quality VCT services.

At a policy level, HMG/N developed the *National Guidelines for Voluntary HIV/AIDS Counseling and Testing* in 2003 with FHI technical assistance. This national policy document sets standards for quality, confidential VCT services and are available in English and Nepali.

FHI has provided assistance to HMG/N to develop human resources to deliver this standard of care. Four national curricula have been developed. From 2001, FHI provided financial support to fieldtest a course on HIV/AIDS, counseling and VCT. Almost 150 people throughout Nepal were prepared as basic counselors in a year through this course, and NCASC endorsed the curriculum in 2002. The *Competency Based Curriculum for VCT Counselors* was developed based on the finalized guidelines in 2003 and finalized and endorsed by NCASC in 2004. By the end of 2004, over 60 VCT counselors had been trained. FHI also supported the training of 11 lab personnel in rapid HIV testing.



National VCT Guidelines (2003) and VCT Counselor Training Course (2004)

FHI is also supporting HMG/N for VCT quality control. In 2004, a draft procedure manual for rapid HIV testing and quality control using Dried Blood Spot (DBS) techniques was developed, and eight National Public Health Laboratory (NPHL) staff were trained.

Care and Support for People Living with and Affected by HIV/AIDS, including Treatment

What Is Care and Support?

Care, support and treatment services respond to the needs of PLHA and their families or households. These services aim to:

- Assure equitable access to diagnosis, medical care, pharmaceuticals and supportive services;
- Reduce morbidity and mortality from HIV/AIDS and related complications;
- Promote prevention opportunities within care, treatment and support clinical services; and
- Improve the quality of life for adults and children living with HIV/AIDS and their families.

Needs for HIV/AIDS care to PLHA and their families vary over time. Clinical services that include medical care and pharmaceuticals—such as prophylaxis and management of opportunistic infections (OI), antiretroviral therapy (ART) and other drugs, nutritional support and palliative care. Supportive services are equally important to assure adequate nutrition, psychological, social, and daily living support, and promote prevention when appropriate. Care and support are most effective when provided in an environment that respects human rights and mitigates HIV/AIDS-related stigma and discrimination.

Why Are Care, Support and Treatment Services Important? Why Are They Needed for HIV/AIDS Programs?

Care, support and treatment services complement the range of prevention services and are essential to meeting PLHA needs. These services help PLHA prevent and manage illness, as well as improve the quality of life. With the current and future numbers of PLHA in Nepal, needs for these services will increase. Care and support services offer hope and health, especially when treatment services also are available. Treatment is vital because it preserves the patient's health and immune system's ability to fight off infections. Treatment and a continuum of care services have the added effect of reducing HIV/AIDS-related stigma and discrimination and increasing demand for VCT services.

What Kinds of Care and Support Activities Does FHI Support in Nepal?

Strengthening and establishing care and support services—as well as promoting self-care practices—are growing priorities in Nepal. Since 2002, care, support and treatment have figured more prominently in the NCASC *National HIV/AIDS Strategy* (2002–2006) and therefore in FHI's work to support the national program.

A PLHA NAMED ASHA SHOWS AUDIENCES THE IMPORTANCE OF ACCEPTANCE AND SUPPORT FROM FRIENDS, COWORKERS AND FAMILY

The video film *Asha* begins with the simple story about a young couple named Raj and Asha who are in love. Before he leaves Nepal to work abroad, they secretly get married. At first, he sends letters and gifts, but these become less and less frequent over time.



Unknown to young Asha, her boyfriend was not always faithful to her and had other risky behaviors, such as occasionally using injecting drugs. Until one day she goes to the hospital and is shocked to learn she is HIV positive. Asha recalls for the audience what happened when she told her family:

When they first found out that I had the AIDS virus, they were shocked beyond belief. Then came crying and scolding. Then came slow acceptance of my condition. In fact, I must say that they took it far better than me.

She and her family are distraught, but together they learn HIV/AIDS is not a death sentence. Living positively, Asha teaches others about the disease. At the end, she shares,

I have realized that AIDS is something that not only kills your body, but it kills your spirit. To win, the spirit is what you have to keep alive. My family and friends have helped me do that so far.

FHI developed this film in 1997 as part of its mass media communications campaign to address misconceptions about PLHA. From 1998 to 2000, video vans were used to show the film along the highways. FHI reached a total audience of over 400,000. The shows also provided a venue to distribute Communications materials promoting condom use. Comic books were also developed.

Initially, FHI has focused on supporting HMG/N for policy development and planning, developing human resources, and articulating its own FHI program strategy in Nepal.

In support of NCASC objectives, FHI has provided technical assistance on ART, care and support. Some examples in the past year include *Standard Operating Procedures for Implementation of Antiretroviral Treatment (Adults and Children)* and the *Assessment and Recommendation for National Rollout Plan: HIV/AIDS Treatment Care and Support in Nepal, October 2004–September 2005*. These documents lay the policy foundation for providing and expanding treatment services.

FHI supports the development of human resources and expertise on care, support and treatment. In addition to supporting training on various topics (such as community care, OI management and ART), FHI has worked with local clinical experts to develop training curricula to be offered in Nepal adapted for the local context and available resources.

While FHI activities for the past few years have been on strategic planning, guidelines and human resource capacity-building, future priorities are on ensuring a minimum package of services are available and accessible. These services will include prevention and treatment of OIs, as well as referral to hospital services when needed. FHI's assistance to HMG/N on treatment has been and will remain as strengthening policies, systems and training, while hospitals and other programs directly provide ART services.

How Have FHI's Care and Support Activities Changed?

In the 1990s, there were few people who knew their HIV status, and there were scarce care, support or treatment services anywhere in Nepal. Based on Nepal's limited data, Joint United Nations Programme on HIV/AIDS (UNAIDS) HIV projections for Nepal indicated up to 10,000 HIV infections as of late 1994³. As people learned their HIV status—such as trafficked women who returned to Nepal—they often contacted FHI's IAs in their communities for support. The NGOs would organize community support through donations of food, clothing or money for medicine, but these needs and support were intermittent.

During these years, FHI supported care and support messages and materials to reduce fears about and generate compassion for PLHA, such as the *Asha* video film and three video spots in the first *Dhaaley Dai* campaign.

In the beginning, providing HIV/AIDS care and treatment was not a focus of FHI's work in Nepal. In the 1990s, ARTs were so prohibitively expensive that treatment was not part of the public health response to the HIV/AIDS epidemic nor part of the national strategy. Since then, the prices of drugs have dropped, HIV/AIDS activists have mobilized, ART services are available, and the numbers of PLHA in Nepal have grown. Treatment is now part of the NCASC *National HIV/AIDS Strategy (2002–2006)* and FHI's technical support to HMG/N.

To support government, FHI will begin to strengthen care and support services that both complement its ongoing prevention activities and support HMG/N's planned expansion. As envisioned, FHI will continue technical assistance and begin strengthening basic community care and support systems and services.

What Has FHI Accomplished?

FHI provided technical assistance to NCASC to develop national guidelines and strategies, such as national *Standard Operating Procedures for Implementation of Antiretroviral Treatment (Adults and Children)* in 2003 and the

³ *Best Practices in HIV Prevention Collection*, FHI/UNAIDS, 2001

Roll-Out Plan in 2004. FHI also participated in the national working group that developed *National Prevention of Mother to Child Transmission (PMTCT) Guidelines* and helped strengthen services in 2004.

FHI has developed human and technical resources on care and support, including about 60 people trained regionally on various topics such as community care, OI management and ART. For example, FHI has supported 11 physicians to attend clinical management of OI and ART training in Thailand, and these doctors are now the leading care providers for PLHA and technical resources for HMG/N. Also, FHI supported community care site visits to Thailand in 2004 to learn about models of care and strengthen the network of care and support services. FHI is also supporting organizational capacity building of small PLHA support groups and the National Association of PLHA in Nepal (NAP+N).

PLHA HELP FHI CREATE CARE AND SUPPORT MATERIALS

To explore and explain issues of VCT, care, support and treatment within ongoing prevention programs, FHI chose to adapt materials developed by PLHA in Cambodia for Nepal—with the help of Nepali PLHA and a local artist. Working as a team to translate text into Nepali, this small, energetic group first adapted the booklet titled *What Should I Do if I Think I Have HIV/AIDS?*. The group had many new ideas for content, text and graphics. Some modifications were made after pretesting and gathering feedback. Watercolor illustrations

of scenes and situations in Nepal were added to make the materials unique. In the end, FHI produced a small flipchart and accompanying brochures.

The group then produced the second booklet, “HIV Positive and Living with Hope”.

Both have been distributed to NCASC, FHI partner organizations and other interested groups. In 2005, three other booklets will be adapted and produced to complete the series for FHI.



Nationally, FHI has distributed thousands of materials with care and support messages over the past ten years, such as a video film, media spots, Care series booklets, brochures and small flipcharts. For families, FHI has supported its partner organizations to organize trainings for PLHA families to reduce stigma and discrimination.

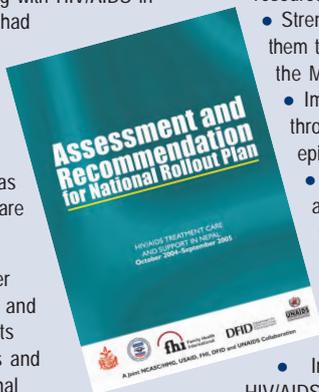
How Has FHI Contributed To HMG/N’s National HIV/AIDS Program?

To date FHI’s support of the government care and treatment objectives has been technical assistance. In 2004, NCASC produced the first national clinical standards for providing ART in the *Standard Operating Procedures for Implementation of Antiretroviral Treatment (Adults and Children)* that were developed by a technical working group with FHI participation. These guidelines were instrumental in standardizing ART at the one government hospital and planning for expansion. Later in 2004, FHI provided assistance in the developing *National PMTCT Guidelines* and in developing a plan to roll out ART. HMG/N envisioned expanding ART with supporting care, support, lab and VCT services into two areas outside of Kathmandu: Nepalgunj and Biratnagar/Dharan. The

NCASC ROLLS OUT PLANS FOR CARE, SUPPORT AND TREATMENT IN 2004

Despite the estimated 60,000 people living with HIV/AIDS in Nepal, only a handful of Nepali with HIV had access to ART and simple prophylactic medicine to prevent bacterial infections in 2004. Recognizing this gap in services, NCASC gathered a team of international and domestic experts (including FHI staff) to determine what was currently needed in terms of treatment, care and support services.

After an intense two weeks of stakeholder interviews, site visits, costing exercises and lively discussions, the group presented its recommendations to government, donors and organizations. With available and additional



resources in the coming year, it was suggested to:

- Strengthen services in Kathmandu and expanding them to Biratnagar/Dharan in the East and Nepalgunj in the Midwest
- Immediately begin cotrimoxazole chemoprophylaxis through community-based organizations to prevent episodes of OI such as pneumonia
- Enroll 450 PLHA on ART supported by appropriate testing, counseling and drug supply (such as alternative first and second line line regimens)
- Develop capacity, providers and resources to foster community and home based care and support for PLHA
- Involve PLHA in monitoring services to address HIV/AIDS-related stigma and discrimination

final report, *Assessment and Recommendation for National Rollout Plan: HIV/AIDS Treatment Care and Support in Nepal, October 2004–September 2005*, will serve as a guiding implementation plan. This plan is a major step toward scaling up ART and care services in Nepal. To move the plan into action, FHI will now contribute activities to help operationalize the Plan.

FHI has also supported government doctors to attend clinical training and regional site visits, such as those working at major government hospitals where many PLHA go for care. Training supported by FHI has helped develop the small cadre of technical experts and active clinicians providing care, support and treatment in Nepal. FHI's support to these extraordinary clinicians was a contribution to HMG/N's health care system and recognition of their commitment to providing care to PLHA.

Stigma and Discrimination Reduction

What Is HIV/AIDS-Related Stigma and Discrimination?

Stigma refers to an attribute of a person, such as a health status or behavior that is considered unacceptable and socially discrediting. Discrimination occurs when a person is treated unfairly for a particular attribute. HIV/AIDS-related stigma and discrimination towards PLHA includes unconscious gestures, neglect, harassment, hostility and rejection.

Why Is Stigma and Discrimination Reduction Important? Why Is It Needed For HIV/AIDS Programs?

Reducing stigma and discrimination towards PLHA helps the individual, family and society accept and care. When PLHA experience HIV/AIDS-related stigma or discrimination, they may deny they are HIV positive, be less cautious about preventive behaviors or delay seeking medical services when needed. If they do seek medical care, they may experience a lack of commitment or a lack of confidentiality and mistreatment by health care providers. Stigma and discrimination cause PLHA social isolation, increased psychological distress and a loss of socio-economic support. Stigma and discrimination also may influence non-HIV positive individuals to avoid being tested for their HIV status.

How Does FHI Help Reduce HIV/AIDS-Related Stigma and Discrimination?

To date, stigma and discrimination activities have been integrated within other ongoing activities for prevention and care. For example, FHI developed communications materials and messages, such as the popular video film *Asha* in 1997 that told the story of an HIV-positive woman. This film portrayed how family emotional support helped overcome fears, worries and frustrations. FHI also allayed fears about PLHA and promoted empathy through messages in two mass media campaigns. One spot featured a PLHA as a spokesperson. Another example is the integration of related content into the *National Competency Based Curriculum for VCT Counselors* through sessions on personal perceptions and biases and empathy—plus involving PLHA in the training to talk to new counselors.

From 2003, FHI began more comprehensive activities to reduce HIV/AIDS related stigma and discrimination, beginning with two studies on PLHA experiences with and community perceptions of HIV/AIDS related stigma and discrimination. This formative research explored issues and helped give voice to PLHA about their experiences.

AFTER FOUR YEARS IN HELL: A TRAFFICKED GIRL FINDS FULFILLMENT, ACCEPTANCE AND LOVE WHILE LIVING WITH HIV/AIDS

For the past nine years, Chhakkali Bal, has been one of FHI's most active PEs. As a trafficked girl who returned from India HIV positive, she is admired in her village for her courage and her dedication to helping others. Telling her story in a documentary called



Four Years In Hell, she was one of the first PLHA in Nepal to openly talk about living with HIV/AIDS.

At 14 years old, her parents paid 15,000 rupees (over \$200)—a fortune to a rural Nepali family—to send her to work in India. Instead, Chhakkali was sold to a brothel in Mumbai and forced to see up to 15 clients a day.

After four years, she managed to escape. Once free, she soon found out she had HIV. Back in Nepal, she found support and a purpose as a PE supported by FHI. This work helped her live more positively and gain acceptance in her community.

Recently, she fell in love with Sukra Bahadur Lama who worked as a truck assistant. He was not dissuaded by her HIV positive status. When they were going to be married, there were few well-wishers. Even her closest friends expressed more concern than joy. Staff from the FHI partner organization where she works talked to community members to allay their fears and dispel misconceptions. Gradually they accepted the marriage, and Chhakkali and her husband were then treated with respect.

Chhakkali used to think that she must have committed some sin in her previous life to give her such sorrow. Today, with a loving husband and a respected work, Chhakkali finds her life very meaningful.

PROMOTING COMPASSION & CARE: A PLHA'S APPEARANCE HELPS ADDRESS STIGMA AND DISCRIMINATION



In 2002, Sharan Chhetri appeared on TV, on radio and on posters to share the following message:

I am a HIV positive. I could be your brother, your son and even your friend. I did not knowingly invite HIV and I am not a bad person. Today, like me more than 58,000 Nepali people are at risk of getting infected by HIV/AIDS. But you can prevent yourself from HIV/AIDS. Let's start talking about HIV/AIDS today.

As the first PLHA to so publicly disclose his status, people who heard this spot were moved. Some people even called the stations to find out if this was an actor or a real person. Lending his voice and face to the campaign, Sharan humanized the HIV/AIDS epidemic.

Another spot encouraged kindness to PLHA, featuring a well-known film actress sharing, "If you know someone who has HIV/AIDS, treat him/her, as you would expect to be treated if it was you. They need our kindness and love."

After six months, a media recall study was conducted and found that 80% of those who were exposed to any HIV/AIDS campaign felt PLHA should be allowed to remain in society.

It was estimated the campaign had reached three million Nepali through television and over three million through radio a month.

In 2004, FHI developed a mass media communications campaign centered on an entertaining and humorous 52-episode weekly radio drama called *Ek Aapash Ka Kura (Talking to Each Other)*. The storyline follows a young couple in daily life as they encounter different types of HIV/AIDS-related stigma and discrimination. FHI will work ongoing popular weekly Nepal TV programs to incorporate HIV/AIDS-related stigma and discrimination themes into over 30 episodes.

At the community level, FHI will complement the campaign with a series of activities involving schools, community leaders, PLHA groups, local government and other civil society groups. FHI will work in four geographic areas (Dharan, Kathmandu, Pokhara and Nepalgunj) in 2005.

How Have FHI's Stigma and Discrimination Activities Changed over the Past Decade?

With the early focus on prevention and control, activities to reduce stigma and discrimination were conducted to raise awareness about HIV/AIDS and build community support. At the community level, partner organizations would help PLHA in their area to deal with discrimination and seek services. Broad communications messages and materials complemented local efforts.

From 2003, FHI launched a more comprehensive plan that included research, mass media communications and community activities. Successful interventions for communities were developed in Africa and will be fieldtested and evaluated in the coming years by FHI. As care, support and treatment activities are integrated

into FHI's programs, the reduction of HIV/AIDS-related stigma and discrimination will be a substantial component of its expanded response.

What Has FHI Accomplished?

Over the years, FHI had incorporated different messages and produced materials that addressed the basic issues of HIV/AIDS-related stigma and discrimination. Most recently, the *Let's Start Talking about AIDS Today* campaign was conducted in 2002. Upon evaluation, about three of four people surveyed who were aware of HIV/AIDS agreed that an HIV infected person should be allowed to stay in society. Reasons cited for this acceptance included: they need love and help; the disease is not spread by eating or sitting together; and it is their right to stay with their family and in society. While it's not clear how these opinions changed as a result of this campaign, this level of acceptance and understanding of PLHA needs and rights is important.

With the beginning of expanded VCT services in 2003, FHI indirectly began addressing and reducing HIV/AIDS-related stigma and discrimination through PLHA support groups and the involvement of PLHA in program design and service delivery. Also, FHI support of the NAP+N has helped formalize this national network and give a collective voice to PLHA to address stigma and discrimination.

FHI has conducted important qualitative research to help better understand what stigma and discrimination are in the Nepali context and how PLHA and their families have experienced them. The findings helped shape the upcoming radio serial drama *Talking to Each Other* on issues related to stigma and discrimination, as well as the complementary community interventions. FHI adapted the innovative community-based *Understanding and Challenging HIV Stigma: Toolkit for Action* developed in Africa to the Nepali context in 2004 to be implemented and evaluated in 2005.

FHI conducted sensitivity training to reduce HIV/AIDS-related stigma and discrimination, and over 300 people participated in 2004.

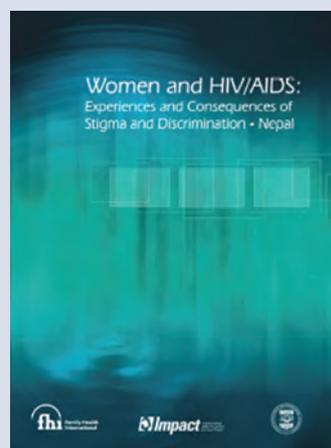
How Have FHI's Stigma and Discrimination Reduction Activities Contributed to HMG/N's National HIV/AIDS Program?

One of the main components in the current NCASC *National HIV/AIDS Strategy (2002–2006)* and Rollout Plan is the reduction of stigma surrounding PLHA. NCASC conceptualized the *Let's Start Talking about AIDS Today* communications campaign in 2002 to commemorate its *Year of HIV/AIDS Awareness*. This campaign involved national celebrities and a PLHA as spokesperson. When FHI developed and disseminated other materials to address stigma and discrimination, many copies were shared with NCASC for their use and distribution among other HIV/AIDS partners and government facilities. Both NCASC and NAP+N endorsed the PLHA-created care booklet series by writing the foreword.

IN NEPAL, WOMEN SUFFER GREATLY FROM HIV/AIDS-RELATED STIGMA AND DISCRIMINATION

In 2003, FHI conducted two studies to learn more about how communities and PLHAs understood and experienced stigma and discrimination. From the findings, it became clear that women PLHA struggled with HIV/AIDS-related stigma and discrimination more than men. As one woman PLHA in Kathmandu shared:

*I am no more considered a person in my family. My father-in-law blames me for his son becoming HIV positive. ...My father-in-law came and took his son and grandson away from me and left me in a house where I have no source of support...I have nowhere to go.—
Female, 32 years*



The report summarized the difficulties faced by women as:

- Receiving less support than their husbands when both were HIV-positive;
- Being morally condemned and blamed for their HIV status;
- Facing serious loss of social and economic support; and
- Confronting the psychological burden of having been trafficked and/or having children.

Highlighting the special needs of these women, the report findings were used by FHI to develop messages and strategies to reduce HIV/AIDS-related stigma and discrimination through a mass media communications campaign and community-based activities, beginning in 2005.

Mitigation

Research and Surveillance, including Epidemiological Estimations

What are HIV/AIDS Research and Surveillance?

Epidemiological studies were conducted to estimate the prevalence, trends, extent and impact of the HIV/AIDS epidemic to assess the priorities and strategies needed. For example, behavioral surveillance surveys (BSS) and integrated bio-behavioral surveys (IBBS) show the risks for exposure to HIV and help interpret prevalence data and changes.

Qualitative research is conducted to better understand the habits, preferences, networks and behaviors of vulnerable groups. Findings both help shape future programming and shed light on quantitative results. Qualitative research can also gather information that would not be otherwise available, such as on sensitive or complex issues.

Why Are Research and Surveillance Important for HIV/AIDS Programs?

Research and surveillance are particularly important to adequately monitor the HIV epidemic and changes in risk behaviors of sub populations. Also, these studies help during a concentrated HIV/AIDS epidemic when national surveillance may not be able to adequately track changes in the epidemic in many sub populations. Also, these studies help monitor trends and changes over time. For example, surveillance showed there was no change in HIV prevalence among FSWs in the Central Nepal from 1999 to 2003, staying at around 3%.

The information collected by epidemiological and behavioral surveillance studies helped to inform policymakers and stakeholders about the realities and priorities of the HIV/AIDS epidemic. In Nepal, all of the BSS and IBBS conducted by FHI have been used within the NCASC national second generation surveillance system.

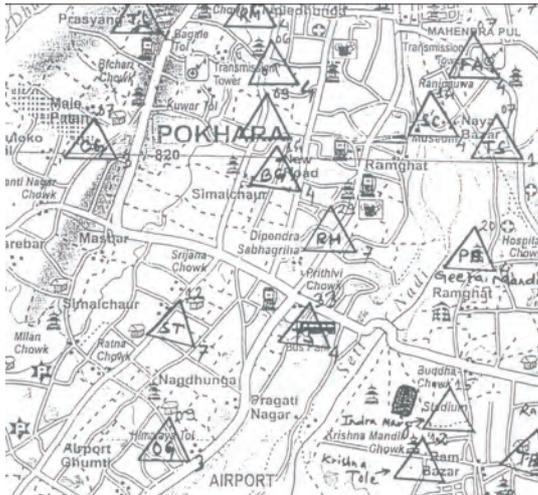
“Repeatedly measuring risk behaviors over time in carefully selected population groups that are both at elevated risk of HIV infection and influential to the growth of the epidemic highlights not only where the epidemic has been, but also where it is going, and how program managers can intervene.”

Source: Best Practices in HIV Prevention Collection, FHI/UNAIDS, 2001

Research and surveillance also guide the development of FHI's programs and interventions, as in all good public health programming. FHI gathers and uses data to design, adjust and monitor its HIV/AIDS programs.

How Are Research and Surveillance Designed, Conducted and Used?

Surveillance research in Nepal for the past 10 years has focused on better understanding how the epidemic is affecting those most at risk for HIV. The most common studies FHI conducts with and for NCASC are the BSS



Mapping: An Essential Step in Conducting a BSS or IBBS

and IBBS as part of national surveillance. For BSS study designs and questionnaires are adapted from international tools for the Nepali context and program needs. All studies are reviewed and approved by FHI's Protection of Human Subjects Committee (PHSC) and the Nepal Health Research Council (NHRC).

Because the populations most at risk for HIV are often hidden and/or mobile, mapping is a key step to getting good quality data. Mapping helps identify places where the target population are concentrated and approximate the numbers in each location to estimate the overall population size. For example, when FHI conducted the size estimation of MSM in Kathmandu in 2004, key informants helped identify 52 public areas as cruising sites to find MSM. At those locations, researchers contacted potential MSM, built rapport and asked about other locations. This snowballing technique helped identify an addition 82 places and get a more detailed map for sampling.

FHI-SUPPORTED RESEARCH PROVIDES INFORMATION ON IDU BEHAVIORS, NETWORKS AND HIV PREVALENCE

Since 2001, FHI with its research IAs has conducted dozens of studies to gather information that informs the national HIV/AIDS program response for many at risk groups. To illustrate the wealth of information available, the seven studies on IDUs in different areas of Nepal are listed below.

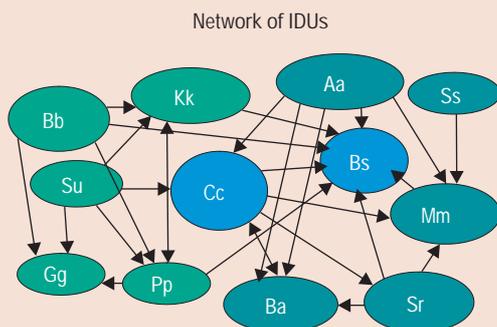
BSS include:

- HIV Prevalence and Risk Behaviors Among Male and Female Injecting Drug Users in Kathmandu Valley (August 2001)
- Behavioral and Sero Prevalence Survey Among Male IDUs in the Pokhara Valley (February–March 2003)

- Behavioral and Sero Prevalence Survey among IDUs in Eastern Nepal (April–May 2003)

Focused ethnographic studies include:

- Injecting and Sexual Behaviors of Male IDUs in Pokhara (August–November 2002)
- Injecting and Sexual Behaviors of IDUs in Jhapa (December 2002–January 2003)
- Injecting and Sexual Behaviors of IDUs in Dharan (December 2002)
- Injecting and Sexual Behaviors of IDUs in Biratnagar (January–February 2003)



Study summaries are available on the NCASC and FHI websites and highlight key findings. The national second generation surveillance system plans IBBS for IDUs are to be conducted every two years. To date, FHI has conducted this research in support of government surveillance objectives.

Once a study is designed and approved, data are collected at the field level usually among 300-500 participants recruited from the target population. Respondents are recruited through respondent driven sampling methods. Once they give informed consent, a study participant will be asked a series of questions from a structured questionnaire on behaviors, knowledge, attitudes and treatment-seeking practices.

In an IBBS, after the interview, pre-test counseling is conducted and then blood and biological samples are collected. Participants are examined by trained medical staff and treated if an STI is diagnosed. FHI gives all respondents the opportunity to find out their results with a study ID card and a password to maintain confidentiality. If they return for their results and have an STI that has and been treated, they receive free STI treatment. If they are HIV positive, they receive pre-test counseling again, their results, post-test counseling and referrals to available services in the area.

FHI also conducts ethnographic studies to gather more in-depth information and often using qualitative data collection methods. Some examples of the types of information FHI has collected through qualitative studies include: PLHA experiences with stigma and discrimination; where males go for advice and treatment if they think they might have an STI; and with who and how often IDUs share needles or drugs to understand user networks.

Data then are analyzed and written into a full report, as well as in a 2-page fact sheet of key findings for policymakers and other stakeholders. Findings are widely disseminated by NCASC and are made available electronically.

Uniquely, FHI works with NCASC, donors and local organizations to use these data collectively to draw a picture of the overall epidemic and possible future trends. Data are used by FHI, UNAIDS, World Bank and the World Health Organization (WHO) for various modeling purposes, such as the UNAIDS national estimates of adult HIV cases.

How Have FHI's Research and Surveillance Changed Over the Past 10 Years?

In the early 1990s, FHI did not provide any technical assistance for HMG/N's HIV/AIDS surveillance activities. A government HIV sentinel surveillance (HSS) was conducted twice a year sampled from STI patients in various sites. This system was the major source of HIV prevalence data in Nepal supplemented by special studies in program areas. After several years, NCASC revised its protocols and began receiving technical assistance from FHI and the University of Heidelberg. FHI supported three rounds of HSS among STI patients in the 1990s.

Because HSS is not meant to monitor all vulnerable groups, surveillance expanded to include BSS and IBBS. These studies were conducted for NCASC by FHI from 1999-2004 and helped track the epidemic in smaller sub-populations such as FSWs and IDUs. The second generation surveillance system was formalized by a NCASC working group in 2002. FHI now conducts the majority of the research required for this second generation surveillance system annually.

Initially, FHI conducted research studies mainly for program design, monitoring and evaluation. Over time, more studies were conducted for the purpose of national surveillance and also produced results useful for FHI programming.

What Has FHI Accomplished?

Since the first baseline study of FSWs and their clients along the highways in Central Nepal in 1994, FHI and its IAs have conducted over 50 studies and surveys for HIV/AIDS-related research and surveillance (including assessments). Of these, 15 studies were specifically for national surveillance purposes and ten ethnographic



NCASC and FHI Regularly Disseminate Research and Surveillance Findings

studies complemented surveillance findings. Groups surveyed include FSWs, clients of FSWs, IDUs, MSM, migrant males, wives of migrant males and PLHA.

Annually, FHI with its research partners are responsible for collecting all of the data for the second generation surveillance system and conducts about four to five studies in 14-25 districts among a total of 1,000-2,000 respondents.

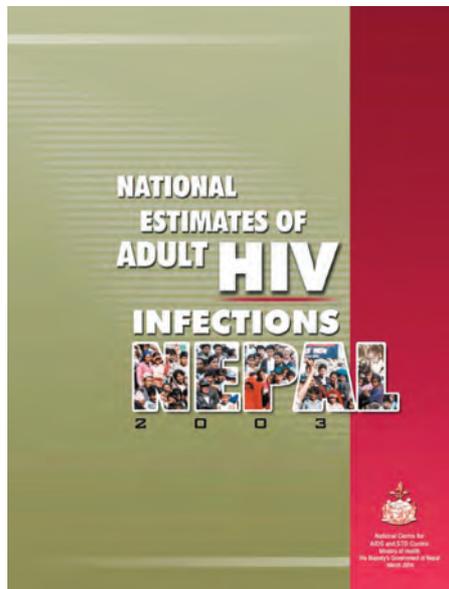
FHI works with several capable local research organizations to conduct quantitative and qualitative HIV/AIDS related research. Technical assistance has been provided to strengthen capacity to design quantitative and qualitative research, in addition to managing, analyzing and interpreting data. Training on the ethical aspects of conducting research on the epidemic and behavioral and psychological aspects of HIV/AIDS was conducted by FHI for its partners and NHRC. In recent years, FHI has stopped relying on international lab facilities. Now all biological testing for research has been done to international standards within Nepal or in Asia.

As part of surveillance, data can be gathered that also feed back into program planning. For example, FHI conducted surveillance studies annually in the 1990s in Central Nepal. Results show that HIV/AIDS and STI prevention messages were well understood by primary target groups, such as nearly over 95% of FSWs and their clients knew by 2002 that the use of condoms helps to prevent HIV/AIDS and STIs. This finding demonstrated knowledge levels were high and prevention programs could shift emphasis to other aspects of BCI.

An important achievement of FHI technical assistance to NCASC is estimating the number of PLHA at a given time using available data and methods. This work began in 1994 and continues today. By 2002, the quantity of data made it possible to detail estimates and the burden of disease among different groups. The resulting analysis and estimations for 2003 were published in 2004 and serves as an important national policy and programming tool.

How Has FHI Contributed to Research and Surveillance of the HMG/N's National HIV/AIDS Program?

Over the past decade, one of the most productive areas of collaboration between FHI and NCASC has been research and surveillance. FHI has primarily offered technical assistance as well as other types of support. Most significantly, FHI has supported the development and implementation of a national second generation surveillance system that has been able to effectively monitor and now estimate trends in the HIV/AIDS epidemic in Nepal. A strong surveillance system exists in Nepal. Surveillance has identified the vulnerable and emerging highrisk groups, and more importantly the underlying behavioral and social factors contributing to the epidemic's spread.



NCASC and FHI together estimate there were 60,000 Adults living with HIV/AIDS in 2003

FHI also has supported NCASC to gather and use available data for epidemiological modeling. FHI first worked with HMG/N in October 1994 and together estimated that there were about 10,000 HIV infected persons in Nepal. A few years later, the estimate through 1996 was 15,000–20,000 PLHA, with up to half of these infections acquired in India. Further collaboration resulted a revised estimate of about 60,000 PLHA in the 2004 publication, *National Estimates of Adult HIV Infections, Nepal, 2003*.

While different models have been used, the process and results from these exercises are essential to better understanding the epidemic and informing policymakers of possible realities and programmatic needs. FHI's support has enabled NCASC to use available data to model the current epidemic and predict future scenarios.

FHI has provided technical assistance to HMG/N to strengthen surveillance systems through technical assistance, training, national workshops and dissemination events.

Policy Development and Support

What is Policy Development and Support?

Policy development is a range of resources and activities provided to HMG/N line agencies, policymakers, civil society and other stakeholders to develop policies, strategic plans and guidelines supportive of HIV/AIDS programs. Effective policies create an enabling environment, ensure human rights and improve public health. Policy development can be a nebulous, legal and long-term political process, yet there are often simple changes that can reduce barriers to services, stigma and discrimination, and other obstacles in HIV prevention and care programs.

Why Is Policy Development Needed in HIV/AIDS Programs?

Policy development and support are essential to ensure national policies facilitate applying best practices and maximizing resources for HIV/AIDS programs. It can help to protect rights, increase access to services, use resources more effectively and adapt to new approaches. When done well, policy development involves stakeholders and beneficiaries in the process for a mutually beneficial outcome for all. No HIV/AIDS program can maximize its potential and impact without a supportive policy environment.

What Kinds of Activities Does FHI Conduct for Policy Development and Support?

Within programs in Nepal, policy support has always been an element of FHI's work but not one of its main objectives. Over time, FHI's involvement in policy development has mainly focused strategic planning and technical resource development (such as clinical guidelines). It has been limited to addressing those areas that directly benefit HIV prevention, care and mitigation activities.

Most of FHI's activities on policy development and support have been in response to requests from HMG/N. Most have been centered on areas of FHI's technical expertise. For example, on surveillance, FHI supported government participation in a regional epidemiological workshop in 1994 and then supported epidemiological assistance that HMG/N requested to estimate the number of HIV cases. FHI repeated this exercise for HMG/N in 2004, resulting in a publication and a persuasive policy tool.

FHI SUPPORTS UNIFORMED SERVICES PROGRAMMING AND STRATEGIC PLANNING IN NEPAL

As early as 1995, FHI began working with uniformed services throughout Asia to raise awareness and build support for HIV prevention programs. With funding from the World Bank, FHI conducted a five-day training seminar for senior civilian and military delegates from Bangladesh, India, Indonesia, Malaysia, Nepal and Thailand.



In Nepal, uniformed services have long been beneficiaries of FHI HIV prevention programs that reach and educate clients of FSWs. The current NCASC *HIV/AIDS National HIV/AIDS Strategy (2002-2006)* includes uniformed services as a intervention group. In 2001, FHI began programming with police in Kathmandu. In 2002, FHI developed a larger, targeted HIV prevention BCI project reaching police, armed police and army at their barracks along the highways in six districts. Through PEs and DICs, FHI oriented has almost 7,300 uniformed service personnel.

In 2003, the Royal Nepalese Army (RNA) began to develop an HIV/AIDS strategy and requested assistance from FHI to learn more about what other militaries in Asia were doing to respond to the impact of the epidemic. FHI supported a group that traveled to Cambodia, where uniformed services have developed comprehensive prevention and care services.



Returning from this visit, RNA started an HIV/STI prevention program in Farwestern Nepal and planned additional activities for Central Nepal. RNA also drafted its strategy that covers prevention, VCT, care and support through its existing infrastructure.

There are several examples of how FHI has responded to specific government requests for advocacy and policy support, such as:

- In 2002, FHI worked with NCASC to develop the *Let's Start Talking about AIDS Today* campaign with a secondary objective of generating political commitment for HIV/AIDS programs among policymakers.
- NCASC requested FHI technical support to develop site protocols for ART services to be able to initiate the first ART program for 25 PLHA in 2003. FHI with the other members of the technical working group responded quickly to this request and with *Standard Operating Procedures for Implementation of Antiretroviral Treatment (Adults and Children)*, services commenced.
- The Royal Nepalese Army (RNA) requested technical assistance to develop its long-term HIV/AIDS strategy. FHI supported an informative exposure visit in 2003 to Cambodia where uniformed services have developed comprehensive prevention and care services. Returning from this visit, RNA drafted its strategy and began activities.

To build support for policy development or change, FHI has supported regional exposure visits, participation in regional and international conference and workshops by government officials and other key stakeholders. For example, perceived reluctance within government to develop oral substitution therapy guidelines and expand services was mitigated once officials saw government-run services for IDUs in Hong Kong. There, they saw services firsthand and heard from their counterparts about reservations and benefits. National guidelines were then developed and endorsed by HMG/N in 2002.

Overall, FHI's activities for policy development support are mainly on technical issues and/or broader strategic planning for HIV/AIDS programs. FHI has participated in Global Fund for AIDS, Tuberculosis and Malaria (GFATM) proposal development, technical working groups to develop the *National HIV/AIDS Strategy (2002–2006)* and other policy processes.

How Have FHI's Policy Development and Support Activities Changed Over the Past 10 Years?

Because policy development has not been a priority for FHI, most policy-related activities have been requested by HMG/N to address a specific obstacle or issue. FHI's activities therefore are always changing. Over the decade, FHI has supported small activities for policy development and support, such as sensitizing and mobilizing journalists through a regional media workshop. FHI also supported small activities to engage the private sector and civil society in HIV/AIDS prevention programs in the 1990s. For example, FHI provided material and technical support for a 1995 World AIDS Day event for private sector involvement. These activities were singular and successful, but did not lead to longer-term support from FHI.

During the Nepal Initiative, FHI was very active in policy development and advocacy. FHI now mainly focuses on strategic planning and technical resource development, such as national clinical guidelines and protocols.

What Has FHI Accomplished?

Over the years, FHI has contributed to some HIV/AIDS-related policy successes. First, FHI has provided technical assistance to develop a number of national policy documents, such as the second generation surveillance system plan and implementation. In 2002, FHI responded to a NCASC request to provide technical assistance to develop the costed, long-term *National HIV/AIDS Strategy (2002–2006)* for HIV prevention and care for vulnerable groups in Nepal. FHI also has supported HMG/N through a series of activities that resulted in policy development, such as assistance to RNA for their strategy development process. Further, FHI has participated in numerous guidelines development processes to set national clinical standards—notably *National*

Guidelines for Voluntary HIV/AIDS Counseling and Testing, National STD Case Management Guidelines and Standard Operating Procedures for Implementation of Antiretroviral Treatment (Adults and Children).

FHI with NCASC implemented a variety of communications and advocacy activities, including the *Let's Start Talking About AIDS Today* mass media communications campaign, targeted primarily at youth but also intended to mobilize resources and commitment among policymakers. In the campaign's qualitative evaluation, policymakers themselves did not feel impacted by campaign messages because they all felt that they were actively involved.



NCASC "Unity Against AIDS" Logo Identified National HIV/AIDS Activities in 2002

FHI has produced numerous fact sheets (on topics such as research findings, basic information on HIV/AIDS and risk reduction) for dissemination to a wider community of policymakers, government officials, HIV/AIDS program implementers and parliamentarians.

How Has FHI Contributed To HMG/N's National HIV/AIDS Program Through Policy Support?

Over the past 10 years, there have been many HIV/AIDS policies developed by HMG/N, and FHI actively participated in the development processes. For example, FHI assisted in the development of a draft national policy on HIV/AIDS that was presented for parliamentary approval in 1996. More recently, the NCASC *National HIV/AIDS Strategy (2002–2006)* was developed with a focus on prevention and care. FHI and its partner organizations participated in many of the working groups that created this strategy. FHI supported the technical experts who integrated working group recommendations, developed implementation plans and costed the set of activities and services.

NCASC declared a *Year of AIDS Awareness* for 2002 during which it launched the *Unity Against AIDS* logo and the *Let's Start Talking About AIDS Today* mass media communications campaign, both developed with FHI support. During this year, National AIDS Council was formed, the Minister of Health shook hands publicly with a PLHA, the *National HIV/AIDS Strategy (2002–2006)* was drafted, and Parliament received an overview of the current HIV/AIDS situation in Nepal. Advocacy helped create an enabling environment for more effective programming, improve coordination between ministries and affect positive policy changes. Whether a result of advocacy and/or effective policy development, national resources for HIV/AIDS have increased considerably since 1994, most notably in the past few years.

HMG/N commitment to fighting HIV/AIDS was evident at the district level too. The active role of outreach organizations in HIV/AIDS preven-



The Royal Family, Government Leaders and the Prime Minister Show Their Commitment to Fighting HIV/AIDS

tion has strengthened the commitment of local government. FHI's partner organizations mobilized and participated in DACCs.

FHI has worked collaboratively in a more technical capacity with NCASC on various clinical guidelines, standards and training curricula over the past decade, including:

- *National STI Case Management Guidelines* (1995, 2001, 2004);
- *Case Management of Sexually Transmitted Diseases: A Training Package* (1996);
- *National Guidelines for Voluntary HIV/AIDS Counseling and Testing* (2003);
- *Standard Operating Procedures for Implementation of Antiretroviral Treatment (Adults and Children)* (2003); and
- *Policy Guidelines For Oral Substitution Therapies in Nepal* (2002).

Capacity Building

What is Capacity Building?

Capacity building is a process in which human resources and organizational capabilities of institutions are improved to better perform priority functions. The overall purpose of capacity building in expanded and comprehensive responses to HIV/AIDS is to ensure effective design, implementation, coordination and management of prevention, care and mitigation efforts. Capacity development includes human resources, management and networks. Capacity is developed or strengthened through training, information resources, national and regional expertise, targeted technical assistance and twinning.

Why Is Capacity Building Needed for HIV/AIDS Programs?

The HIV/AIDS pandemic has given urgency to the need for rapid assessment and capacity development. Without capable organizations and individuals making informed decisions, interventions can not have maximum impact. An HIV/AIDS epidemic can drain existing human and material resources. Capacity building helps effectively mobilize available resources and develop additional ones for anticipated needs of an expanded and comprehensive response to HIV/AIDS prevention, care and mitigation.

OPERATIONAL MAPPING IMPROVED CAPACITY TO PLAN, IMPLEMENT AND MONITOR ACTIVITIES—WHILE IMPROVING THE QUALITY AND REACH OF SERVICES

FHI uses maps for project development, community assessments and research, but recently began supporting its partner organizations also to use operational mapping to look at their project area, target groups and regular monitoring data in a different way. Introduced in 2001 in interactive trainings, field staff learned mapping techniques using their actual project data.



In 2003 in Rupandehi district, FHI provided support in the field to use the maps to make project improvements. Field staff,

OREs and PEs together made maps that made needed changes visually evident. For example, a DIC for rickshaw pullers should be closer to their frequent routes—and downhill. PEs and OREs could be reassigned to areas where most FSWs worked. Even inefficiencies in some daily outreach and monitoring routes were visible—such as the time-consuming outreach visits to a remote village where there were few or no FSWs.



Many changes were made at no cost to the project. Within ten months, the project estimated its coverage of FSWs in Rupandehi increased from increased from 36% to 76.5%. This capacity building exercise illustrates how simple techniques and minimal technical support can support project staff to assess and significantly improve their work.

What Kinds of Capacity Building Activities Does FHI Support?

FHI works to support the capacity of developing countries such as Nepal to prevent and control HIV. This philosophy underlies the design of every activity supported in Nepal. Within projects, FHI primarily supports:

- Technical capacity building;
- Organizational strengthening (including financial, organizational and project management); and
- Networking.

Technical capacity building is one area where FHI is uniquely positioned with national, regional and global expertise on prevention, care and mitigation. In Nepal, FHI helps develop or revise technical policies, strengthen human resources, innovate and share best practices. For example, when FHI began VCT activities, technical assistance helped develop *National Guidelines for Voluntary HIV/AIDS Counseling and Testing*, assess existing services, advise HMG/N on testing protocols and conduct technical and programmatic workshops for new projects. Technical assistance is provided not only to FHI partner organizations but to many stakeholders, individuals, associations and government.

Organizational strengthening is the area where FHI has consistently supporting its partners to develop effective financial, organizational and project management. Regular field visits, annual audits, trainings and workshops all help organizations be more effective. With new partners, this type of capacity building can be quite intensive, but over time become more technical in nature. FHI has helped almost 30 small organizations and associations develop their organizational capacity.

Networking is another area where FHI concentrates capacity development. FHI supports existing networks such as NAP+N but also links its partner organizations together. Team meetings, twinning visits, cross border collaboration, trainings, workshops and publications facilitate sharing across projects. Capacity building for VCT centers referral service networks will be an area for future development.

How Has Capacity Building Changed Over the 10 Years of FHI Programs?

FHI has consistently developed and implemented programs that by process, strengthen capacities. Capacity building in the beginning consisted of regional technical assistance and local organizational assistance from effective projects in Nepal with expertise in HIV/AIDS and outreach. Over time, more technical expertise began available in Nepal, and partner organizations developed capacity to the point where little additional external assistance was needed.

FHI also shifted from organizing capacity development activities for its IAs to building its resources into each project and giving the organization the independence to determine how best to use those resources. As requested, FHI provides technical assistance but currently most capacity building on organizational development can be provided by FHI staff or local consultants in Nepal. This is true in many technical areas as well.

What Has FHI Accomplished?

Capacity development is one of FHI's greatest contributions to HIV/AIDS programs in Nepal, resulting in increased sustainability of many NGOs. Since 1994, FHI's goal has been to *"build the capacity of Nepalese organizations to conduct HIV prevention activities to reduce the transmission of HIV in Nepal"*. FHI/Nepal has funded 90 partner organizations—including a majority of indigenous organizations, associations, companies and government facilities—to address emerging issues in prevention, care and mitigation and adapt program

strategies to local realities of those most at risk and their communities. Capacity building among these diverse partners has included:

- Pairing experienced NGOs with new partners to transfer capacity, including exchange visits and technical assistance
- Dozens of community assessments, such as for expansion into seven new districts in 1999 and along uncovered highways in Midwestern and Farwestern Nepal in 2002
- Technical assistance and monitoring support from local, regional and international technical experts (for example, FHI supported 20 regional and international technical assistance (TA) visits by 14 technical experts in 2004)
- Financial, administrative and managerial support—through training, on-site support, specially designed project accounting software and audits
- Participation in trainings, conferences and workshops within Nepal and Asia

FHI’s commitment to human resources development has resulted in thousands of trained health care providers, PEs, technical experts and program staff over the past decade.

Organizational strengthening focused on developing systems and improving financial management. FHI partners have the basic accounting, financial reporting, database management and planning skills to effectively and responsibly manage projects. Annual audits have produced no major actionable findings. FHI supports its partners to develop and adhere to organizational policies, such as operational and personnel policies. Strategic planning, budgeting, workplan development, monitoring and report writing are other important skills for supporting IA projects and the overall health of the organization itself. Accomplishments in capacity development are evidenced by the findings of a capacity assessment in 2003. FHI partners conducted self-assessments, and the findings showed areas such as financial management were strongest.

Further, several long-term FHI partner organizations have leveraged their organizational management capacity and proven technical expertise in HIV prevention to diversify funding and expand their activities.

In the area of technical skills building, FHI provided direct technical assistance in STI case management, BCI, CSM, evaluation research design, VCT, ART, care and HIV estimations and modeling primarily by external consultants. The staff at FHI partner organizations reported greater understanding and sophistication in the use of management tools for strategic planning, financial management, monitoring, and reporting, and in the use of technical skills for peer education, BCI materials development, evaluation methodologies, social marketing and STI service delivery.

In the area of networking and global learning enhancement, FHI regularly disseminated recent HIV/AIDS and STI literature, periodicals, publications, research

FHI PARTNER ORGANIZATIONS ASSESS THEIR OWN STRENGTHS AND PLAN FOR IMPROVEMENTS IN 2003

As FHI expanded its programs, more partner organizations were added to help implement new services and in new areas. To help identify which were common areas for FHI support for capacity building, FHI supported a process for interested organizations to self assess their needs and strengths. The objectives were to:

- Empower the organizations to identify their challenges to defining and/or achieving their mission, formulating effective strategies, designing effective projects, monitoring and managing their implementation to optimize impact; and
- Enhance the ability of the organizations to assess their own capacity needs and identify areas they needed external help to address the identified needs.

Thirteen organizations participated by conducting internal discussions guided by a questionnaire that covered 10 different areas. While each organization could then use its findings to address many of the areas without any additional technical support from FHI, there were five areas were prioritized for external assistance:

- Strategic planning
- Financial management
- Human resources management
- Monitoring and evaluation
- Service delivery

Within ongoing projects, capacity building activities were added or modified. Each organization was given additional copies of the tool and encouraged to routinely revisit findings for continual learning.

findings, and FHI newsletters and materials. Mechanisms to share information among FHI partners have been effective, such as research findings dissemination and FHI program meetings with all implementing partners. FHI and its IAs continually collaborate and coordinate with other projects, stakeholders and community groups on an informal basis.

How Has FHI's Capacity Building Efforts Contributed HMG/N's National HIV/AIDS Program?

FHI's commitment to capacity building has helped prepare dozens of organizations and individuals to contribute to the national HIV/AIDS response. HMG/N can mobilize people, organizations, associations and institutions that have the capacity and expertise in HIV/AIDS prevention, care and mitigation. As they are in Nepal, available resources can be better utilized and involvement can be regular.

More information about best practices in HIV/AIDS prevention, care and mitigation is available, and more communications materials are produced and disseminated to share key messages and findings. Capacity on organizational and financial management are key to efficiently using funds, creating sustainability and demonstrating existing systems can be expanded.

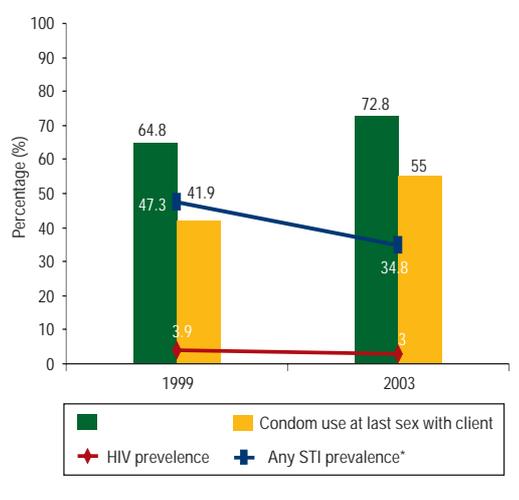
Have Interventions Made a Difference?

The range of FHI/ interventions for HIV/AIDS prevention and control in over a decade of work in Nepal has shown some positive impacts. An increased awareness of the importance of using condoms among high-risk groups, especially among FSWs, transport workers and male laborers is an important indicator of this. Behavior Surveillance Surveys (BSS) show that knowledge regarding condom use for HIV prevention among FSWs has increased from 85% in 1998 to 97% in 2002 while among transport workers, this has increased from 89% in 1998 to 98% in 2002. As a result of this change in awareness and knowledge, the ratios of those using condoms at their last sex act has also increased. Results of various integrated bio-behavioral surveys (IBBS) also demonstrate FSWs exposed to FHI interventions are reported to carry condoms with them and more likely to negotiate with their clients to use them during sex, give them condoms to use, use condoms with their clients and use condoms consistently. BSS among FSWs showed that consistent condom use with a client increased from 33% in 1998 to 54% in 2002 while among transport workers, consistent condom use with a FSW increased from 36% in 1998 to 80% in 2002.

Similarly, the prevalence of STI (syphilis, gonorrhoea and chlamydia) has decreased significantly in FHI program areas. A HIV prevalence study conducted in 1999 in 16 districts along the highways showed a syphilis prevalence of almost 20% among FSWs and over 5% among truckers. A similar study repeated in 2003, showed that syphilis was halved among FSWs and dropped by 20% among truckers. The number of people diagnosed and treated for STIs has grown significantly. Almost 33,000 individuals have been treated in the past eight years of STI service delivery for HIV prevention.

The 1999 HIV prevalence study had indicated that HIV prevalence among FSWs and truckers (their main client group) was under 5%. When the study was repeated in 2003, findings suggested that HIV has been contained and there was no increase in HIV prevalence in either of the two groups. This means HIV prevalence among FSWs and truckers has remained at the same level in FHI program areas.

HIV AND STI PREVALENCE ARE DECREASING AND CONDOM USE BEHAVIOR IS IMPROVING AMONG FSWs, 1999 - 2003



Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ART	Anitretroviral therapy
BCI	Behavior Change Interventions
BSS	Behavioral Surveillance Survey
CIP	Community-based Information Point
CSM	Condom Social Marketing
DACC	District AIDS Coordination Committee
DBS	Dried Blood Spot
DIC	Drop-In Center
FHI	Family Health International
FSW	Female Sex Worker
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
HIV	Human Immunodeficiency Virus
HMG/N	His Majesty's Government of Nepal
HSS	HIV Sentinel Surveillance
IA	Implementing Agency
IBBS	Integrated Bio-behavioral Survey
IDU	Injecting Drug User
JICA	Japan International Cooperation Agency
MSM	Men Who Have Sex with Men
MSW	Male Sex Worker
NAP+N	National Association of PLHA in Nepal
NCASC	National Center for AIDS and STD Control
NGO	Non-Governmental Organization
NHRC	Nepal Health Research Council
NPHL	Nepal Public Health Laboratory
OI	Opportunistic Infection
ORE	Outreach Educator
PE	Peer Educator
PHC	Primary Health Care
PHSC	Protection of Human Subjects Committee
PLHA	People Living with/Affected by HIV/AIDS
RNA	Royal Nepalese Army
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TA	Technical Assistance
VCT	Voluntary Counseling & Testing
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	United States Agency for International Development
WHO	World Health Organization

Family Health International

HIV/AIDS Prevention, Control and Care Program

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