HIV/AIDS Curriculum for

THE SENIOR-LEVEL OFFICER

Nepal Police

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THE SENIOR-LEVEL OFFICER

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Foreword

Nepal Police is committed to support His Majesty's Government's initiatives in developing HIV & AIDS Strategy and its actions to meet the commitment to the UN General Assembly Sessions on HIV/AIDS (June 2001) for strategic interventions in the uniformed services. Nepal Police is proud and privileged to work in this direction and herewith, launch Nepal Police 'HIV/AIDS curriculum' for the entire benefit of its personnel.

I strongly believe this important document should avail trainees with the opportunity to acquire minimally required knowledge and skills on prevention and protection from the spread of HIV/AIDS and STIs, which will enable them to behave in a responsible manner, protect their own health and promote the well being of their family members and communities and also share the knowledge and skills with their subordinates and colleagues. Uniformed Services offer a unique opportunity for HIV awareness and training with a large 'captive audience' in a disciplined and highly organized setting. As uniformed Services are often perceived as the role models in their society, this will not only help one such organization but to the community as a whole.

Nepal Police have several ongoing training activities including basic training to professionally prepare the new recruits for their jobs and on the job training to provide required additional skills and competencies for better performances. This curriculum has been drafted with a view to integrate HIV/AIDS and STIs in the above training activities. This important document should provide trainees with the minimally required knowledge and skills on HIV/AIDS and STIs, which will enable them to behave in a responsible manner to protect themselves, their family members and communities. This will also provide opportunity for them to speak freely and share the knowledge and skills on this disease.

In conclusion, I highly value the efforts put together by all concerned to the development of this HIV/AIDS Curriculum. On behalf of Nepal Police, I would like to convey special thanks to the Futures Group, POLICY Project and United States Agency for International Development (USAID) for their support in this endeavors.

Shyam Bhakta Thapa
Inspector General of Police

Kumar Koirala

Deputy Inspector General of Police

March 17, 2005

Acknowledgement

In less than a quarter of a century, tackling the HIV/AIDS outbreak has become the most outstanding challenge this universe has ever faced. Over 30 million lives have been lost due to this devastating disease and about 40 million people are estimated to be living with HIV. HIV/AIDS causes unacceptable human suffering to the infected and affected individuals, their families, communities and nations. Nepal has been impacted by this complex epidemic, with an estimated 0.5 percent of the general population being HIV positive (National estimates of Adult HIV infections Nepal, 2003, NCASC, March 2004). Even a recent UNAIDS estimate puts the number of people living with HIV/AIDS (PLWHA) in Nepal at over 61,000.

Member of Uniformed services and their communities are highly vulnerable to sexually transmitted infections (STIs) mainly due to their work environment, mobility, age and other facilitating factors that expose them to higher risk of HIV infection. Although HIV/AIDS prevalence in the Nepal Police Service is not known, it is reasonable to estimate it to be comparable with the national average of 0.5 percent. Education programs have been very successful in various countries in reducing incidence (new cases) in recent years. Therefore taking this reality into serious consideration, Nepal Police has developed this curriculum as and effort to prevent and reduce the spread and impact of HIV/AIDS and STI among Nepal police personnel and their epidemic effectively, and equip Police personnel with necessary knowledge, skills and attitude to serve the society more effectively in the fight against HIV/AIDS epedemics.

The Nepal Police Services would like to acknowledge the support, commitment and collaboration of the POLICY Project and United States Agency for International Development (USAID) in developing the HIV & AIDS Curriculum. We would like to extend gratitude to Mr. Bhojraj Pokharel and Sumi Devkota of the POLICY Project for their conitunous support in the development of this curriculum. Our acknowledgement goes to Mr. Bimal Chapagain, Consultant who provided technical guidance in the initial phase of the development of this curriculum. We appreciate the valuable inputs and feedback provided by the most at risk groups, external development partners, civil society members and other individuals in the development process of the document.

I owe special thanks to my seniors in the organization and colleagues of the Nepal Police HIV and AIDS Advisory Team for their continuous support and assistance to bring this curriculum to its final shape.

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DIGP
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Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretrovirals
BCC	Behavior Change Communication
BDS	Blue Diamond Society
FHI	Family Health International
FWLD	Forum for Women, Law, and Development
GWP	General Welfare Pratisthan
HIV	Human Immunodeficiency Virus
HMG/N	His Majesty's Government/Nepal
IDU	Injection Drug User
LALS	Life Saving and Life Giving Society
MOH	Ministry of Health
MOHA	Ministry of Home Affairs
MSM	Men who have Sex with Men
MTCT	Mother-to-Child Transmission
NCASC	National Centre for AIDS and STD Control
NGO	Nongovernmental Organization
OI	Opportunistic Infection
PLWHA	People Living with HIV or AIDS
STI	Sexually Transmitted Infection
SW	Sex Worker
UN	United Nations
UNAIDS	Joint United Nations Program on HIV/AIDS
UNDP	United Nations Development Program
USAID	United States Agency for International Department
VCT	Voluntary Counseling and Testing
WATCH	Women Acting Together for Community Health
WHO	World Health Organization

Important Skills in a World with HIV/AIDS

Learn to appreciate the severity of the epidemic.

Learn to recognize a risky situation.

Learn to make sound decisions about relationships and sex and to stand up for those decisions.

Learn to deal with pressures for unwanted sex or drugs.

Learn to negotiate for postponed or protected sex.

Learn how and where to ask for support.

Learn to show compassion and solidarity toward people with HIV/AIDS and their families.

Learn more about the difficulties and needs of people with HIV/AIDS and their families.

CHAPTER *One*

BACKGROUND[1]

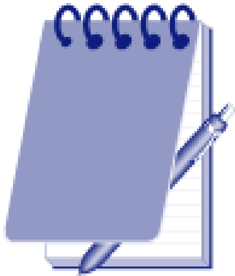
This introductory chapter presents the goals, purpose and objectives of this curriculum followed by information on its design, methods to be used, and required time to impart the training.

- Introduction
- HIV/AIDS Curriculum
- Curriculum Goals
- Curriculum Purpose
- General Objective
- The Design
- Training Methodology
- Required Time

[1] Majority of information contained in this chapter is taken from the following sources:

a) AIDS Epidemic updates, UNAIDS, Geneva, 2003
b) National Estimates of Adult HIV Infection Nepal 2003: NCASC, MOH, March 2004
c) HIV/AIDS Strategy (2002-2006) Nepal: MOH, January 2003.
d) HIV/AIDS: The Situation in Nepal: NCASC, 2001

NOTES FOR THE FACILITATOR



Introduction

In less than a quarter of a century, the HIV/AIDS outbreak has become the most outstanding challenge worldwide. Over 30 million lives have been lost due to this devastating disease and about 40 million people are estimated to be living with HIV. HIV/AIDS causes unacceptable human suffering to the infected and affected individuals, their families, communities, and nations.

Nepal has been affected by this complex epidemic, with an estimated 0.5 percent of the population being HIV positive (National Estimates of Adult HIV Infections–Nepal, 2003, NCASC, March 2004). Even a conservative estimate puts the number of people living with HIV or AIDS (PLWHA) in Nepal at over 61,000. Although HIV/AIDS prevalence in the Nepal Police Service is not known, it is reasonable to estimate that it is comparable with the national average of 0.5 percent. The prevalence may be even greater due to the nature of police work, which places them in vulnerable situations. Even by using the figure of 0.5 percent prevalence, the total number of HIV-positive personnel in the Nepal Police could be as high as 230. If only 60 percent of them were to be married, about 138 of their spouses or partners are also at very high risk. Furthermore, if those spouses are already infected and pregnant, their children may be born with HIV. This relatively small-scale problem, if not addressed effectively, could ultimately bring serious consequences to the Nepal Police Service. Giving this reality serious consideration, the Nepal Police is in the process of formulating a comprehensive HIV/AIDS strategy and workplan. The development of this curriculum is an additional effort in this regard.

An effective HIV/AIDS response requires adequately addressing the social and structural epidemics of poverty, conflict, war, gender inequality, stigma and discrimination, and human rights violations, which are fertile grounds for the spread of HIV/AIDS. These issues highlight the significant need for an educational program for the Nepal Police. This curriculum seeks to contribute to this purpose.

HIV/AIDS Curriculum

The Nepal Police have several ongoing training activities including basic training to prepare the new recruits for their jobs and on the job training to provide required additional skills and competencies for existing staff. This curriculum has been drafted with a view to integrate HIV/AIDS/sexually transmitted infection (STI) information with the above training activities.

The ideas proposed and activities planned in this curriculum focus specifically on activities related to HIV/AIDS and STIs. However, HIV/AIDS cannot be isolated from a range of other social and economic problems, including drug and alcohol abuse, sex work, teenage pregnancy, sexual behavior of migrant populations, poor living conditions, violence, war, and unemployment. Many of the skills and attitudes needed to prevent infection with HIV and STIs are life skills useful in responding effectively to a variety of other problems.

Curriculum Goals

This curriculum seeks to provide information to the trainees on the following:

(1) Preventing and reducing the spread and impact of HIV/AIDS and STIs among Nepal Police personnel and their families
(2) Strengthening the roles and capacities of Nepal Police to respond to HIV/AIDS and STI epidemics effectively
(3) Equipping police personnel with the necessary knowledge, skills, and attitude to serve the society more effectively in the fight against HIV/AIDS and STIs

Curriculum Purpose

The purpose of this curriculum is to provide trainees with the minimally required knowledge and skills on HIV/AIDS and STIs that will enable them to behave in a responsible way, protect their own health, and promote the well-being of their families and communities.

General Objectives

The general objectives of this curriculum are to enable the learner to

- Know the global scenario of HIV/AIDS and develop a positive attitude toward implementable initiatives to overcome the burden of HIV/AIDS and STIs
- Acquire adequate knowledge and information about HIV/AIDS and STIs
- Gain knowledge and skills to avoid risky behaviors
- Have a deeper understanding of the social factors behind the spread of HIV/AIDS and STIs

- Understand the concept of voluntary counseling and testing (VCT)
- Internalize the concepts of care, support, stigma, and discrimination in the context of HIV/AIDS
- Develop positive attitudes toward those infected and affected by HIV/AIDS
- Identify ways of protecting and helping the vulnerable groups
- Create an environment allowing for an interface with the vulnerable groups

The Design

This curriculum is designed to provide a comprehensive training package to the trainees on HIV/AIDS and STIs so that personnel of the Nepal Police are adequately prepared for the mitigation of the HIV/AIDS epidemic.

This curriculum is divided into four chapters: (1) Background, (2) Guidelines on the Delivery of the Training, (3) Class Materials, and (4) Tips for the Facilitator.

Chapter One: Background sets the tone by giving background information on the curriculum, its goals, purpose, and objectives followed by the description of the design and methodology envisaged.

Chapter Two: Guidelines on the Delivery of the Training describes the purposes, objectives, content, materials, processes of delivering the training package, and basic skills related to HIV/AIDS. Notes accompany each unit for the facilitator that provides factual information on each topic.

Chapter Three: Class Materials provides a set of materials for easy reference and adaptation by a facilitator. These include pre- and post-test questionnaires, quizzes, and quotes to assist the training facilitator in imparting the training package in an effective and efficient manner.

Chapter Four: Tips for the Facilitator describes preparation, qualities, evaluation, and follow-up for facilitators.

The curriculum also includes slides for each topic to be used during the training.

Trainees

It is presumed that the participants who would undergo this training will have a bachelor-level education and have already acquired basic knowledge about human reproductive and sexual health, as well as use of condoms and other contraceptive methods. This curriculum is developed primarily for newly recruited police officers, with the hope of secondary transfer of knowledge and skills to their spouses, dependents, or subordinates

Training Methodology

This curriculum is designed with an assumption of using participatory methods, for example, group work and discussions, including field visits and interaction with the vulnerable groups. Active learning by trainees is considered to be the main strength of this program, involving participants in most of the classroom activities. This is especially important in dealing with sensitive topics such as sexuality and relationships. Unless people are able to be open and honest about their experiences, views, and fears, it is difficult for them to see how HIV/AIDS and STIs affect them and what they personally can do about these infections/ diseases. In the case of a very large class size, it may not be possible to interact with students to the point where they are able to hold frank, open discussions. In such a situation, the facts are to be presented using other classroom techniques.

It is very important to realize that the participants of a training session have different experiences in relation to sex and sexuality. Hence, the language used in delivering this training should not be judgmental, which could make some learners feel excluded and, therefore, not interested in prevention.

Required Time

The total time estimated to implement this curriculum is about 18 to 24 working hours—12 hours for classroom activities and 6 to 12 hours for field placement (or interaction with vulnerable group members, including PLWHA).

Guidelines on The Delivery of The Training[2]

This chapter describes the purposes, objectives, content, materials, and processes of delivering the training package. Suggestions on imparting the required information and basic skills related to HIV/ AIDS are included. Factual information on the relevant topics is included at the end of each unit.

Pre- and Post-Test

Unit 1: Basics on HIV/AIDS

Unit 2: An Overview of the Global and National HIV/AIDS Scenarios

Unit 3: Sexually Transmitted Diseases

Unit 4: Voluntary Counseling and Testing

Unit 5: Care and Support

Unit 6: Stigma and Discrimination

Unit 7: Protecting the Rights of Vulnerable Groups

Unit 8: Interface with Vulnerable Groups

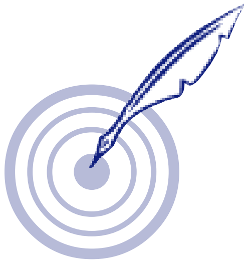
CHAPTER *Two*

[2] Technical information contained in this chapter has been taken form the following sources:

a) AIDS and HIV Infection, Information for Employees and their Families, UNAIDS
b) HIV/AIDS Training Tool Kit, GTZ and UNAIDS, 2003
c) HIV/AIDS and VCT, National Guidelines for voluntary HIV/AIDS Counseling and testing, NCASC, 2003
d) National Estimates of Adult HIV Infection Nepal 2003: NCASC, MOH, March 2004
e) National Guidelines for Voluntary HIV/AIDS Counseling and Testing: MOH, NCASC, July 2003.
f) National HIV/AIDS Strategy (2002-2006) Nepal: MOH, January 2003. AIDS Epidemic Update: UNAIDS, December 2003.
g) AIDS and HIV Infection, Information for Employees and their Families, UNAIDS
h) Peer Education Kit for Uniformed Services, Implementing HIV/AIDS/STI: UNAIDS, September 2003

Pre-and Post-Test

Training will begin with the administration of a pre-test questionnaire and finish with a post-test (repeat of the pretest).



The aim

The aim of this test is to assess the knowledge and attitudes of trainees with respect to the prevention of HIV/AIDS prior to and following the training. The test will thereby also gauge the contribution made by the training to the knowledge of the participants.

The questionnaire

The pre- and post-test questionnaires are at the beginning of Chapter Three, Unit One.

Estimated time

30 minutes

Process

Give the questionnaire to the trainees for reading. Clarify if they have any questions. Advise them not to discuss the questionnaire with each other. Inform the trainees that the pre- and post-tests are assessment tools and trainees will not be given pass or fail marks. The questionnaires will be used only to assess the effectiveness of the training and the progress made by the trainees.

Repeat the test at the end of the training. Analyze the answer sheets. Compare the pre- and post-test scores, measure the gains made by the trainees, and discuss the outcomes.

UNIT

1

Basics on HIV/AIDS

The purpose of the unit

To present facts about HIV/AIDS and its transmission, to empower participants to make an informed risk assessment, and to embrace sound prevention measures

Unit objectives

By the end of this module participants should be able to

- Define HIV and AIDS
- Know HIV/AIDS-related facts
- State the modes of HIV transmission
- State ways to prevent HIV infection
- Understand the stages of HIV infection
- Know about HIV testing

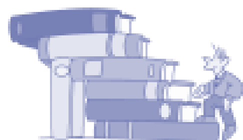
Instructional materials

Chart paper, markers, Meta cards, handouts, (copy of the facilitators' notes—Unit One)

Estimated time

Three hours:

Introductory presentation	15 minutes
Group Work	40 minutes
Brainstorming on the various topics and clarification	90 minutes
Factual presentation and discussion (PowerPoint presentation)	35 minutes



Process

This unit will be taught through short lectures, brainstorming sessions, class presentations, and discussions.

Step one: Introduce the topic and its objectives

Step two: Present the major headings that will be covered in the unit:

- The meaning of HIV and AIDS
- Routes of transmission
- The stages of HIV/AIDS
- Testing and diagnosis for HIV and available treatment
- Methods of protection and prevention
- Measures to take if you and/or your partners have been exposed

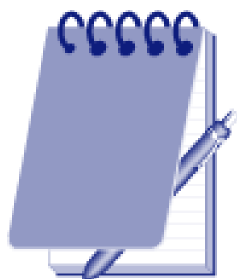
Step three: Divide the participants into six groups according to the above topics. Ask participants to brainstorm on each topic and record answers on Meta cards or chart paper.

Step four: Each group will present their answers in the plenary, followed by discussion and clarification.

***Step five*:** Make a PowerPoint presentation to summarize the highlights and major points of each topic covered.

Step six: Distribute handouts (a copy of the facilitators' notes and/or OHP slides for Unit One) for reference.

NOTES FOR THE FACILITATOR



Basics on HIV/AIDS

What do HIV and AIDS mean?

HIV is a virus that can be passed from one person to another.

H = Human—it only affects humans
I = Immunodeficiency—it attacks the body's immune system, which means it attacks the body's ability to fight off diseases
V = Virus

AIDS is NOT a disease but the name for a collection of symptoms of various diseases that only occur as a result of a weakened immune system due to HIV infection.

A = Acquired—you get it from someone; it does not just happen
I = Immune—it affects the immune system
D = Deficiency—in AIDS, the immune response is "deficient"
S = Syndrome—a collection of infections that occur when the body's immune system has become too weak to fight them off

Knowing the difference between HIV and AIDS is important. Someone who is HIV positive is not ill. S/he can look healthy and well and able to operate like anyone else. The time between infection with HIV and development of AIDS can be anywhere between 6 months–12 years or even more.

How does one get infected with HIV?

HIV is transmitted from an HIV-positive person through his or her infected body fluids, such as semen, pre-ejaculate fluid, blood and blood products, vaginal secretions, and breast milk. HIV can only be transmitted when infected fluid gets into a person's bloodstream.

There are four ways of transmitting HIV:

1. Sexually (whether vaginally, orally, or anally)
2. Through infected injecting equipment (such as needles and syringes)
3. Infected blood transfusions and organ transplants
4. From an infected mother to a child

An HIV-positive person is infected and infectious for life. Even when feeling and looking healthy, s/he can transmit the virus to others.

HIV is NOT transmitted through the following:

You ***do not get HIV*** through casual contact with an infected person at home, in a workplace, in society, or

- Playing sports
- Working together
- Coughing, sneezing, or breathing the same air
- Sharing food, eating, or drinking
- Sharing utensils or towels
- Sharing toilets or showers
- Using public swimming pools
- Getting a mosquito or insect bite
- Using a public phone
- Visiting a health facility
- Shaking hands, hugging, or outer kissing
- Donating blood

Insects do not transmit HIV (remember it is HUMAN Immunodeficiency Virus). A mosquito takes blood out of you to eat. It only bites again when the blood is digested. Malaria exists in the mosquito but HIV does not.

There are no documented cases of HIV being transmitted by tears or saliva, but it is possible to be infected with HIV in rare cases through deep kissing, especially if partners have open sores in the mouth or bleeding gums.

The stages of HIV/AIDS

HIV enters the bloodstream and begins to take up residence in the cells. People with HIV are considered to be infectious immediately after infection with the virus and will remain infectious at all times, even when they look perfectly healthy. HIV progression generally is broken down in two to four distinct stages. Here the stages of HIV infection will be described in the following four stages: (1) primary infection, (2) clinically asymptomatic stage, (3) symptomatic HIV infection, and (4) progression from HIV to AIDS. The time it takes for an individual to go through these stages varies from person to person.

Stage one: primary infection (or acute infection or window period). This is the first stage of HIV infection. The term acute HIV infection is used to describe the period of time between when a person is first infected with HIV virus and when the body starts producing antibodies against the virus before the antibody becomes detectable. It is often accompanied by a short flu like illness (in up to 70 percent of newly infected persons), which usually lasts no more than a few days. It might include fevers, chills, night sweats, and rashes. The remaining percentage of people either do not experience such an illness or they have such mild symptoms that they do not notice them. People with acute HIV infection initially will not test HIV antibody positive because it takes the body up to three months to produce antibodies against HIV. As such, people who suspect they have been infected by HIV need to wait at least three months for an antibody test. At this stage, available lab tests cannot detect the infection, but an infected person is able to infect others.

If a person's first test result is negative, s/he should follow-up with a second test three months later. About 95 percent of people infected with HIV will develop antibodies within three months after infection. Nearly all people will develop antibodies within six months after infection.

Stage two: clinically asymptomatic stage. This stage is observed lasting for an average of ten years, and as its name suggests, is free from any symptoms although some may have swollen glands. The level of HIV in the peripheral blood drops to very low levels. However, people remain infectious during this stage, and HIV antibodies are still detectable in the blood. HIV is not dormant during this stage and is very active in the lymph nodes.

The virus appears to slowly damage the immune system for a number of years after infection. In most people, however, a faster decline of the immune system occurs at some point, and the virus rapidly replicates.

Stage three: symptomatic HIV infection. Once the immune system is damaged, many people will begin to experience some mild symptoms (skin rashes, fatigue, slight weight loss, night sweats, thrush in the mouth, etc.) before developing more serious illnesses. Although one's prognosis varies greatly depending on his/her ability to access support services and preventative treatment, it is generally believed that it takes the average person five to seven years to experience the first mild symptom.

Usually, symptoms occur when the virus has already caused considerable damage to the immune system. For that reason, people who test HIV-positive should not wait until symptoms appear to get medical attention. Also, people

with high risk for HIV should not wait to get symptoms to take an HIV-antibody test.

Symptomatic HIV infection is mainly caused by the emergence of opportunistic infections (OIs) and cancers that the immune system would normally prevent. These can occur in almost all the body systems.

Stage four: progression from HIV to AIDS. In this stage, as the immune system becomes more and more damaged, the illnesses become increasingly severe leading eventually to an AIDS diagnosis. When immune system damage is severe, people may experience OIs (e.g., tuberculosis (TB), malaria, pneumonia, meningitis, skin infections), which are eventually diagnosed as AIDS. These infections are called "opportunistic" because they are caused by organisms that cannot induce disease in people with normal immune systems but take the "opportunity" to flourish in people with HIV.

Diagnosing AIDS does not necessarily mean that the person will die shortly. Some people have lived many years after their diagnosis. However, it is extremely important that people in this stage of HIV get adequate care for any symptoms or conditions that develop.

Is there a cure for HIV/AIDS?

No, there is still no cure or a vaccine for HIV/AIDS. There are, however, new drug treatments that can slow down the impact of HIV and decrease the damage to the infected person's immune system.

The new set of drugs can help people with HIV stay healthy longer and can also delay the onset of AIDS. As a result of the availability of these drugs, the number of HIV cases that develop into AIDS and the number of AIDS-related deaths have dropped dramatically. However, there is no way to permanently remove all the HIV from an infected person's body and cure him/her.

A= Abstinence
B= Being faithful to a single partner
C= Consistent and correct use of condoms

How can you protect yourself from HIV infection?

You are safest if you do not have unprotected sexual intercourse, oral sex, or share needles or injection equipment. You are also safe if you are in a relationship in which you and your partner are both free of HIV and neither of you has had other sexual partners. Whenever you are unsure about the risk

of infection, always use a condom/latex barrier when having sex of any kind—vaginal, oral, or anal. There are guidelines available on HIV prevention. The ABC model offers easy to remember options for safe sexual activity:

Know your partner's sexual history, understand which sexual acts put you at risk, and always use a condom during unsafe penetrative sexual acts.

Infection through sexual contact. Your risk of acquiring HIV through sexual acts is directly related to the likelihood that your partner is infected. One can avoid any risk of HIV if s/he practices abstinence (not having sex, being faithful to your partner); however, this may not be possible in many cases. People can practice safer behavior instead. Safe activities include soft kissing, erotic massage, masturbation or hand jobs (mutual masturbation), and reducing the number of sexual partners. You can reduce the risk of infection with HIV and other STIs by using barriers like condoms.

Injection drug use is one of the fastest routes to HIV infection. Do not share needles or syringes; avoid invasive, skin piercing procedures.

Increased risk through drug use. One way drug use increases risk of infection is that a person high on drugs or alcohol might forget to use protective measures during sex. Also, if you use someone else's equipment (needles, syringes, cookers, and cotton or rinse water), you can get infected through the tiny amounts of blood present in these items. The best way to avoid infection is to not use drugs. If you have to use drugs, you can prevent infection by not injecting them. If you do inject, do not share needles or equipment.

Contact with blood. HIV is one of the many diseases that can be transmitted through blood and blood products. Always ask healthcare professionals, clinics, or hospitals if they follow "universal precautions" or safety measures to prevent the transmission of HIV in their facilities. In case you need to take blood or blood products or need to transplant any organs, ensure that they have been screened for HIV and hepatitis B and found safe. Be careful if you are helping someone who is bleeding. If your work exposes you to blood, be sure to cover any cuts or open sores on your skin, as well as your eyes and mouth. Due to the window period (the fact that an HIV antibody test may not detect HIV in the blood until three months after infection), always weigh blood transfusion risk against life and death.

Mother-to-child infection. HIV transmission from a mother to her child can happen during pregnancy, during delivery, or as a result of breastfeeding. In the absence of any intervention, rates of mother-to-child transmission (MTCT) of HIV can vary from 15 to 30 percent without breastfeeding, and can reach as high as 30 to 45 percent with breastfeeding, up to 18 to 24 months.

What if I've been exposed?

If you think you have been exposed to HIV, talk to your doctor or a health official and get tested. If you are sure that you have been exposed, seek professional help within 72 hours to discuss whether you should start taking anti-HIV drugs, called post-exposure prophylaxis (PEP). If advised for PEP, you would take two or three medications for several weeks. These drugs can decrease the risk of infection, but they have some serious side effects as well. Discuss such issues with your healthcare provider. Do not take the drugs on your own; take them only as prescribed by a trained and experienced healthcare practitioner.

Blood test

The most commonly used clinical blood test for HIV looks for antibodies to HIV. The test does not look for the virus itself. This is problematic in that the body takes up to three months to develop antibodies to HIV (different infections have different times for development of antibodies). This means that if a person is tested immediately after exposure, s/he may test negative. This does not mean s/he has not been infected, though. In order to be certain, one needs to return for a test three months later. Additionally, it is important to not put one's self at risk again during the three-month period.

What if both partners are already infected?

Some people who are HIV-infected do not see the need to follow safe sex guidelines when they have sex with other infected people. However, it still makes sense for one to "play safe." Without practicing safe sex, a person could be exposed to other STIs such as herpes, syphilis, or hepatitis. If s/he already has HIV, these diseases can be more serious.

Also, a person might get "re-infected" with a different strain of HIV. This new version of HIV might not be controlled by the medications s/he is taking. It might also be resistant to other HIV antiretroviral drugs. There is no way of knowing how risky it is for two HIV-positive people to have unsafe sex, but following the guidelines for safe sex will definitely reduce risk.

FACTS ABOUT HIV&AIDS

What is HIV?

H-human **I**-immune deficiency **V**-virus
HIV is the virus which causes AIDS

What is AIDS?

A - Acquired
I - Immune
D - Deficiency
S - Syndrome

No Vaccine, No Cure

What happens after HIV infection?

- HIV destroys the natural defence mechanism of the body
- Infected person gets exposed to infections, such as Tuberculosis

HIV infected persons can look healthy over many years

HIV is transmitted:

Through unprotected sexual contact

Anal

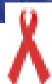
Vaginal

Oral

HIV is transmitted:

Through infected blood

- Sharing needles
- Use of contaminated needles and syringes



HIV is transmitted:

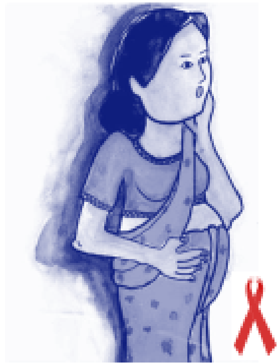
Through infected blood

Transfusion of HIV infected blood

HIV is transmitted:

From mother to child

- During pregnancy
- During child birth
- Through breast feeding



HIV is NOT transmitted by

Sharing swimming pool

Eating together

Mosquito bite

HIV is NOT transmitted by

Coughing / sneezing

Sharing toilet

Hand shake

HIV is NOT transmitted by

Caring for infected person

Living together in family

HIV is NOT transmitted by

Sharing comb

Sharing cloths

Kissing

HIV/AIDS can be prevented by...

A = Abstinence

B = Being faithful to a single partner

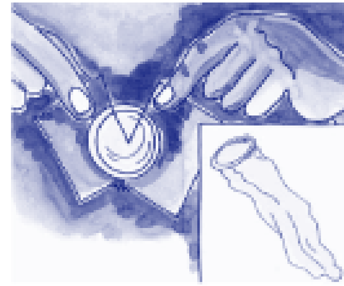
C = Consistent and correct use of condoms

AIDS can be PREVENTED by

Being mutually faithful to your partner

AIDS can be PREVENTED by

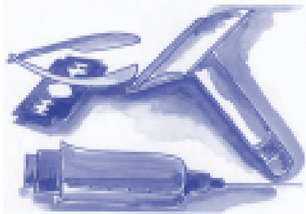
Using a condom for safer sex



AIDS can be PREVENTED by

Always using new

- Needles
- Syringes
- Blades
- Razor



AIDS can be PREVENTED by

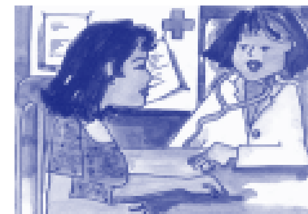
Using only HIV screened blood or blood products when required

AIDS can be PREVENTED by

Avoiding injectable drugs and needle sharing

AIDS can be PREVENTED by

HIV infected women seeking advice before planning to have a baby



Stages of HIV/AIDS

- **Stage one:** primary infection (or acute infection or window period
- **Stage two:** clinically asymptomatic stage
- **Stage three:** symptomatic HIV infection
- **Stage four:** progression from HIV to AIDS

Cure for HIV/AIDS

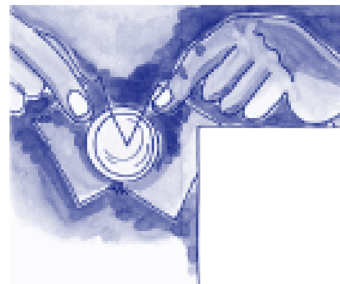
- NO CURE! Only drugs can slow down the impact
- PEP within 72 hours of exposure

Use of a Condom

Condoms provide protection from sexually transmitted infections including HIV

Note:
Condoms also prevent pregnancy

How to use a Condom?



Never use teeth / sharp object to take condom out of packet

How to use a Condom?

Always put on a condom before entering partner

How to use a Condom?

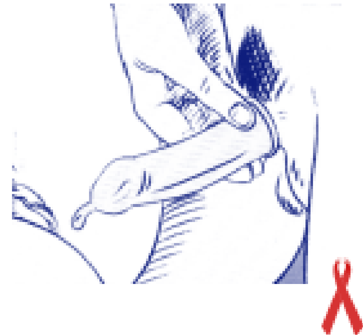
Squeeze the tip of the condom and put it on the erected penis

How to use a Condom?

Unroll the condom until it covers all of penis

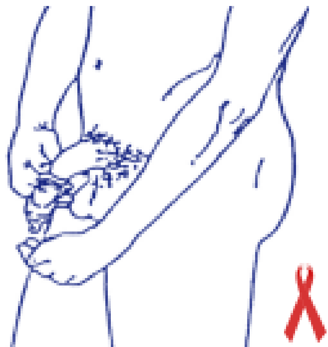
How to use a Condom?

After ejaculation hold rim of the condom and pull penis out before penis gets soft



How to use a Condom?

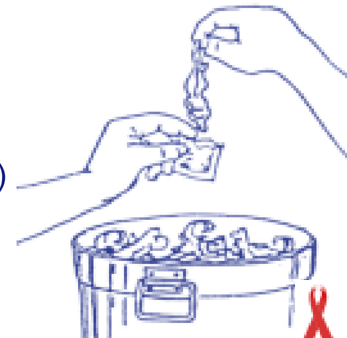
Slide condom off without spilling semen



How to use a Condom?

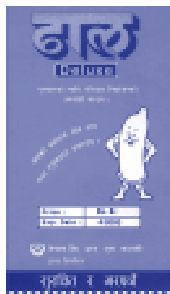
Tie and wrap the condom (in paper) then throw in a dust bin

Wash hands



Things to remember

- Use good quality condoms
- Avoid using condoms which are:
  - dry / brittle
  - sticky
  - discoloured
  - past their expiry date
- Store condoms in a cool, dry place out of direct sunlight



Things to remember

- Use a condom in every sexual contact
- Never reuse a condom
- Do not use grease, oils, lotions or vaseline
- Only use water-based lubricants for added lubrication

Frequently Asked Questions

Can one get HIV through oral sex?

YES

Increased risks, when:

- there are wounds in mouth or throat
- partner ejaculates in mouth
- partner has sexually transmitted infection

How to prevent? Use a condom

Can one get HIV from vaginal sex?

YES

- Most common mode of HIV transmission

How to prevent? Use a condom

Can one get HIV from anal sex?

YES

HIV can enter through blood and sores

Increased risk for people with sexually transmitted infections

How to prevent? Use a condom

Can one get HIV from intense kissing?

YES

- Very low risk for HIV transmission, but HIV can pass through sores in the mouth

How to prevent?
Avoid intense kissing

Should an HIV infected mother breast feed her baby?

NO

if cow, buffalo or other milk is

- available
- affordable
- prepared safely

In any other case breast milk is best food for baby

Is there a link between HIV and Sexually Transmitted Infections?

YES

- 9 times higher risk of getting HIV
- HIV enters through sores / ulcers into the skin during sexual contact

How to prevent? Use a condom

Is injecting drugs a risk for HIV?

YES

- Intravenous drug users share needles and syringes
- HIV could be present in the blood
- Infected blood will be injected directly in the blood

How to prevent?
Avoid needle sharing

The RED RIBBON stands for

- An international symbol of AIDS awareness
- A call to join the fight against AIDS
- Concerns and care about those living with HIV/ AIDS
- A tribute to millions of people who have died from AIDS

Thank You

UNIT

2

An Overview of the Global and National HIV/AIDS Scenarios

The purpose of the unit

To foster an understanding for and appreciation of the gravity of the global and national HIV/AIDS situation of Nepal

Unit objectives

By the end of this unit the participants will

- Be aware of the global scenario of HIV/AIDS
- Gain knowledge of the current HIV/AIDS situation in Nepal
- Be aware of the HIV/AIDS Strategy of Nepal

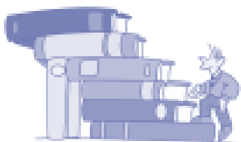
Instructional materials

AIDS quiz (Chapter Three, Unit Two), chart paper, markers, Meta cards, handouts (copy of the facilitators' notes-Unit Two)

Estimated time

1 hour

Administration of the quiz	15 Minutes
Factual presentation, questions, and answers	45 Minutes



Process

This unit will be taught through the administration of a quiz, short lectures and presentations, questions, answers, and discussions.

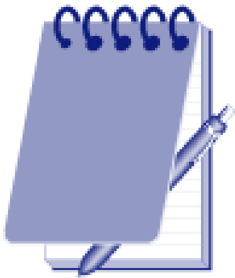
Step one: Introduce the topic and its objectives.

Step two: Administer the quiz.

Step three: Make a factual presentation on the global and national scenario and provide an opportunity to the trainees for questions and clarifications.

Step four: Distribute handouts (a copy of the facilitators' notes and/or OHP slides for Unit Two) for reference

NOTES FOR THE FACILITATOR



An Overview of the Global and National HIV/AIDS Scenarios

The global scenario of HIV/AIDS

In 2003, almost 5 million people became newly infected with HIV—the greatest number in any one year since the beginning of the epidemic. At the global level, the number of people living with HIV continues to grow—from 35 million in 2001 to 38 million in 2003. In the same year, almost 3 million were killed by AIDS; over 20 million have died since the first cases of AIDS were identified in 1981.

The epidemic varies in scale or impact within regions; some countries are more affected than others, and within countries there are usually wide variations in infection levels between different provinces, states or districts, for example.

Asia

The epidemic in Asia is expanding rapidly. This is most evident with sharp increases in HIV infections in China, Indonesia, and Viet Nam. An estimated 7.4 million people are living with HIV in the region and 1.1 million people became newly infected last year alone—more than any year before. Home to 60 percent of the world's population, the fast-growing Asian epidemic has huge implications globally.

In Asia, the HIV epidemic remains largely concentrated among injection drug users (IDUs), men who have sex with men (MSM), sex workers (SWs), clients of SWs and their immediate sexual partners, and migrant workers. Effective prevention coverage in these groups is inadequate, partly because of stigma and discrimination. Asian countries such as Thailand and Cambodia, which have chosen to tackle openly high-risk behavior, such as sex work, have been more successful in fighting HIV, as shown by the reduction in infection rates among SWs.

However, there is no room for complacency. Although there is a reduction in the numbers of young Thai men visiting brothels, for example, there is also an increase in casual sex. Behavioral surveillance between 1996 and 2002 shows a clear rise in the proportion of secondary school students who are sexually active, and at the same time consistently low levels of condom use. If other

Asian countries fail to target populations at higher risk, the epidemic will affect much greater numbers of people in the general population.

India has the largest number of people living with HIV outside South Africa—5.1 million. But knowledge about the virus and its transmission is still scant and incomplete, and there is concern that many MSM may be infecting women with whom they also have sex.

Africa

An estimated 25 million people are living with HIV in sub-Saharan Africa. There appears to be a stabilization in HIV prevalence rates, but this is mainly due to a rise in AIDS deaths and a continued increase in new infections. Prevalence is still rising in some countries such as Madagascar and Swaziland, and is declining nationwide in Uganda.

Sub-Saharan Africa is home to just over 10 percent of the world's population, and almost two-thirds of all people living with HIV. In 2003, an estimated 3 million people became newly infected and 2.2 million died (75 percent of the 3 million AIDS deaths globally that year).

There is no such thing as the 'African' epidemic; there is tremendous diversity across the continent in the levels and trends of HIV infection. In six countries, adult HIV prevalence is below 2 percent while in six other countries it is over 20 percent. In southern Africa, all seven countries have prevalence rates above 17 percent, with Botswana and Swaziland having prevalence above 35 percent. In West Africa, HIV prevalence is much lower with no country having a prevalence above 10 percent and most having prevalence between 1 and 5 percent. Adult prevalence in countries in Central and East Africa falls somewhere between these two groups, ranging from 4 to 13 percent.

African women are at greater risk, becoming infected at an earlier age than men. Today there are on average 13 infected women for every 10 infected men in sub-Saharan Africa—up from 12 for 10 in 2002. The difference is even more pronounced among 15 to 24-year-olds. A review compared the ratio of young women living with HIV to young men living with HIV; this ranges from 20 women for every 10 men in South Africa to 45 women for every 10 men in Kenya and Mali.

In North Africa and the Middle East, around 480,000 are living with HIV, but systematic surveillance of the epidemic is not well developed, particularly among high-risk groups such as IDUs. Yet in much of the region HIV infection appears

concentrated among this group. There is also concern that HIV may be spreading undetected among MSM, as male-male sex is widely condemned and illegal in many places.

Eastern Europe and Central Asia

Eastern Europe and Central Asia continue to have expanding epidemics, fuelled by injection drug use. About 1.3 million people are living with HIV, compared with about 160,000 in 1995. Strikingly, more than 80 percent of them are under the age of 30. Estonia, Latvia, the Russian Federation, and Ukraine are the worst-affected countries, but HIV also continues to spread in Belarus, Kazakhstan, and Moldova.

The main driving force behind the epidemic in this region is injection drug use, but in some countries, sexual transmission is becoming increasingly common, especially among IDUs and their partners. Russia, with over 3 million IDUs, remains one of the worst-affected countries in the region. Women account for an increasing share of newly diagnosed cases of HIV—up from one-in-four in 2001 to just one-in-three in 2003.

Latin America

Around 1.6 million people are living with HIV in Latin America. The epidemic is concentrated among populations at high risk of HIV infection—IDUs and MSM. Low national prevalence hides some serious local epidemics. For example, in Brazil (the region's most populous country), national prevalence is below 1 percent, but in certain cities, 60 percent of IDUs are infected with HIV. In Central America, HIV is spread predominantly through sex—both heterosexual and among MSM.

Caribbean

Three Caribbean countries have national HIV prevalence rates of at least 3 percent: the Bahamas, Haiti, and Trinidad and Tobago. Around 430,000 people in the region are living with HIV. The Caribbean epidemic is mainly heterosexual, and in many places it is concentrated among SWs, but it is also spreading in the general population. The worst-affected country is Haiti, where national prevalence is around 5.6 percent—the highest outside of Africa.

High-income countries

An estimated 1.6 million people are living with HIV in these countries. Unlike the situation in other regions, the great majority of people living with HIV in

high-income countries who need antiretroviral therapy have access to it, so they are staying healthy and surviving longer than infected people elsewhere. The report finds that infections are on the rise in the United States and Western Europe. In the United States, an estimated 950,000 people are living with HIV—up from 900,000 in 2001. Half of all new infections in recent years have been among African Americans. In Western Europe, 580,000 people are living with HIV, compared to 540,000 in 2001.

TABLE 1 Global summary of the HIV/AIDS epidemic (December 2004)

Description	Affected Population	Total Number
Number of people living with HIV/AIDS	Total	**39.4 Million (35.9 – 44.3 Million)**
	Adults	37.2 Million (33.8 – 41.7 Million)
	Women	17.6 Million (16.3 – 19.5Million)
	Children under 15 years	2.2 Million (2.0 – 2.6) Million
People newly infected with HIV in 2003	**Total**	**4.9 Million (4.3 – 6.4 Million)**
	Adults	4.3 Million (3.7 – 5.7 Million)
	Children under 15 years	640,000 (570 – 750,000)
AIDS deaths in 2003	**Total**	**3.1 Million (2.8 – 3.5 Million)**
	Adults	2.6 Million (2.3 – 2.9 Million)
	Children under 15 years	510,000 (460,000 – 600,000)

The numbers in parenthesis are ranges of the estimates, which in this table define the boundaries within which the actual numbers lie, based upon the available information. These ranges are more precise than those of previous years.

SOURCE: AIDS epidemic update 2004. UNAIDS.

TABLE 2 Regional HIV AIDS statistics and features (End of 2004)				
Region	Number of HIV infected persons	Number of deaths	New infection	Adult Prevalence %
Sub-Saharan Africa	25.4 million	2.3 million	3.1 million	2.3
North Africa and the Middle East	540,000	28,000	92,000	0.3
South and South-east Asia	7.1 million	490,000	890,000	0.6
East Asia	1.1 million	51,000	290,000	0.1
Latin America	1.7 million	95,000	240,000	0.6
Caribbean Region	440,000	36,000	53,000	2.3
East Europe and Central Asia	1.4 million	60,000	210,000	0.8
Western and central Europe	610,000	6,500	21,000	0.3
North America	1.0 million	16,000	44,000	0.6
Oceania	35,000	700	5,000	0.2
Total	**39.4 million**	**3.1 million**	**4.9 million**	**1.1**

SOURCE: UNAIDS Epidemic update 2004

As shown in Table 2, many countries in Asia have less than 1 percent national HIV prevalence. This reported national HIV prevalence is considered by many experts as deceptive—"many countries in this region are so large and populous that national aggregations can obscure serious epidemics in some provinces and states." There are also increasing warning signals of serious HIV outbreaks because injection drug use (with a high proportion of injectors using contaminated needles and syringes) and sex work (with a very low level of condom use among SWs and other vulnerable groups) are so pervasive.

One third of the world's population resides in the countries of the South Asian region. Large numbers of people are living in a state of poverty, illiteracy, unemployment, and disease, all contributing factors to the infection and spread of HIV/AIDS. The region is fertile ground for the spread of HIV/AIDS.

The HIV/AIDS situation in Nepal

The first case of AIDS in Nepal was reported in 1988, and since then, the number of people living with AIDS has increased considerably. The available data indicate that around 0.5 percent of the general population of Nepal is HIV positive. The number of cases is probably underreported as recent estimates suggested the

number of PLWHA at the end of 2003 could have been above 60,000. However, the number of reported cases of HIV as of October 2004 is 4,354.

When compared with other countries, Nepal has a low level of HIV prevalence among the general population. However, even this low level of HIV/AIDS masks a rise in the number of PLWHA in several groups such as IDUs, SWs, migrant workers, etc.

As of October 2004, the National Center for AIDS and STD Control (NCASC) of the Ministry of Health (MOH) has recorded 4,354 HIV infections out of which 835 cases were found to be AIDS. In October 2004, 97 new cases of HIV and 26 new cases of AIDS had been identified.

The table below shows the national estimates of behavioral and seroprevalence data, which indicate the high potential for a generalized epidemic in Nepal.

TABLE 3 National estimates of adult HIV cases

	Estimated number of PLWHA				
	Low-Low	Low-High	High-Low	High-High	Average
Kathmandu Valley	5,915	8,042	7,550	10,250	7,939
Highway Districts	10,730	32,466	18,389	52,368	28,488
Far-West Hills	6,888	14,327	11,240	23,399	13,963
Remaining Districts	4,735	11,519	6,979	16,337	9,893
Total	**28,268**	**66,353**	**44,158**	**102,354**	**60,283**

SOURCE: National estimates of Adult HIV infections-Nepal, 2003

TABLE 4 Regional HIV AIDS statistics and features (End of 2004)

Particulars	Kathmandu Valley	Highway Districts	Far-West Hills	Remaining Districts	Total	% of Total Cases
IDU	3,060	4,960	228	214	8,462	14
MSM	75	499	42	255	871	1
Sex workers	423	510	42	60	1,035	2
Clients of sex workers	2,647	7,458	393	293	10,791	18
Seasonal labor migrants	713	8,456	9,690	5,700	24,559	41
Urban female low risk population	613	991		137	1,741	3
Rural female low risk population	408	5,614		3,234	9,256	15
Partners of IDU			46		46	0
Female partners of MSM			13		13	0
Partners of Clients of sex workers			118		118	0
Partners of migrants			3,391		3,391	6
Total	**7,939**	**28,488**	**13,963**	**9,893**	**60,283**	**100**

SOURCE: National estimates of Adult HIV infections-Nepal, 2003

National HIV/AIDS Strategy (2002–2006)

The MOH, through the NCASC, has devised a National HIV/AIDS Strategy stressing the need for an effective management of the response to the epidemic. The National Strategy has been devised with the overall objective "to contain the HIV/AIDS epidemic in Nepal."

The stated vision of the National HIV/AIDS Strategy of Nepal is "to expand the number of partners involved in the national response and to increase the effectiveness of the response." To realize this vision, five major priority areas have been specified in the strategy document.

The following are the five major priority areas stated in the National HIV/AIDS Strategy (2002–2006):

1. Prevention of STIs and HIV infection among vulnerable groups
2. Prevention of new infections among young people
3. Ensuring availability of care and support services to HIV/AIDS infected and affected people

4. Expansion of monitoring and evaluation frame through surveillance and research
5. Establishment of management and implementation mechanism for an expanded response

The Nepal Police have been specified as one of the key partners by the National HIV/AIDS strategy (2002–2006) for creating an enabling environment and STI management and behavior change communication (BCC).

HIV/AIDS and the Nepal Police

Reason for vulnerability:

- Mostly young and sexually active
- Often posted far from their community/families
- Often under peer pressure versus social convention
- Surrounded by opportunities for casual sex
- During conflict situation, blood safety becomes an issue
- Nepal Police personnel are deployed to UN peacekeeping missions in the countries where HIV prevalence is very high
- Tend to feel invincible and take risks (unprotected sex)

Considering the circumstantial increase of vulnerability of Nepal police to HIV/AIDS, a strategy—with the workplan and activities—for the next five years for the Nepal Police is being developed to combat the HIV prevalence in Nepal.

HIV/AIDS

IN THE WORLD

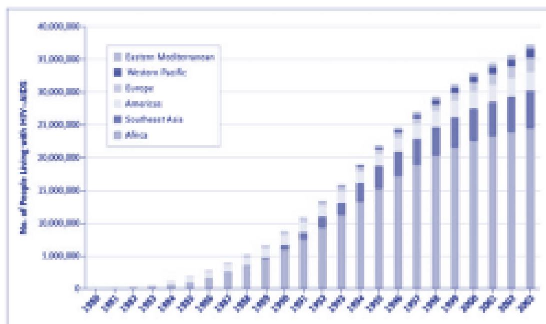
IN THE REGION

IN NEPAL

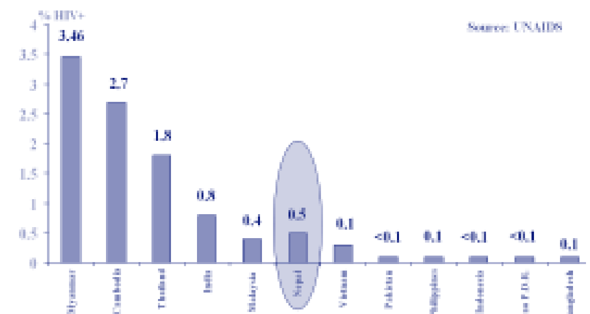
Global HIV/AIDS Situation

- Number of people living with HIV/AIDS by December 2004
  40 millions
- Newly HIV infected people in 2004 alone
  5 millions
- Deaths due to AIDS in 2004
  3 millions

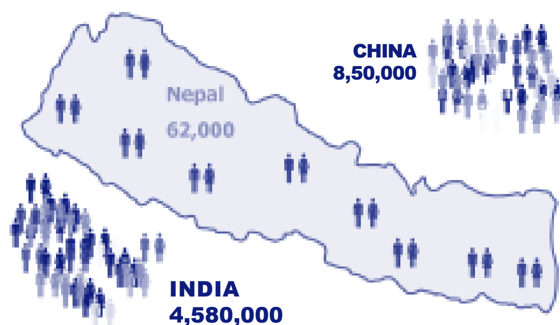
Region wise HIV/AIDS Trend of epidemic



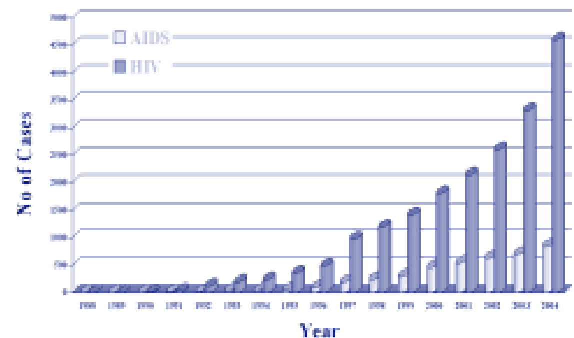
Estimated HIV prevalence among adults in selected Asian and Pacific countries



HIV/AIDS Situation (India, Nepal & China)



HIV/AIDS Epidemic in Nepal



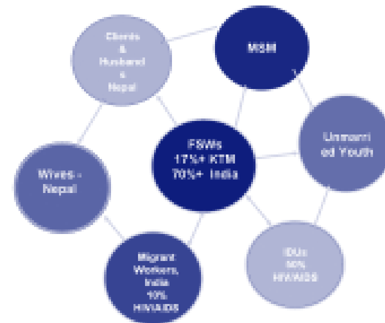
Nepal is in the phase of

"CONCENTRATED EPIDEMICS"

that is prevalence of infection > 5% in one or more sub-population.

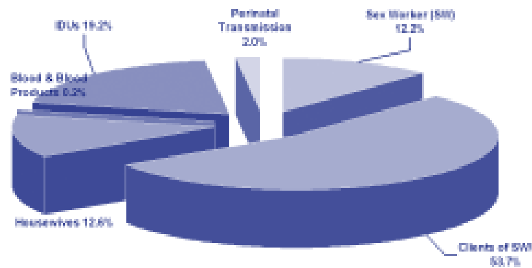
Therefore it is situated in the threat of transforming into more dreadful generalized epidemic.

Chances for a Generalized Epidemic: Multiple and complex linkages



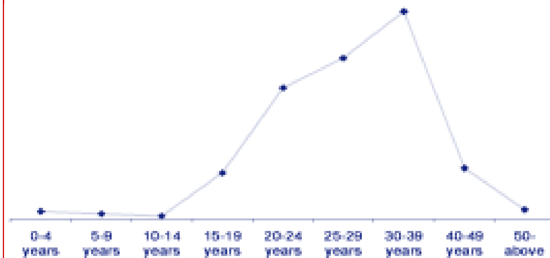
Cumulative HIV/AIDS Situation

(By categories – as of Dec 31, 2004)



Cumulative HIV/AIDS Situation

(By age-group as of Dec 31, 2004)



Estimated HIV Infections-Nepal 2003

No. of PLWHA (average) by subpopulation		
	n	%
IDU	8,462	14.1
MSM	874	1.5
Sex workers	1,033	1.7
Clients of sex workers	11,743	19.5
Seasonal labor migrant	21,052	35.0
Partners of IDU	3,299	5.5
Urban female low risk pop	1,743	2.9
Rural female low risk pop	8,572	14.3
Partners of Clients of Sex worker	344	0.6
Partners of migrants	3,014	5.0
Total	**60,137**	100.0

Summary estimate

National Estimates for year:	2003
Number of Adults (15-49) LWHA	60,137
Adult Prevalence (15-49)	0.52%
Number of Women (15-49) LWHA	18,006
% of adults (15-49) who are women	29.94%

Why is Nepal vulnerable?

- Poverty
- Low education and literacy level
- Gender inequalities
- Stigma and Discrimination
- Lack of adequate health care delivery
- Lack of financial resources
- Insurgency and insecurity
- Migration

HIV /AIDS and Nepal Police

Vulnerability...

- Mostly young and sexually active
- Often posted far from their community / families
- Often under peer pressure versus social convention
- Surrounded by opportunities for casual sex
- During conflict situation, blood safety becomes an issue
- Nepal Police personnel are deployed to UN peacekeeping missions in the countries where HIV prevalence is very high
- Tend to feel invincible and take risks (unprotected sex)

Supportive Data..

Estimated 0.5 percent of the general population in Nepal is HIV positive (prevalence in the Nepal Police could be much higher due to their increased vulnerability).

Research on sex work in Nepal reveals that 38.3 percent of the clients of female sex workers (FSWs) come from the army and police.

Family Health International Nepal (FHI/Nepal) has found a very high risk of HIV among uniformed services, based on STI and treatment referrals.

Impact...

- Increased cost with regards to recruitment and training for replacements
- Increased cost with regard to health care
- Loss in productivity
- Loss of continuity at command level and within the ranks
- Reduction in preparedness
- Reduction of internal stability and external security
- Psychological / Economical / Health impact on the uniformed services family and community
- Risk of transmission to civilian population

Recommended Interventions...

1. Establishing and sustaining high level leadership and commitment
2. Prevention of HIV infection among the Nepal police and their families
3. Treatment, Care and Support Services.
4. Interface with vulnerable groups
5. Surveillance system
6. Developing an effective monitoring and evaluation system
7. Building effective institutional mechanism

How can I contribute?

- Protect yourself , family and subordinates from HIV
- Do not discriminate against family, friends and colleagues suffering from HIV&AIDS
- Support HIV program risk reduction program among vulnerable groups (IDUs, FSWs, MSM & PLHAs) implemented among civilian

UNIT

3

Sexually Transmitted Infections (STIs)

The purpose of the unit

To increase awareness related to STIs

Unit objectives

By the end of this unit participants will

- Gain a basic understanding of STIs and common symptoms
- Develop greater awareness of STI transmission
- Understand prevention of STIs
- Know how STIs are generally treated
- Develop an understanding of STIs in Nepal

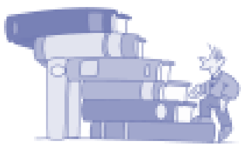
Instructional materials

Chart paper, markers, handouts (copy of the facilitators' notes-Unit Three)

Estimated time

1 hour

Introduction of the topic	5 Minutes
Presentation of guiding questions and brainstorming	45 Minutes
Summary highlights	10 Minutes



Process

This unit will be taught through brainstorming, class presentations, and discussions.

Step one: Introduce the topic and its objectives.

Step two: Ask a few guiding questions:

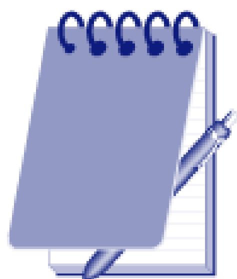
- What are STIs?
- What do you call them in Nepali?
- How are they transmitted?
- Are they curable?

- What are the consequences if not cured?
- How STI is related to HIV?

Write the answers in a large sheet of paper pasted on the wall and discuss the answers provided by the participants.

Step three: Summarize by making factual presentation on STIs and provide opportunity for clarifications.

Step four: Distribute handouts (a copy of the facilitators' notes or OHP slides for Unit Three) for reference.



Sexually Transmitted Infections (STIs)

What are STIs?

STIs, also known as sexually transmitted diseases (STDs), are infections primarily passed—as suggested by the name—through sexual intercourse. However, STIs also can be transmitted through blood and blood products and also from a mother to her child. A person infected with other STIs has a higher risk of acquiring HIV because STIs often cause ulcers (openings on the skin in and around the genitals), which make it easier for the virus to get into the body. However, STIs and HIV can be acquired by same risk behavior.

The interrelation between STI and HIV includes the following:

- STIs increase the risk of acquisition and transmission of HIV.
- Other STIs may influence the progress of immunodeficiency in HIV-positive individuals.
- Concurrent HIV in an STI patient may change the natural history of STI:
  - Infectivity may be increased and prolonged.
  - Response to treatment may be impaired.

STIs can be divided in two broad categories, namely, (1) those that can be cured and (2) those that are incurable. Curable STIs, such as syphilis, gonorrhea, and chlamydia are treated with antibiotics or antimicrobials. HIV/AIDS, hepatitis C, and herpes are not curable. However, some treatments are available to prevent, relieve, or reduce these incurable infections.

How are STIs transmitted?

The leading mode of transmission of STIs is sexual acts (vaginal, anal, or oral) while some STIs are passed through bloods and blood products or from a mother to her child during pregnancy, delivery, or breastfeeding.

STIs are ***not transmitted*** by daily life activities, such as

- Sharing a toilet, telephone, kitchen utensils, or drinking glasses with a person who has an STI
- Wearing the clothing of a person with an STI

- Eating food with or prepared or served by a person who has an STI
- Touching, hugging, or kissing a person who has an STI
- Attending schools, temples, restaurants, or other public places where persons with STIs are present

Symptoms of STIs

Burning and/or pain during urination or defecation; sores or blisters near the genitals or the mouth; swelling near the genitals; and fever, chills, and aches are the symptoms of STIs observed in ***both men and women***.

The main symptoms of STIs in ***men*** are burning or itching in or around the tip of penis and a drip or discharge from the penis.

Burning or itching in or around the vagina, unusual discharge or odor from the vagina, pain in the area between the lower abdomen and genitals, internal vaginal pain during intercourse, and non-menstrual bleeding are the main symptoms of STIs in ***women***. Many women are asymptomatic, i.e., a woman could have syphilis and have no symptoms, so she must be tested to find out.

Some symptoms may resolve themselves; however, the infection will remain until proper medical treatment is received.

Some STIs do not have observable symptoms. Therefore, clinical testing is required in order to determine if you have an STI.

How are STIs treated?

Most STIs, resultant from bacterial infections, are cured through proper medication and use of antibiotics. A doctor should examine, diagnose, and prescribe the correct medications. Buying and ingesting medicines without consultation with a physician can be dangerous to your health. Unfortunately, there are no specific medications for viral infections. Symptomatic treatment is available to reduce symptoms and minimize the suffering of the patient.

Treatment compliance

Patients should always follow the doctor's advice and complete the full course of medications, particularly when antibiotics are prescribed. It is essential to take all medications *as prescribed*. This means to complete all doses within the designated time period. Incomplete or improper treatment may result in serious consequences to the patient's life. In order for treatment to be effective, all the patient's partners must be notified and undergo treatment. It is crucial that all

partners complete the prescribed treatment properly; otherwise, they will reinfect each other.

An STI patient may discuss the following with healthcare providers:

- The present infection (cause and possible consequences)
- The needed treatment to complete full course
- The need to avoid sex until cured
- The need to inform and treat all partners
- Risk reduction: safe sex, promoting/using condoms
- The need for early treatment if any future problem
- The risk of HIV from sex
- When to come back
- Referral

Healthcare providers can instruct patients when to return for follow-up treatment. If necessary, the physician will advise further action including a referral to a specialist.

Situation of STIs in Nepal

Significant ignorance exists among the general population of Nepal regarding STIs. Due to the existing stigma and discrimination, people do not often report their infections. Access to healthcare services for STI patients is also limited. For these reasons, it is difficult to develop an accurate picture of STIs in Nepal. A UNAIDS estimation in 2003 showed the rate of STIs in adult women in Nepal to be about 4.7 percent.

Preventing STIs

STIs are primarily prevented by:

(1) Abstinence

(2) Safer sexual behavior:

- Having sex with only one faithful partner
- Proper use of condoms in all sexual intercourse: (vaginal, anal, and oral sex)
- Practicing non-penetrative sex
- Avoiding sex while intoxicated

These practices help to avoid contact with body fluids including semen, vaginal fluid, and blood that can transmit STIs. Reducing the number of sexual partners, knowing your partner's sexual history, and not engaging in risk-taking behaviors are important for preventing STIs.

TABLE 5 Features of common STIs

STIs	Causative Agents	Incubation period	Main Clinical Features
1. Syphilis	Treponema Pallidum	9-90 days	Single/multiple painless genital ulcers
2. Gonorrhea	Neisseria Gonorrhea)	(4-7 days)	Watery or purulent urethral or vaginal discharge, conjunctivitis, proctitis
3. Chancroid	Homophilus Ducrei)	(3-6 days)	Painful, single, or multiple ulcer, vulvo-vaginitis
4. Chlamydia	Chlamydia Tachomatis	1-2 weeks	Watery or purulent urethral or vaginal discharge, conjunctivitis, proctitis
5. Genital herpes	Herpes Simplex Virus	(2-10 days)	Vesicles, shallow superficial ulcers, painful, Itching, burning
6. Genital Warts	HPV	1-8 months (3 Months)	Many papules, growing papilloma, filiform
7. HIV/AIDS	HIV-1, HIV-2	Long incubation period	Prolonged fever chronic cough, chronic diarrhea, weight loss, skin infection, herpes zoster, oral though, TB, PCP, PGL
8. Lympho Granuloma Venerium	Chlamydia Trachomatis sero type 1,2,3	7-14 days	Painless papules or ulcersbubo, groove sign, elephantiasis of genitalia
9. Granuloma Inguinale	Calymato bacterium Granulomatis	4-40 days (8-80 days)	Painless vesicles or papules or serpiginous ulcerspsuedo-bubo
10. Trichomoniasis	TrichomonasVaginalis	7-14 days	Vulvitis, vulval erosion, oedema, vaginitis, vaginal discharge in female, urethral dischrge in male
11. Candidiasis	Candida Albicans	Few hours to several weeks	Vulvitis, vulval erosion, oedema and itching, vaginitis, vaginal discharge in female, urethral discharge in male
12. Scabies	Sarcoptes Scabei	1-2 weeks	Small multiple itching papules

Discussion points:

- What is the current practice in police?
- What would be best practices to follow?
- What happens if someone comes to the police hospital for STI treatment (stigma and discrimination issues)?

Sexually Transmitted Infections

Significance of STIs

- STI remain one of the major public health problems which cause acute illness, morbidity & complications for millions of men, women and children all over the world.
- STIs are responsible for greatest number of healthy live years lost among women of developing countries

What are STIs?

Sexually transmitted infections are infectious diseases which are transm itted mainly by sexual contact with an infected person.

STIs can also be transmitted by other routes like blood transfusion and from infected mothers to children

How are STIs transmitted?

- Sexual Transmission
  The leading mode of transmission of STIs is sexual (vaginal, anal or oral) acts
- Mother to child
  Some STIs are passed to a baby during pregnancy, delivery or breastfeeding.
- Blood and blood product

Prevention of STIs

A = Abstinence

B = Being faithful to your partner

C = Correct condom use in every sexual act

D = Diagnosis and treatment

E = Excluding penetrative sex

Signs & Symptoms of STIs

In Males

- Watery purulent discharge from urethra
- Burning and painful urination
- Itching, sores and ulcers around genitals
- Genital warts

Signs & Symptoms of STIs

In Females

- Abnormal, white and foul smelling discharge
- Burning urination
- Backaches and lower abdominal pain
- Itching sores and ulcers around the genitals
- Pain during intercourse
- Vaginal warts

How are STIs treated?

Most STIs, resulting from bacterial infections, can be cured with proper medical treatment

It is essential to take all medications as prescribed.

A patient's partners must be notified and undergo reatment. All partners must complete the prescribed treatment otherwise they will re-infect each other.

There are no specific medications for viral infections. Symptomatic treatment is available to reduce symptoms and minimize the suffering of the patient.

Follow-up after treatment is important

STI & HIV/AIDS

STI	increased risk of HIV	Curability
Chancroid	++++	> 95%
Syphilis	+++	> 95%
Chlamydia	++	> 95%
Gonorrhoea	++	> 95%
Trichomoniasis	+	> 95%
Herpes	+	0

Consequences of not treating STDs

Incomplete or improper treatment may result in serious consequences to the patient's life including:

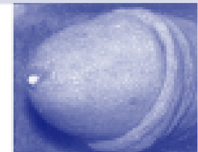
- Sterility
- Abortion/still birth
- Ectopic pregnancy
- Neonatal eye infection
- Pneumonia, ear infection
- Congenital syphilis
- Increased risk of getting and transmitting HIV
- Social consequences

Common STIs in Nepal

- Syphilis
- Gonorrhoea
- HIV/AIDS
- Trichomoniasis
- Chancroid
- Lymphogranulona venereum
- Granuloma Inguinale
- Herpes genitalis

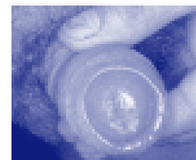
Commonly found STIs in Nepal

Urethral discharge



- Discomfort on passing urine

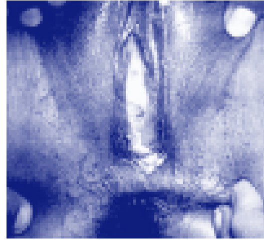
Most common: **Gonorrhoea**



Commonly found STIs in Nepal

Vaginal discharge

- Itching
- Pain during intercourse

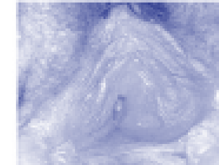


Commonly found STIs in Nepal

Genital ulcers

In men or women

- ulcers
- sores
- blisters



Most common: **Syphilis**

UNIT

4

Voluntary Counseling and Testing (VCT)

The purpose of the unit

To promote VCT as an effective preventive practice for police personnel, their dependents, and subordinates

Unit objectives

By the end of this unit the participants will

- Be able to describe what VCT is and what it entails
- Know when one should seek VCT
- Know the benefits of VCT
- Know about VCT locations

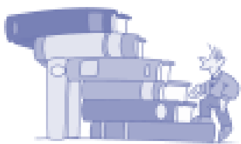
Instructional materials

Chart paper, markers, handouts (copy of facilitator's notes—Unit Four)

Estimated time

1 hour, 30 minutes

Introduction of the topic	10 Minutes
Presentation of guiding questions and brainstorming	50 minutes
Summarize/factual presentation	30 minutes



Process

This unit will be taught through short lectures, class exercises, brainstorming sessions, class presentations, and discussions.

Step one: Introduce the topic and the objectives.

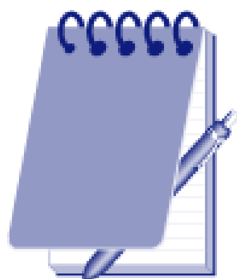
Step two: Ask a few guiding questions and discuss the answers provided by the participants.

- What does VCT stand for?
- What is the definition of voluntary?
- Why should testing be voluntary?
- What does counseling mean?

- Why there is a need for counseling before and after testing?
- What is testing?
- What are the advantages of testing?
- Additionally, ask the group if they know about any VCT centers in Nepal.

Step three: Summarize by making factual presentations on VCT and provide opportunity for questions from the trainees. Clarify any misinformation.

Step four: Distribute handouts (a copy of the facilitator's notes or OHP slides for Unit Four) for reference.



Voluntary Counseling and Testing (VCT)

VCT Defined

In the abbreviation "VCT", V stands for voluntary, which means an act done willingly, not compulsion. C stands for counseling, which means a confidential dialogue between a client and a trained counselor aimed at enabling the client to cope with stress and make personal decisions related to HIV/AIDS. T stands for testing, which means any form of test carried out to identify the HIV status of a person. VCT is a strategic intervention for prevention, care, and treatment. VCT services consist of pre-test counseling, HIV testing, post-test counseling, and follow-up counseling support. Follow-up counseling should be adapted to the individual needs of each person being counseled.

VCT is an entry point for accessing care and support, but the fear and stigma associated with HIV discourages people from getting tested. In order to increase the number of persons receiving VCT services, barriers to those services must be identified and removed. The stigma and discrimination directed against persons with HIV is a barrier to VCT. The groups most affected by HIV, including MSM, SWs, and IDUs, are also profoundly affected by stigmatization.

VCT is also a key entry point for helping individuals in decision-making regarding testing. VCT is founded on the principle that an HIV-positive diagnosis could lead to psychosocial difficulties. The positive status, if discovered by others, may create discrimination or rejection. Thus it is essential that the following steps accompany testing:

- Counseling prior to testing is necessary to enable people to make an informed decision on whether or not to take the test.
- For those whose results are positive, post-test counseling to live positively by avoiding risky behaviors is the priority. For those whose results are negative, counseling to avoid risky behaviors in the future is essential.

Some countries have instituted mandatory HIV testing for the police, army, or other uniformed forces. However, mandatory testing has no demonstrated individual or public health benefit. VCT is considered most effective in preventing HIV transmission.

What is VCT counseling?

Counseling, in general, is a process of offering the time, attention, and respect necessary to explore, discover, and clarify ways of living more resourcefully with dignity. According to the World Health Organization, "counseling is a confidential dialogue between a person and care provider aimed at enabling the person to cope with stress and make personal decisions related to HIV/AIDS and learn about the fact of HIV and to make choice. The counseling process includes an evaluation of personal risk of HIV transmission and facilitation of preventive behaviors and appropriate referrals for care and support services."

The main components of VCT counseling include determining the HIV/AIDS knowledge level of the person being counseled; giving accurate and appropriate information; assessing personalized risks; developing a personalized risk-reduction plan; demonstrating appropriate condom use; explaining the test; discussing implications of the result; assessing and providing coping abilities/strategies; giving results; and providing psychological and emotional support and referral.

Counseling *does not include* giving advice; making decisions on behalf of the other person; or judging, interrogating, blaming, preaching, lecturing, or arguing with the person being counseled. Neither is it appropriate to make promises that cannot be kept or to impose one's own beliefs.

What is an HIV test?

An HIV test, detecting antibodies against HIV, shows if someone is infected with HIV, the virus that attacks the body's immune system. A wide range of HIV antibody tests are available, based on different principles, to determine if you are carrying HIV. The first test developed is still the most frequently used for the initial detection of HIV infection: the enzyme-linked immunosorbent assay or, as it is more commonly known, the ELISA. If it is reactive, the result is confirmed by testing the specimen with a method called Western Blot. Studies have shown that the latest generation of ELISAs and rapid tests are as reliable for confirmation as Western Blots. In addition, compared with Western Blots, ELISAs and rapid tests are less expensive, do not require as high a level of technical expertise to perform and interpret, and produce fewer indeterminate results. In Nepal ,the ELISA, Western Blot, and rapid tests are performed to know whether someone is infected with HIV. More information on testing can be obtained from the National VCT Guidelines, which are available at the NCASC in Teku.

When should I get tested?

To make certain that you receive a reliable test result, it is necessary to wait at least three months (13 weeks) after your last possible exposure to the virus before being tested. During this "window period", the body takes time to produce antibodies after HIV infection has begun, and testing in this period may produce a negative result. For the vast majority of those who will test positive, antibodies to HIV will develop within four to six weeks after exposure; others will take a little longer to develop antibodies. Note the following:

- To make certain that you receive a reliable test result, it is necessary to wait to pass the window period—at least three months (13 weeks) after your last possible exposure to the virus—before being tested.
- Getting tested before three months may result in a negative result.
- Getting tested at a VCT center is the best option.

How do I know if I should get tested for HIV?

An HIV test is recommended if any of the following applies:

- You have been sexually active, particularly with more than one sexual partner, in the last 12 months or in the past.
- You had a possible exposure to HIV either through vaginal or anal intercourse without the use of a condom.
- You have shared/reused needles or syringes to inject drugs (including steroids), or for body piercing, tattooing, or any other reason.
- You are a healthcare worker who had a work-related accident such as direct exposure to blood or have been stuck with a needle or other object.
- You are uncertain about your sexual partner's risk behaviors or your sexual partner has been tested HIV-positive.
- You are pregnant or are considering becoming pregnant.
- You have had certain illnesses including TB or an STI, such as syphilis or herpes.
- You have any reason to be uncertain about your HIV status.

Why do I need to know my HIV status?

When it comes to HIV testing, the old cliché "knowledge is power" still holds true. Knowing your accurate HIV status, whether negative or positive, puts you in the best position to protect your health. With regard to HIV, ignorance is definitely not bliss. Not knowing your HIV status can be very dangerous. If you are in doubt, knowing your status as early as possible (after 13 weeks of possible exposure) puts you in the best position to preserve your health, as well as that of your partner(s) and your children (if you have or are planning to have a family). Effective medications and good healthcare have been enabling many

who are HIV positive to live successful and fulfilling lives. Not knowing whether you are HIV positive means you are not getting the healthcare you need to stay well. You may also be putting others in your life at risk. If you test negative, that knowledge can be a powerful incentive to consistently follow the guidelines that will help you to remain HIV negative. It can also spare you a lot of unnecessary worrying and stress that often occurs when someone is uncertain about his/her status.

Where can I get tested?

It is important to be aware that counseling is an important part of HIV testing. The conversations with a trained counselor play a valuable role in informing anyone who is tested negative about maintaining their negative status and advising those who test positive about their healthcare. However, HIV testing facilities, test kits, and skilled counselors are very limited in Nepal.

Almost all the regional, subregional, and zonal hospitals have HIV testing facilities in their regular labs. Some central and specified hospitals have VCT services too. In addition, there are also non governmental organizations that provide the VCT services. Following are the available VCT services in Nepal:

TABLE 6 VCT Service Centers in Nepal (March 2005)

Organization	Place	Phone
Youth Vision	Putalisadak, Kathmandu	4299192
SACTS	Thapathali, Kathmandu	4246612
AMDA	Hetauda, Makawanpur	057-525038
NSARC	Nepalgunj, Banke	081-526522
Paluwa	Pokhara, Kaski	061-527818
Naulo Ghumti	Pokhara, Kaski	061-523350
ADRA	Banepa, Kavre	01-661635
Patan Hospital	Patan	5521034, 5522266
Teku Hospital	Kathmandu	4253396
NCASC/NPHL	Kathmandu	4261653, 4258219, 4261141
Bheri Zonal Hospital	Nepalgunj	081-520193
Koshi Zonal Hospital	Biratnagar	021-524357
Tribhuwan University, Teaching Hospital-TUTH	Kathmandu	4412808, 4412707

Discussion points

VCT with Nepal Police institution and steps to be followed to have VCT in Nepal Police

VCT
Voluntary Counseling and Testing

What is VCT

V = stands for voluntary, means an act done willingly, without payment or compulsion

C = stands for counseling, means a confidential dialogue between a client and a trained counselor aimed at enabling the client to cope with stress and take personal decision related to HIV/AIDS

T = stands for testing, means any form of test carried out to identify the HIV status of a person

VCT – Entry Point for HIV Prevention & Care

- Acceptance of HIV sero status and coping
- Facilitates behavior change
- Reduces MTCT
- Helps to manage OIs & STIs
- Facilitates preventive therapy (TB/Bacteraemia)
- Helps to refer to social and peer support
- Neutralizes HIV/AIDS
- Planning for future orphan care/ will making

Importance of VCT

Key entry point for helping individuals in decision making regarding testing. The positive result may create discrimination or rejection, requiring the following steps to accompany testing:

- Provide counseling prior to testing to enable people to make an informed decision on whether or not to take the test
- Provide post-test counseling to all; for those whose results are positive, counseling to live positively by avoiding risky behaviors is the priority. To with negative results, counseling to avoid risky behaviors in the future.

What is HIV test?

The test looks for antibodies to HIV.
It does not look for the virus itself.

- Elisa Test/ Western Blot Test/ Rapid Test
- False positive
- False negative (window period)

How do I know I need a HIV test?

If

- You have been practicing unsafe sex
- Exposed to contaminated needles
- Have had accident and were exposed to blood
- Had blood transfusion without testing the blood
- You have been suffering from STDs
- You have any other reasons to be uncertain about your status

Where Do I get VCT Services

In the Government Facilities

- Teku hospital, Kathmandu
- National Centre for AIDS & STD Control,
- Kathmandu
- National Public Health Laboratory, Kathmandu
- Bheri Zonal Hospital, Nepalgunj
- Koshi Zonal hospital, Biratnagar
- Tribhuwan University,Teaching Hospital
- TUTH,Kathmandu).

Where do I get tested?

Non- Government Organizations

1. Youth Vision (Putalisadak – 4299192)
2. Sacts (Thapathali – 4246612)
3. AMDA/ STI (Hetauda – 057525038)
4. NSARC (Nepalgunj – 081526522
5. Paluwa (Pokhara – 061527818
6. Naulohumti (Pokhara – 061523350)
7. ADRA (Banepa Kavre 01-661635)
8. Patan Hospital
9. BP Koirala Memorial Hospital (Dharan)

UNIT

5

Care and Support

The purpose of the unit

To sensitize and prepare the participants for the care and support of PLWHA

Unit objectives

By the end of this unit the participants will

- Be able to describe what VCT is and what it entails
- Be positively oriented on the value of proper care and support
- Understand the need for home-based care in cases of terminal illness
- Learn about treatment and the risks of non-compliance
- Know the ways of preventing transmission from mother to infant
- Understand the importance of psychological support

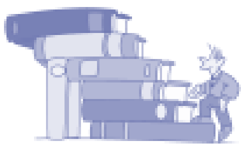
Instructional materials

Chart paper, markers, Meta cards, handouts, (copy of the facilitator's note—Unit Five)

Estimated time

1 hour, 30 minutes

Introduction of the topic	10 Minutes
Presentation of guiding questions and brainstorming	60 Minutes
Summary highlights/factual presentation	20 Minutes



Process

This unit will be taught through short lectures, group exercise, brainstorming session, class presentations, and discussions.

Step one: Introduce the topic and objectives.

Step two: Write the words CARE & SUPPORT on one Meta card and stick it on chart paper. Present a situation where a person is sick and brainstorm with the participants to list

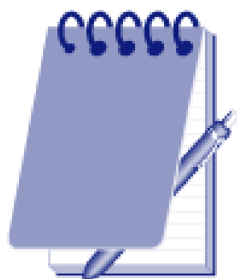
- What actions they would take to provide care and support for the sick person?

Write the responses from the participants on the chart paper. Continue the discussion by asking participants to discuss

- How would it be different to care for a person who has HIV?
- Why is care and support so vital for someone living with HIV?

Step three: Summarize by making factual presentations on the importance of care and support and its components, e.g., personal hygiene, nutritional food, treatment of OIs, ARVs, psychological support, economic support, etc. Clarify any misinformation.

Step four: Distribute handouts (a copy of the facilitator's notes or OHP slides for Unit Five) for reference.



Care and Support for PLWHA

Why care and support

HIV is different from health problems because it is related to sexual behavior, which is sensitive, secretive, and most private. Also, it is attached with misconceptions and ignorance leading to fear, stigma, and discrimination. Therefore, a PLWHA needs not only medical but also emotional and psychological support.

Due to stigma and discrimination associated with the very name of HIV/AIDS, the infected person may go down mentally, financial resources may be scarce to look after him/her, or he/she may have no one to share the burden. If the HIV-positive status of an infected person is common knowledge, even the families may need more social support. This is the most difficult stage of the disease cycle in which a PLWHA and/or the affected families require care and support. But unfortunately this is the time in which unrealistic fears of infection through casual contact and negative attitudes towards people who are infected with HIV take away the dear and near ones from providing care and support to individuals and families affected by the virus. Some people are reluctant to help people living with HIV/AIDS because they are not willing to spend their time and resources caring for someone who will never "recover."

Tragically, stigma and discrimination result in PLWHA not receiving encouragement, care, and support at a time when they need them the most. The quality of care provided by families to PLWHA is often poor or non-existent and the much needed community support is hard to find. Fear of stigmatization and discrimination discourages people from finding out if they are HIV-positive and also inhibits providing care and support to PLWHA.

Proper care and support keeps one healthy longer

The immune system of a PLWHA is weaker than that of a non-infected person. PLWHA can be more susceptible to infections. However, HIV-positive people can live healthy, productive lives for many years with proper care and support. PLWHA can do many things to stay healthy longer:

- Seek nutritional assessment support from a trained/experienced person and develop healthy eating habits.

- Exercise regularly, sleep, and rest to stay strong and fit.
- Make sure you have a doctor who knows how to deal with HIV and follow your doctor's instructions. Keep your appointments.
- Take the medications exactly as your doctor or other healthcare provider tells you to take them.
- If you get side effects from your medications, contact your doctor for advice rather than relying on the advice of your friends or family members.
- Don't smoke cigarettes, drink alcohol, or use drugs. Your body can fight the virus more effectively if you stop smoking, drinking alcohol, and/or taking drugs. Seek help if you can't stop on your own.
- Learn stress-management techniques. Many people find it easier to cope with the chronic stress of living with HIV/AIDS if they have a good social support network or if they engage in activities such as prayer or meditation.

Home-based care for persons with terminal illnesses

People facing the end of life prefer to be at home rather than in a hospital. To fulfill this desire, family members need to learn how to take care of a bed-ridden person and to provide effective home-based care and basic treatment.

If the person with HIV/AIDS has a fever, drugs can be prescribed through a doctor to control it. Routine care as would be appropriate for someone with a fever (sponge bath, wearing light clothes or removing clothes, providing a cool environment, providing cool beverages, etc.) can help make a feverish patient feel more comfortable and reduce the fever.

Preventing dehydration through provision of clean water, juice, ORS, rice water, or soup is essential. Encourage the patient to meet the recommended daily fluid intake. It is important to make sure that they are prevented from losing weight through proper intake of healthy, nutritious food and adequate fluids.

Dehydration should be recognized as soon as possible and treated. For this to take place the family members need to know the signs and symptoms of dehydration. (Feeling thirsty, unusually irritable or lazy, and in the severe case, when you pinch the person's skin and let it go, it goes back only slowly to its original state.) Remember that dehydration can cause death.

Treatment

Prevention and timely treatment of OIs is critical for a PLWHA to remain healthy. TB, pneumonia, meningitis, and skin infections are common OIs.

Antiretrovirals (ARVs) are combinations of drugs that slow down the development of HIV. ARVs do not cure AIDS but reduce the presence of the virus, thereby extending the life of the person taking them. Taking ARVs is a choice, but once someone is on ARVs, he/she should have to take ARVs lifelong and in a timely manner. At times, unbearable side effects may cause people to stop taking ARVs; at other times people may stop taking ARVs because they are feeling better. In either case, their body may develop resistance to one or more of the drugs.

Taking each medication correctly every time and every day helps the body fight HIV more effectively. It is very challenging to take all the medications at the correct times throughout the day and in the correct manner. An HIV-positive person may need to maintain a complicated treatment regimen for many years or for the rest of his or her life.

Preventing transmission from mother to infant

Women with higher viral loads are found to be more likely to bear a child with the virus. Pregnant women who are living with HIV can reduce the risk of transmission to the fetus by taking medicine during pregnancy. To prevent MTCT, there are few steps to consider, e.g., HIV counseling and testing for the mother, providing appropriate medication for the HIV-infected mother and infant, infant feeding counseling and support, safe obstetrical care, family planning counseling and referred services, and referral for care and support of HIV-infected mothers and infants. More information on prevention of MTCT (PMTCT) can be obtained from the National PMTCT Guidelines, which are available at the NCASC in Teku.

Psychological support

For PLWHA, adopting a sensible lifestyle, getting regular exercise, eating a balanced diet, eliminating alcohol, and reducing stress can help greatly. PLWHA who receive psychosocial support from family members, neighbors, coworkers and support groups, have been found to be "doing much better than others."

Being rejected and abandoned because of their HIV/AIDS status is a difficult and often distressing experience for PLWHA. Loving, compassionate care makes PLWHA feel better and even helps to live longer. Understanding, empathy, and care (not tension, disgust, and resentment) from loved ones and family members can improve the quality of life of PLWHA.

Compassion and tolerance

Care and support is often enhanced by compassion and tolerance. Compassion is showing understanding and sympathy for the misfortunes of others. Every religious tradition urges believers to love their neighbor and lend a helping hand to those in need. In the case of HIV/AIDS, it means overcoming fears about infection and negative associations with sexual behavior as well as becoming tolerant toward those who are infected. It also means offering love, care, and support to PLWHA whether they are within your family, neighborhood, or faith-based group.

Tolerance means accepting people with whom you feel uncomfortable because they are different or are perceived to be a threat. Understanding other's situations and sympathizing with them is part of being tolerant.

Those who offer compassion to PLWHA can feel good about themselves knowing they have helped some one who is in need. Being compassionate to PLWHA not only contributes towards the development of acceptance, but also limits the impact of HIV/AIDS by improving opportunities for prevention and care.

Discussion points

What can I do if someone falls ills at work?

Care & Support for PLWHAs

Care & Support for PLWHAs

The National strategy…
Has clearly emphasized care,support and treatment services asone of the priority components

It has aimed to make quality care, support and treatment services available and accessible to all infected and affected people through comprehensive care continuum

The immune system of a PLWHA is weaker than that of a Non-infected person. PLWHA can be more susceptible to infections. However, HIV-positive people can live healthy, productive lives for many years with proper care and support

Rationale for Care & Support

- HIV/AIDS is different from other health problems
- HIV infection is chronic and life long
- It is related to sexual behavior which is sensitive, secret and most private
- It is attached with misconceptions and ignorance leading to fear, stigma and discrimination
- It needs not only medical but emotional, social and psychosocial support

Rational of Care and Support

- Health system has to be reoriented to meet these needs
- VCT has enabled to cope with problems and initiated Care & Support services
- PMTCT has been effective in reducing mother to child transmission
- Preventive therapy for TB and PCP has been useful

Component of comprehensive HIV/AIDS Care support

- Establishment of VCT site
- Clinical care of symptomatic infections
- Nursing care
- Counseling
- Care at home and community
- Formation of community and peer support groups
- Elimination of stigma and discrimination
- Social support
- Linkages, partnership and networking

Multisectoral Approach to care and support

- Human Rights and advocacy
  (education, network of PLWHA, information, legal safeguarding of rights)
- Psychological support
  (Counseling, spiritual support, positive living, support groups)
- Clinical care
  (testing, enhanced provision for familiar presentations, new AIDS care services, palliative care)
- Employment
  (employment conditions, health insurance, sick leave, income generation, micro finance schemes)
- Social Welfare
  (economic support, nutritional support, care groups, home- based care
- Child care
  (family support, orphans, school fees, child support, general economic suppport, education)

Some tips for care and support……

- Seek a nutritional assessment from a registered dietitian specializing in HIV
- Exercise regularly, sleep and rest to stay strong and fit
- Make sure you have a doctor who knows how to treat HIV, and follow your doctor's instructions. Keep your appointments
- Take the medications exactly as your doctor or other health care provider tells you to take them

Some tips for care and support contd..

- If you get sick from your medications, contact your doctor for advice rather than relying on the advice of your friends or family members
- Don't smoke cigarettes or use drugs. Your body can fight the virus more effectively if you stop smoking and/or taking drugs. Seek help if you can't stop on your own
- Learn stress-management techniques. Many people find it easier to cope with the chronic stress of living with HIV/AIDS if they have a good social support network or if they engage in activities such as prayer or meditation

Some tips for home based care…..

Family members can provide basic care and arrange for social support.

Incase of fever, drugs can be prescribed through a doctor to control fever. Sponge bath, wearing light, removing clothes, providing a cool environment, providing environment, providing cool beverages can help.

Preventing dehydration through provision of clean water, juice, ORS, rice water, or soup is essential.

Prevent from loosing weight through proper intake of healthy, nutritious food and adequate fluids.

Compassion & Tolerance

Compassion is showing understanding and sympathy for the misfortunes of others

Tolerance means accepting people with whom you feel uncomfortable because they are different or are perceived to be a threat. Understanding other's situations and sympathizing with them is part of being tolerant.

Being compassionate to PLWHA not only contributes towards the development of acceptance, but also limits the impact of HIV/AIDS by improving opportunities for prevention and care.

UNIT

6

Stigma and Discrimination

The purpose of the unit

To understand sources of stigmatization and to positively modify behavior toward those who are infected and affected

Unit objectives

By the end of this unit participants will

- Understand HIV/AIDS related stigma and discrimination
- Understand how stigma and discrimination occurs in various settings
- Understand the causes of stigma and discrimination
- Understand the consequences of stigma and discrimination
- Understand ways of reducing stigma and discrimination

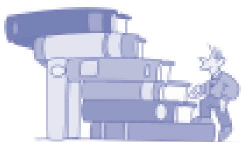
Instructional materials

Chart paper, markers, Meta cards, Quote (Chapter 3, Unit 3), handouts (copy of the facilitator's notes-Unit Six), and question and answer sessions

Estimated time

1 hour, 30 minutes

Introduction of the topic	10 Minutes
Exercise based on quotes from Chapter 3, Unit 3	60 Minutes
Summary highlights	20 Minutes



Process

This unit will be taught through short lectures, group exercises, brainstorming sessions, class presentations, and discussions.

Step one: Introduce the topic and objectives.

Step two: Read a quote of a woman who is HIV positive and has been treated inhumanely at work, by her family members, and by the community. After the story, guide the discussion by asking the following questions:

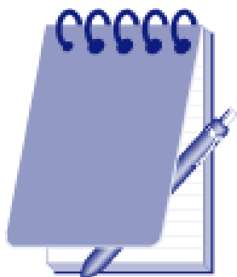
- Why was the woman treated in such a way?
- What are the consequences of discriminating against PLWHA?
- How can stigma and discrimination be avoided?

Step three: Ask one or two participants to share other stories related to stigma and discrimination.

Step four: Summarize by making factual presentations on discrimination that can occur in different sectors, e.g., workplace, health setting, educational facilities, family level, etc. Clarify any misinformation.

Step five: Distribute handouts (a copy of the facilitator's notes or OHP slides for Unit Six) for reference.

NOTES FOR THE FACILITATOR



Stigma and Discrimination

Stigma

HIV/AIDS-related stigma generally refers to prejudice, discounting, discrediting, or discrimination directed at a person either perceived to be or actually infected with HIV or impacted by the infection. Often stigma affects the social groups and individuals with whom PLWHA are associated. HIV/AIDS stigma is expressed in a variety of ways, including:

- Ostracism, rejection, and avoidance of PLWHA
- Discrimination against PLWHA
- Violence against persons who are perceived to be infected with HIV or to have AIDS
- Compulsory HIV testing without prior consent or protection of confidentiality
- Quarantine of persons with HIV

Stigmatization involves the creation of a hostile and fearful environment concerning everything related to HIV/AIDS. It results in the condemnation of people living with HIV/AIDS. Fear and prejudice may cause people to react to HIV/AIDS by blaming those infected for their infection and seeing them as shameful.

Stigma seems universal

HIV/AIDS-related stigma appears to be universal, varying in its form from country to country. Whatever form it may take, stigma inflicts suffering on PLWHA, their family members and hinders efforts to fight the AIDS epidemic. Overcoming stigma is an important step in assisting persons seeking to know their HIV status and practice safer behavior.

The stigma that still surrounds HIV/AIDS causes many people to worry that they would suffer discrimination if their HIV-positive status became known. Prevailing attitudes concerning people with HIV/AIDS often center on the myths that only MSM and drug users can contract HIV. The truth is that anyone who practices unsafe behavior can be at risk for HIV/AIDS.

Stigma is also linked to power and domination. Most communities perpetuate stigma and discrimination out of fear and ignorance, or because it is convenient to blame those who have been affected. In any case, ignorance, fear and denial lead to further vulnerability. HIV/AIDS is one of the diseases for which no cure has been found yet. HIV/AIDS not only affects the physical health of individuals but also their social identity; the stigma and discrimination associated with HIV/AIDS can be more destructive than the disease itself. In such a situation, the goal is to create an environment in which children and adults with HIV/AIDS can live free from stigma and discrimination.

Discrimination towards PLWHA

Discrimination towards PLWHA takes place when a person suffers negatively from a prejudicial rule, law, or attitude because they have HIV/AIDS. It can result in people unfairly losing their jobs, health benefits, membership in groups, or material wealth. They can be driven from their homes and communities.

Stigma and discrimination toward vulnerable groups

Stigma, a powerful tool of social control, can be used to marginalize, exclude, and exercise power over individuals who show certain characteristics. While the societal rejection of certain groups (MSM, IDUs, and SWs) may predate HIV/AIDS, the disease has, in many cases, reinforced this stigma. By blaming certain individuals or groups, society can excuse itself from the responsibility of caring for and looking after such populations. Discrimination has spread rapidly, fueling anxiety and prejudice against the groups most affected, as well as those living with HIV/AIDS.

Stigma and discrimination toward women

The impact of HIV/AIDS on women is particularly acute. Women often are economically, culturally, and socially disadvantaged and lack equal access to information, treatment, and financial support. Traditional beliefs in Nepali society about sex provide a basis for further stigmatization of women within the context of HIV/AIDS. HIV-positive women are treated very differently from men in many countries; men are likely to be 'excused' for their behavior that resulted in their infection, whereas women are not. Often women keep their HIV status a secret, which keeps them from accessing services, even during pregnancy, thereby increasing the chances of MTCT.

Stigma and discrimination in the workplace

While HIV is not transmitted in the majority of workplace settings, the perceived risk of transmission has been used by numerous employers to terminate or refuse employment. There is also evidence that if people living with HIV/AIDS are open about their infection status at work, they may well experience stigmatization and discrimination from their coworkers.

Stigma and discrimination in healthcare settings

Many reports reveal the extent to which people are stigmatized and discriminated against by healthcare systems. Studies reveal the reality of withheld treatment, isolation of HIV-positive patients, non-attendance by hospital staff, HIV testing without consent, lack of confidentiality, and denial of access to hospital facilities and medicines. Ignorance and lack of knowledge about HIV transmission and lack of proper guidelines and provision for universal precaution are fueling such neglectful practices.

Stigma and discrimination within the family

Too often, when a family learns that one of its members is infected with HIV or has become sick with an AIDS-related illness, the reaction is one of fear and rejection. Friends, family, neighbours, and employers all have the potential to make the lives of people living with HIV/AIDS miserable, and often do so by isolating them. (See the box at the end of this section under the heading "Statements that blame, stigmatize or discriminate people living with HIV/AIDS"). Women in Nepal are often afraid of telling their husbands they are infected due to fears they will be beaten or divorced and forced to live in poverty facing their infection alone. Men are afraid to admit they are infected because it may be interpreted as evidence they have been unfaithful to their wives.

Stigma and discrimination have far reaching consequences

The stigma and discrimination associated with HIV/AIDS has powerful psychological consequences for how people see themselves. Stigma and discrimination can lead to depression, lack of self-worth, and suffering. Often, PLWHA are seen to be some kind of "problem" rather then part of the solution. This further perpetuates deep-rooted social fears and anxieties. Stigma and discrimination associated with HIV/AIDS are the greatest barriers to preventing further infections, providing adequate care, support, and treatment, and alleviating the impact of HIV/AIDS.

Why should families help PLWHA?

People caring for those who have become sick with an AIDS-related illness can rest assured that it is extremely rare for caregivers to contract HIV and an infected person needs all the available support. The virus is almost exclusively spread through sexual transmission. Casual contact such as touching another's skin, hugging, kissing, sharing cooking utensils, cups, plates or hairbrushes are perfectly safe.

What can be done?

In order to eliminate destructive societal behaviors and minimize vulnerability, the Nepal police must recognize HIV/AIDS as a key concern and be prepared to respond adequately to the social behaviors that reinforce HIV/AIDS-related stigma and discrimination. The Nepal Police can develop an environment where nobody in the force will be discriminated against because of his/her HIV/AIDS status. At the same time, Nepal Police have a significant role to play in the prevention of stigma and discrimination against individuals that are largely repressed, marginalized, and systematically discriminated against by society so that they can access HIV/AIDS services more easily. Imparting appropriate knowledge to the force to protect themselves and others and create a tolerant, equitable, and compassionate attitude among the force towards people living with HIV/AIDS can help in addressing the issue of stigma and discrimination.

Discussion point

What would be the steps to follow to reduce stigma and discrimination in the police force?

Statements that blame, stigmatize, or discriminate against PLWHA

Oh my god, tell me, that is not true. You disgust me. You are evil.
With your lifestyle, this was bound to happen. You deserve it.

Don't come any nearer, stay away, don't touch me and don't touch anything.
Don't come here any more, I am going to leave you, what do you want from me?
Go away, don't come here and please don't call me any more!

You are not my son anymore; you are not my daughter anymore.
You are a disgrace, you are a junkie, and you are already dead!

Shame, shame, and shame on you, you have brought shame on our family and you have brought shame on our country. How could you do this to us?

Don't follow me. I am leaving you. The wedding is off.
I loved you. I thought you loved me. I don't want to hear about that.
Don't waste my time. I won't help you.
I knew I could not trust you. What will our friends say?

What are you doing here? I don't want to work with you; I have to tell the boss.
You are fired. Go away, we don't want AIDS here; look it is not my problem.

You will have to leave the village. Get out of this space.
You will have to live somewhere else.
I cannot help you, just go away and die.

You cannot join this class. We are not allowed to play with you.
Your CV is great, but we need your HIV test report.
I am sorry, we cannot give you insurance.
Sorry we cannot grant you a visa.
We cannot give you medication.

Mom said you will be dead soon.
You will die any way.

Stigma and Discrimination

……HIV-positive woman

• "Although it was not from me, my mother-in-law tells everybody, 'because of her, my son got this disease. My son was a simple as good as gold-but she brought him this disease". She has kept everything separate for me-my glass, my plate, my place; they never discriminated like this to their son. They used to eat together with him. For me, 'don't do this or don't touch that' and even if I use a bucket to bathe, they yell- 'wash it, wash it'. They really harass me. I wish nobody comes to be in my situation and I wish nobody does this to anybody. But what can I do? My parents and brother also do not want me back."

What is Discrimination?

- Discrimination towards PLWHA takes place when a person suffers negatively from a prejudicial rule, law or attitude because they have HIV or AIDS.
- It can result in people unfairly losing their jobs, health benefits, membership in groups or material wealth.

Stigmatization Involves

- The creation of a hostile and fearful environment concerning everything related to HIV and AIDS.
- The condemnation of PLWHA.
- Power and domination
- Social control
- Marginalization and exclusion of certain individuals from society
- Exercising power and control over individuals with certain characteristics
- Societal rejection of vulnerable groups

How is HIV/AIDS Stigma Expressed?

- Ostracism, rejection, and avoidance of PLWHA
- Discrimination against PLWHA
- Violence against persons who are perceived to be infected with HIV or to have AIDS
- Compulsory HIV testing without prior consent or protection of confidentiality
- Quarantine of persons with HIV

Stigma & Discrimination towards Women

- Women blamed for their HIV-positive status
- Increased economic, cultural, and social deprivation
- Impacts children
- Women afraid of telling their husbands
- Women fear being beaten or divorced
- If divorced, forced to live in poverty facing their infection alone

Stigma & Discrimination in the Workplace

- Employers use HIV status to terminate or refuse employment.
- Employees experience stigmatization and discrimination from others.

Stigma & Discrimination at health care setting

- Withheld treatment
- Non-attendance by hospital staff to HIV/AIDS patients
- HIV testing without consent
- Lack of confidentiality
- Denial of access to hospital facilities and medicines.
- Ignorance and lack of knowledge about HIV transmission

Stigma & Discrimination at Home:

- Reaction is one of fear and rejection.
- Friends, family, neighbours, and employers all have the potential to make the lives of PLWHA miserable
- Isolating PLWHA
- Women afraid of telling their husbands they are HIV+
- Women beaten or divorced
- Men are afraid to admit they are infected because it may mean they have been unfaithful to their wives.

What Can be Done?

- Recognize HIV/AIDS as key concerns
- Initiate discussions with family, friends
- Object to mistreatment of vulnerable persons/groups
- Seek early diagnosis and treatment
- Develop HIV/AIDS workplace policies which include:
- Equipping the officers on appropriate knowledge and skills to prevent oneself and others from HIV/AIDS
- Providing information on locally available services
- Providing Staff entitlements to those who are HIV positive
- No mandatory testing
- Non discrimination against HIV for hiring or promotion.

....A skilled technician

“When my boss learnt, through my supervisor (I had approached him for guidance), that I was HIV positive, he advised me not to come to work from the next day. I explained the doctor had said that there was no risk to other workers; my boss said he did not want any trouble in his organization because of me."

What Can be Done?

"Nobody will come near me, eat with me in the canteen, nobody will want to work with me, I am an outcast here".

–HIV positive man aged 27

"I am illiterate; I ran away with a neighbor several years ago… But in less than six months I learnt that I was sold by my lover... Now I have a daughter….To feed her and myself I have been selling my body. But I am being stigmatized and discriminated by the society.."

–A 24 year old sex worker

UNIT 7

Protecting the Rights of Vulnerable Groups

The purpose of the unit

To sensitize and prepare the participants for appreciating the HIV risks and realities of vulnerable members of the society

Unit objectives

By the end of this unit participants will

- Understand the relationship between human rights and HIV/AIDS
- Be informed on the interrelationship between the work of Nepal Police and the vulnerable Groups (SWs, IDUs, MSM, and PLWHA)
- Internalize the consequences of policing practices with vulnerable groups

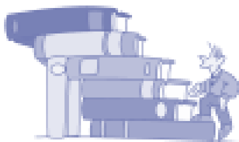
Instructional materials

Chart paper, markers, handouts, (copy of the facilitator's notes-Unit Seven)

Estimated time

1 hour, 30 minutes

Introduction of the topic	10 Minutes
Meaning of Human Rights	20 Minutes
Exercise based on quotes from Chapter 3, Unit 4	40 Minutes
Summary highlights	20 Minutes



Process

This unit will be taught through short lectures, brainstorming sessions, class presentations, and discussions.

Step one: Introduce the topic and objectives.

Step two: Brainstorm with the group by asking:

- What does "rights based approach" means

Step three: Share with the participants a quote from a sex worker on sexual violence. Followed by the quote, ask the participants:

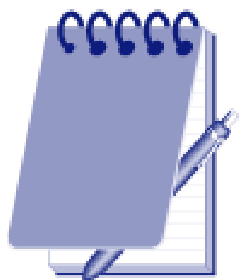
- Is this (an example of) human rights violence/violation?
- Why is it a human rights violation?
- Why does this happen?
- What will the consequences be if women are taken into custody when caught with condoms in their bags?
- How can such incidences be avoided?
- What should the police have done to protect the women?

Step four: Make a presentation on the important role the police have with vulnerable groups. Discuss the following:

- How their relationship with vulnerable groups indirectly impacts the spread of HIV/AIDS?
- The relationship between human rights and HIV/AIDS

Step five: Distribute handouts (a copy of the facilitators' notes or OHP slides for Unit Seven) for reference.

NOTES FOR THE FACILITATOR



Protecting the Rights of Vulnerable Groups

Rights-based approach to HIV/AIDS

Human rights are the rights and freedoms of human beings and are fundamental and universal. They consist of civil and political rights as well as economic, social, and cultural rights. They express recognition of and respect for human dignity.

It has been observed that where individuals and communities are able to realize their rights (to education, free association, information and, most importantly, non-discrimination), the personal and societal impact of HIV/AIDS is reduced. The reasons for this are threefold. The promotion and protection of human rights (1) reduces vulnerability to HIV infection by addressing its root causes; (2) lessens the adverse impact on those infected and affected by HIV; and (3) empowers individuals and communities to respond to the pandemic. The protection and promotion of human rights are therefore essential to preventing the spread of HIV and to mitigating the social and economic impact of it.

HIV/AIDS-related human rights include the right to life; the right to liberty and security of a person; the right to the highest attainable standard of mental and physical health; the right to non-discrimination; the right to freedom of movement; the right to privacy; the right to freedom of association; the right to work; and the right to be free from torture and other cruel, inhuman or degrading treatment or punishment.

Human rights and HIV/AIDS

Lack of recognition or denial of basic rights to PLWHA or vulnerable groups not only causes personal suffering and loss of dignity but also contributes to the spread of the epidemic by impeding an effective response. It has been observed that when human rights are not respected people are less likely to seek counseling, testing, treatment, and support. Promoting human rights, in the context of ever increasing HIV/AIDS, is not only an imperative of justice, but it is also a tool to prevent further spread of the epidemic.

None-adherence of human rights has been seen contributing to increased vulnerability, discrimination, and stigmatization against HIV/AIDS victims and impeding an effective response to this epidemic.

Discrimination and stigma

The rights of people living with HIV/AIDS often are violated because of their presumed or known HIV status, causing them to suffer both the burden of the disease and the consequential loss of other rights. Stigmatization and discrimination may obstruct their access to treatment and may affect their employment, housing and other rights. This, in turn, contributes to the vulnerability of others to infection, since HIV-related stigma and discrimination discourages individuals infected with and affected by HIV from contacting health and social services. The result is that those who are in the need of most of the information, education, and counseling, will not benefit even where such services are available.

Impeded effective response: In an environment where human rights are not respected, effective HIV prevention, treatment, support, and care strategies are hampered.

Nepal Police and vulnerable groups

In relation to HIV/AIDS, the word 'vulnerable' generally connotes groups such as sex workers, (SWs), injection drug users, (IDUs), men having sex with men, (MSM), and people living with HIV/AIDS, (PLWHA) whose lifestyles, social, or professional context and behavior make them most vulnerable to HIV/AIDS and STI.

The police forces often in carrying out their duties interact with vulnerable groups. The vulnerable groups often carry with them the stigma of being 'criminals' and very often get confronted by the police. The policing practices of police officers can often impact on the effectiveness of HIV prevention initiatives and in perpetuating stigma and discrimination. Harassment and intimidation of people vulnerable to HIV infection such as SWs, MSM, IDUs, and PLWHA may further drive them underground thereby making it more difficult to reach with HIV/AIDS services.

SWs and Nepal Police. The Nepalese Constitution confers the freedom to practice any profession or carry on any occupation, industry, or trade, except acts that may be contrary to public health or morality. No law exists regarding voluntary sex work therefore voluntary sex work has not been criminalized. In one case, the Supreme Court of Nepal gave its verdict that prostitution is a type of profession and every person has the right to choose a profession. Despite

the provision, the police often have been reported restricting the practices of SWs without considering their rights or realities in the name of maintaining the norms and practices of the society under the Public Offense and Punishment Act 2027 There have been reports that SWs are harassed for carrying condoms, in direct opposition to HIV/AIDS prevention recommendations. Further, SWs complain about being arbitrarily arrested by police personnel and treated badly. It is also reported that about 38.3 percent of clients of female SWs are those from the uniformed services including police personnel, where the regular condom use is less than 50 percent.[3]

IDUs and Nepal Police. Drug addiction is a disease and IDUs require support and treatment to recover from the disorder. Harm-reduction programs provide assistance to IDUs to protect themselves from HIV/AIDS. However, these programs have not reached all IDUs. Vulnerability of IDUs to HIV is considered high due to the use and sharing of contaminated needles and syringes by most of the IDUs in Nepal. The law regarding needle and syringe exchange is silent. While the Ministry of Health sees needle exchange program as ways of protecting public health, the Ministry of Home Affairs perceives it as indirect promotion of drug use. This conflicting views between the two ministries has further complicated this issue and the thereby lead to drug users to being persecuted on the ground of carrying needles/syringes. During Focus Group Discussions with IDUs, they frequently complain about the arbitrary arrest by the Police and their abusive behavior while in custody. IDUs have reported that they have been forced to confess to crimes they did not commit due their previous life styles which stigmatizes them as 'criminals'.

There are also examples of the police supporting harm reduction programs for IDUs in various parts of the country. The police are caught in between the lack of appropriate legal provisions and the demands put on them by society. In either case, the rights of the IDUs are found at risk in many occasions, and protecting the rights of this group is essential to reduce the spread of HIV/AIDS.

MSM and Nepal Police. There is significant amount of denial that sex between men takes place in Nepal. Stigmatizing attitudes prevail in the society toward the MSM community. The law does not use the words 'homosexuals' or 'homosexuality' in any legislation; however, the chapter on Bestiality in the country code states the acts of unnatural sex are prohibited, with the provision for punishment of up to one year imprisonment. This law can be used to

[3] Behavior Surveillance Survey in the Highway Route of Nepal, Op cit.

prosecute people engaging in homosexual acts. Furthermore, the chapter on marriage in country code and the marriage registration act provide that marriage to be solemnized only between a man and woman. As a consequence, conjugal relationship and sexual intercourse are legally possible between a man and a woman.

Despite the law not addressing MSM directly, the police often have been reported restricting the practices of MSM without considering their rights or realities in the name of maintaining the norms and practices of the society under the Social Disturbance Act. MSM narrate their stories of abuse-verbal and mental harassments committed by the police personnel. MSM conducting outreach educational programs also reported arrests for carrying condoms. There have been recent reports and incidents where MSM were detained and mistreated by police officers. This incident received widespread publicity. The negative and unsympathetic behavior of some police toward MSM is the major barrier to effectively utilizing the measures for HIV/AIDS prevention or accessing services for its treatment.

However, there have been reports from BDS that there has been a considerable decline in such behavior on the part of the Nepal Police recently after various interaction programs organized between police officers and the MSM community to explain about the sexual preference of MSM and the fact that they are born 'that way' and it is not a western influence. The MSM also reported having many partners from the uniformed services who often refuse to use condoms.

Dos and Don'ts in Regard to Human Rights and HIV/AIDS

Do	Don't
Recognize HIV/AIDS as a key concern	Do not be judgmental and prejudiced against MSM, SWs, IDUs, or PLWHA because of your profession
Promote, facilitate, and practice preventive, safer, non-risky behaviors	Do not mistreat or condemn MSM, SWs, IDUs, or PLWHA
Provide needed care and support to a PLWHA or a vulnerable group member	Do not harass the vulnerable group members verbally, physically, or mentally because they have different choices, beliefs, or practices than yours
Protect civil, economic, social, and, cultural rights of the vulnerable group members	Do not abuse the vulnerable group members verbally, physically, or sexually
Respect people's freedom of choice and resultant behavior	Do not exploit SWs or MSMDo not force the vulnerable group members to confess a crime that has not been committed
Support positive behaviors of the members of vulnerable groups	Do not impose your beliefs and practices on someone
Assist in the harm reduction initiatives	Do not reveal the identity of a PLWHA, MSM, SW, or IDU
Show understanding, sympathy, and tolerance for the misfortunes of others	Do not promote misconceptions and ignorance that lead to fear, stigma, and discrimination
Participate in campaign to prevent, reduce, and eliminate HIV/AIDS-related stigma and discrimination	Do not contribute to creating a hostile and fearful environment
Be tolerant and trying to understand other's situation	Do not promote societal rejection of vulnerable groups
Support for CSM through high-risk outlets	Do not arrest on the grounds of condom possession

International Human Rights Convention/Covenants Nepal is a State Party to

S. N.	Name of Convention/Covenant	Date Passed On	Date of Nepal's Ratification. Accession
1	Slavery Convention of 1926	25 September 1926	7 January (1963) (A)
2	Slavery Convention of 1926 as Amended	23 September 1953	7 January (1963) (A)
3	Supplementary Convention on the Abolition of Slavery, the Slave Trade and Institutions and Practices Similar to Slavery	7 September 1956	7 January (1963) (A)
4.	Convention on the Political Rights of Women	20 December 1952	20 April 1966 (A)
5.	Convention on the Prevention and Punishment of the crime of Genocide	9 December 1948	17 January 1971 (A)
6.	International Convention on Elimination of all Forms of Racial Discrimination	21 December 1965	30 January 1971 (A)
7.	International Convention on the Suppression and Punishment of the Crime of Apartheid	30 November 1973	12 July 1977 (A)
8.	International Convention against Apartheid in Sports	10 December 1985	1 March 1989 (R)
9.	Convention on the Rights of the Child	20 November 1989	14 September 1990(R)
10.	Convention on the Elimination of All Forms of Discrimination Against Women	18 December 1979	22 April 1991 (R)
11.	International Covenant on Economic, Social and Cultural Rights	16 December 1966	14 May 1991(A)
12.	International Convention on Civil and Political Rights	16 December 1966	14 May 1991 (A)
13.	Optional Protocol to International Covenant on civil and Political Right	16 December 1966	14 may 1991 (A)
14.	Convention Against Torture and Other Cruel, Inhumane and Degrading Treatment or Punishment	10 December 1984	14 May (A) 1991
15.	Convention on the Suppression of Trafficking of Women and Exploitation of Others by Prostitution	2 December 1949	27 December (A) 1995
16.	Second Optional Protocol to the International Covenant on Civil and Political Rights with Provision for the Elimination of Capital Punishment	15 December 1989	4 June 1998 (A)

Signatory

Optional Protocols to the Convention on the Rights of the Child on the involvement of children in armed conflict

Optional Protocols to the Convention on the Rights of the Child on the sale of children, child prostitution and child pornography

Optional protocol to Convention on the Elimination of All Forms of Discrimination Against Women

High Level Treaties and Commitments

UNGASS on HIV/AIDS	-	June 2001
UNGASS on Children	-	May 2002
SAARC Regional Forum	-	2003

HIV/AIDS has been identified as Number One priority agenda in the Tenth Five-Year Plan of Nepal.

Nepal Police & Vulnerable Groups

(IDUs, Sex workers, MSM, PLHAs)

Human Rights & HIV/AIDS

- **Lack of recognition or denial of basic rights to vulnerable groups leads to…..**
  - **Personal suffering and loss of dignity**
  - **Impeding an effective response.**
  - **People less likely to seek counseling, testing, treatment and support.**

Increased vulnerability, Discrimination and stigma, Impedes an effective response

Existing Laws & Policy towards Sex workers

- Supportive HIV&AIDS strategy
- The Nepalese Constitution confers the freedom to practice any profession or carry on any occupation, industry or trade, except acts that may be contrary to public health or morality.
- No law exists regarding voluntary sex work
- The Supreme Court of Nepal gave its verdict that prostitution is a type of profession and every person has the right to choose a profession

Existing Laws & Policy towards IDUs

- Supportive National HIV/AIDS Strategy
- The law regarding needle and syringe exchange is silent.
- Ministry of Health sees needle exchange program as ways of protecting public health, the Ministry of Home Affairs perceives it as indirect promotion of drug use.

Existing Laws & Policy towards MSM

- Supportive National HIV/AIDS Strategy
- The law does not use the words 'homosexuals' or 'homosexuality' in any legislation
- The chapter on Bestiality in the country code states the acts of unnatural sex are prohibited, with the provision for punishment of up to one year imprisonment.
- The chapter on marriage in country code and the marriage registration act provide that marriage to be solemnized only between a man and woman.

Nepal Police & Vulnerable groups

- Vulnerable groups (SWs, MSMs, IDUs) are looked as '*criminals*' therefore often encounter the police
- The lack of proper knowledge and education on vulnerable groups, particularly in the lower ranks, creates misunderstandings and discomfort between the police and vulnerable groups.
- 'Public Offence and Punishment Act- 2027'.
- This conflicting views between the two ministries has further complicated this issue and the thereby lead to drug users to being persecuted on the ground of carrying needles/ syringes and sex workers being persecuted for carrying condoms

Finding a balance between responsiveness to public outcry and protecting the rights of the vulnerable groups is an on-going challenge.

Police & sex workers

- They are Clients of sex workers
- Arrest for carrying condoms
- Sexual harassment and violence
- Practise Extortion

Police & IDUs

- Arrest IDUs for carrying needles
- Forced to confess to crimes not committed (seen as criminals!)
- Extortion
- Harassment

Police & MSMs

- Clients of MSMs
- Verbal, physical, mental and sexual harassments/violence
- extortion
- Arrest for carrying condoms

Police & PLWHAs

- Generally, police personnel have fewer interactions with PLWHA than other vulnerable groups.
- PLWHA who are also sex workers or injecting drug users may face discrimination or harsh treatment at the hands of the police.

UNIT

8

Interface with the Vulnerable Groups

The purpose of the unit

To facilitate an interaction between the Nepal Police and vulnerable group members

Unit objectives

By the end of this unit participants will

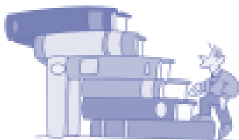
- Interact with SWs, IDUs, MSM, and PLWHA and learn about their lifestyle
- Appreciate constraints and complains of SWs, IDUs, MSM, and PLWHA in regards to policing and develop empathy towards them
- Learn to live in a world with HIV/AIDS
- Understand the value of interface between Nepal Police and the vulnerable groups

Information guide

Refer to Unit Eight of Chapter Three.

Estimated time

1-2 days



Process

This unit is dependent on fieldwork. The training facilitators should arrange meetings with civil society organizations working with vulnerable groups. Take the trainees to these organizations and provide an opportunity to have meaningful interaction with the representatives of the vulnerable groups. Alternatively, the representatives of the vulnerable groups could be brought in to the police academy training centers.

Relevant facilities

Ideally, each batch of police trainees should spend at least 1 to 2 days with SWs, MSM, IDUs, and PLWHA in their settings and have open and non-judgmental interactions with them. There are few organizations in Kathmandu and outside

Kathmandu who work with the vulnerable groups. These organizations are willing to discuss the issues openly. Addresses and contact numbers for the agencies are listed in the last part of this unit.

Interaction with a police PLWHA

It would be ideal if a police PLWHA could be found to come as a volunteer to the police academy/training center and share the difficult experiences s/he had to go through after being diagnosed as HIV positive. The involvement of a PLWHA would be particularly beneficial to the trainees and allowing them to share their experiences of living with HIV/AIDS, and breaking the stigma and silence would be helpful for the trainees to internalize the HIV/AIDS-related difficulties/realities. The personal testimonies of HIV-positive police personnel could help to create a highly positive environment with a tremendously lasting impact for the care and support of PLWHA. If there are no police PLWHA, interaction with other PLWHA can be arranged. Such an initiative may facilitate to begin support groups for PLWHA as well.

Audiovisual options

In case of the unavailability of vulnerable group representatives, the facilitator will use audiovisual aids to stimulate discussions. Audiovisual materials will present personal stories of stigma and discrimination shared by vulnerable group members.

The following table provides names and contact addresses of some key NGOs working with/created by the vulnerable groups.

TABLE 7 **Some NGOs working with/created by vulnerable groups**

Organization	Address	Contact No.	Email Address	Area of work	Geographic coverage
NAP+N	Sorhakhutte, Kathmandu	4245483	napn@napn.org.np	PLHAs	Kathmandu
NAVA KIRAN PLUS	Dhapasi, Kathmandu	4371422	nkplus@wlink.com.np	PLHAs	Bharatpur, Kathmandu, Pokhara
NEPAL PLUS	Dhumbarahi, Kathmandu	4372017	nepalplus@wlink.com.np	PLHAs	Kathmandu
SNEHA SAMAJ	Bhaispati, Kathmandu	2210202	snehasamaj@enet.com.np	Infected & affected Women PLHAs	Kathmandu
BDS	Lazimpat, Kathmandu	4443350	cspsb@hotmail.com	MSMs	Rupandehi, Dharan, Janakpur, Kathmandu
LALS	Babarmahal, Kathmandu	4222751	lals@wlink.com.np	Harm reduction/ IDUs	Lalitpur, Kathmandu
RICHMOND FELLOWHIP	Kathmandu	4332532	sabera@ntc.net.np	IDUs	Kathmandu, Pokhara
YOUTH VISION	Maharajgunj, Kathmandu	4429192	yvision@mos.com.np	IDUs/VCT	Kathmandu
GWP	Tinkune, Kathmandu	4473915	gwp@ntc.net.np	Sex workers	Kathmandu valley and Highway districts (Central, West, & Far West)
WATCH	Battisputali, Kathmandu	4492644	watchftp@wlink.com.np	Sex workers	Bhaktapur, Kathmandu, Lalitpur, Rupandehi
CAC	Bhaktapur	4375086	cac_nepal@yahoo.com	Sex workers	Bhaktapur, Kathmandu
AMDA	Kathmandu	4487235	amda@healthnet.org.np	STI, VCT	Kathmandu Valley & Highway districts (Central & East)
PALUWA	Pokhara	061-527818		Sex workers/ VCT services	Pokhara
NAULO GHUMTI	Pokhara	061-523350	naulo_ghumti@wlink.com.np	IDUs/VCT	Pokhara
TRINETRA	Nawalparasi	056-526077	trinetra@ecomail.com.np	Sex workers	Nawalparasi

Guiding questions for discussion with vulnerable groups

- As leaders, what other types of advocacy or awareness raising work are you involved in?
- In carrying out your advocacy work, have you faced any difficulties when being open about your identity/status?
- Can you provide us with some examples of stigma and discrimination you have faced?
- What about concerns/issues of stigma and discrimination from the police?
- Do you have any suggestions for ways to improve relations with the police?

People often do not want to disclose certain information about them. As such, it is NOT appropriate to ask questions on the following:

- The way they became HIV positive
- Amount of money they earn (as sex workers)
- Source of getting drugs (IDUs)
- Personal sexual preferences or practices

Remember: People may be more comfortable (and willing to disclose more) if encouraged to share their experiences in an anonymous fashion. You may ask them to share the experiences of another person they know, such as a friend or associate.

CLASS MATERIALS

This chapter provides some useful materials in imparting the training.

Unit 1: Pre- and Post-Test Questionnaire

Unit 2: Global and National HIV/AIDS Scenarios Quiz

Unit 3: Quotes about Stigma and Discrimination

Unit 4: Quotes about Human Rights Violations

UNIT 1

Pre-and Post-Test Questionnaire

(To be administered before and after the delivery of training)

The aim. The aim of this test is to assess knowledge, attitudes with respect to the prevention of HIV infection and AIDS. The response provided at the beginning of the training will be used to measure the gains made by the trainee comparing it with the responses given after completing the training and to assess the effectiveness of the training as well the progress of trainees.

Age	Sex	Date

STATEMENT	YES	NO
1. HIV is transmitted through semen, vaginal fluids, blood and mother to child.		
2. One can recognize a person infected with HIV by how she/he looks.		
3. No condom, no sex" is a good rule to protect yourself from HIV and STD.		
4. The more sexual partners a person has, the greater the chanceof getting infected with HIV or a sexually transmitted disease.		
5. I would feel comfortable hugging a close friend who has AIDS.		
6. A person can get HIV from living in the same home with a person,who has HIV/AIDS.		
7. Sex workers, drug users, MSM are criminals and deserve to beInfected with HIV		
8. There are drugs to cure AIDS		
9. People who choose only healthy-looking partners won't get infected with HIV.		
10. People living with HIV/AIDS should be a part of the society		

Answers: 1. Yes, 2. No, 3. Yes, 4. Yes, 5. Depends on individual answer, 6. Depends on individual answer, 7. Depends on individual answer, 8. No, 9. No, 10. Depends on individual answ

UNIT

2

Global and National HIV/AIDS Scenarios Quiz

Time

To answer these questions the trainees would require about 15 minutes

The questions

1. Does HIV/AIDS affect only people from developing countries?
   - Yes
   - No

2. Approximately how many people are infected with HIV world wide?
   - 3.5 million
   - 25 million
   - 40 million

3. Approximately how many people are infected with HIV in Nepal?
   - 10,000
   - 60,000
   - 150,000

4. What percentage of those infected with HIV are women?
   - 19%
   - 46%
   - 74%

5. Worldwide, what is the age range of the most infected with HIV?
   - 0-14 years old
   - 15-24 years old
   - 45-34 years old

Answers: 1. No, 2. 40 million, 3. 60,000, 4. 46%, 5. 15-24 years.

UNIT

3

Quotes about stigma and discrimination

"My mother-in-law tells everybody, 'Because of her, my son got this disease. My son is a simple as good as gold-but she brought him this disease"

— A 26 year old HIV-positive woman

"My foster son Raghu, aged 8, was born HIV-positive and diagnosed with AIDS at the age of 8 months. I took him into our family home. At first relations with the local school were wonderful and the Raghu thrived there. Only the head teacher and his wife knew about Raghu's illness. Then someone broke the confidentiality and told a parent that Raghu had HIV. That parent, of course, told all the others. This caused such panic and hostility that we were forced to move out of the area. The risk is to Ragu and us, his family. Mob rule is dangerous. Ignorance about HIV means that people are frightened. And frightened people do not behave rationally. We could well be driven out of our home yet again."

— A parent speaking to a National AIDS support group

"My mother-in-law has kept everything separate for me-my glass, my plate, they never discriminated like this with their son. They used to eat together with him. For me, 'don't do this or don't touch that' and even if I use a bucket to bathe, they yell- 'wash it, wash it'. They really harass me. I wish nobody comes to be in my situation and I wish nobody does this to anybody. But what can I do? My parents and brother also do not want me back."

— A 23 year old HIV-positive woman

"Though we do not have a policy so far, I can say that if at the time of recruitment there is a person with HIV, I will not take him. I'll certainly not buy a problem for the company. I see recruitment as a buying-selling relationship. If I don't find the product attractive, I'll not buy it."

— A Head of Human Resource Development

"Nobody will come near me, eat with me in the canteen, nobody will want to work with me, I am an outcast here."

— HIV positive man aged 27

UNIT 4

Quotes about human rights violations

Inadequate information

"Nobody explained me about the risks and possible protective measures...I was told that the first time one cannot get pregnant or catch HIV. I did not know about condom, use of it could have protected me... Now it is too late for me."

— A 16 year old HIV positive girl.

Lack of freedom to choose a profession

"I am illiterate; I ran away with a neighbor several years ago... But in less than six months I learnt that my lover sold me... Now I have a daughter.... To feed her and myself I have been selling my body. But I am being harassed by the police and the society."

— A 24 year old sex worker

Lack of access to affordable medicine

"My son is identified as HIV positive. I have heard that there are medicines that could keep the negative impact of the disease away for long time. But these medicines are very expensive, hence we can not afford to them. Now I will lose my son soon".

— Father of an HIV positive young man

Police harassment

I was returning home from my work in a nearby restaurant around 10.00pm. Suddenly, a police van stopped next to me and the police asked where I was coming from. They forcefully checked my bag and found condoms. Then they started calling me by all kinds of names and dragged me inside the van. I could not shout because in this area, everybody knows me and I was embarrassed. Inside the van, they started touching my breast...and they asked me for some money. If not, they threatened to take me into custody.... I gave them money because I have a small child to look after and I do not want any complications.

— Sex worker

Lack of privacy and loss of dignity

I was pregnant and I wanted to take ARV before I delivered to protect baby inside me. My husband and me had not shared about our status with the family. After I shared my status with the doctors and after that they immediately labeled all my prescriptions with a heading AIDS patient . Everybody started pointing their fingers and visiting my bed just to look at my face. We were very upset. When my child was born, they even labeled his bed AIDS baby.

— A young HIV Positive mother

Discrimination to employment

"When my boss learnt, through my supervisor (I had approached him for guidance), that I was HIV positive, he advised me not to come to work from the next day. I explained the doctor had said that there was no risk to other workers; my boss said he did not want any trouble in his organization because of me."

— A skilled technician who lost his job recently

Police harassment

"The police know that I am a drug user. They have seen the needle exchange program staff coming and meeting me. One day they just picked me up and took to inside their van. They checked my pocket and found a clean syringe. I asked them what crime I had committed that I was picked up. They told me to just shut up and give some money otherwise they will take me because I was carrying needle. They even gave examples of friends who had not obeyed and are now inside the jail right now. I got scared and gave them money. It is scary to carry needles and more scary if we do not have needles and we share!"

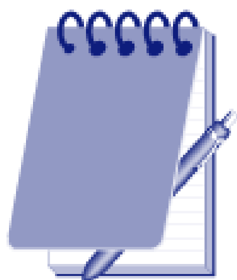
— Drug User

Tips For The Facilitator

This chapter provides some tips for the facilitator useful in implementing the training.

- Step 1: Identifying the participants and their training needs
- Step 2: Preparation
- Step 3: Qualities of a good facilitator
- Step 4: Evaluation
- Step 5: Follow-up

NOTES FOR THE FACILITATOR



Step one:
Identify the participants and their training needs

Try to identify a group of participants with similar background in terms of education, experiences, job, and activities they are involved in. The more homogenous the background of your participants, the easier it is to have purposive and focused discussions and for group itself to interact freely and share their experiences at the same level of understanding and competence. To identify their training needs, the facilitator can administer simple pre-test questionnaires to try collecting this information before the training starts. This will help the facilitator to plan better and adapt the aim/objectives, content, training methods, and training aids one wants to use in order to make the training relevant for the participants.

Step two:
Preparation

It is essential to prepare many things and perform tasks before the facilitation process is initiated. Following are the tasks to be completed before the training starts:

- Venue and time
- Number of participants
- Send invitations and follow up
- Training materials (markers, chart papers, meta cards, glue, masking tape etc) and visual aid
- Handouts for the participants
- Identifying resource people
- Refreshments arrangement

Step three:
Facilitation

Have an icebreaker or introduction exercise with the participants before the process of facilitation starts. This will help them to feel comfortable. There are various methods, which the facilitator can use to help participant to learn with ease. They are presentation/lecture, group discussions, brainstorming, collecting ideas, using case study or quotes, role-playing, etc. The methods will depend on the allocated time and the number of participants too.

Qualities of a good facilitator

A good facilitator should have the following attributes:

- Capacity to transfer own skill and capacity
- Capacity to facilitate and providing feedback
- Understanding of group mechanisms
- Excellent interpersonal communication and excellent active listening
- Willingness to learn and use new skills
- Capacity to accept the professional challenge
- Joyful and informal style
- Smiling nature
- Skill to recognize the participants
- Skill to ask question appropriately
- Skill to bring together various thoughts
- Skill to pacify the difficult participants
- Skill not to use unethical words
- Skill to present oneself politely before the participants

Step four: Evaluation

At the end of each day, it will be useful to have a brief evaluation session to get the feedback on what went well and what needs improvement for the coming days. This will provide an opportunity for the facilitator to further improve the training. At the same time, there could be a bigger evaluation by administering the same questionnaire used during the pre-test just to compare the answers and get to know if the training has been effective!

Step five: Follow-up

Training is not just a course. It is a process involving behavior change. This may not start and end with the course. Those you have trained need to practice what they have learnt in real life. You need to periodically check on what they are doing. This will help you find out whether the participants use what they learned and what needs to be done.

References

1. Abuse of Commercial Sex Workers and Homosexuals in Nepal: Women Cell, Nepal Police and FWLD in collaboration with BDS, WATCH, GWP, Kathmandu, October 2003.
2. AIDS and HIV Infection, Information for Employees and their Families, UNAIDS
3. AIDS and Men, Martin Foreman (ed), Panos, 1999.
4. AIDS and the Military, UNAIDS Point of View/Best Practice Collection, May 1999
5. AIDS Epidemic Update: UNAIDS, December 2003.
6. AIDE-Memoires: Policy Guidelines on HIV/AIDS Prevention and Control for UN Military Planners and Commanders, United Nations Department of Peacekeeping Operations/ Civil Military Alliance, February 2000
7. Behavioral and Seroprevalence Survey Among Injecting Drug Users: NCASC, USAID, Impact, FHI, Nepal, 2004.
8. Behavioral and Seroprevalence Survey Among Male Injecting Drug Users in the Pokhara Valley: NCASC USAID, Impact, FHI, February-March 2003.
9. Civil-Military Collaboration, M Ricardo Calderon (ed), Family Health International, 1997
10. Combat AIDS HIV and the World's Armed Forces: Healthlink Worldwide, 2002.
11. Coverage of Essential HIV/AIDS Services in Nepal-A Survey: Nirmal Prasad Pandey, November 2003
12. Declaration of Commitment of HIV/AIDS: UN, June 2001.
13. Fighting AIDS "The Case of Eritrea": UNAIDS, August 2003.
14. HIV/AIDS and Human Rights: A Legislative Audit: NCASC, Policy Project/Nepal, FWLD, March 2004.
15. HIV/AIDS Training Tool Kit, GTz and UNAIDS, 2003
16. HIV/AIDS Profile: Nepal: International Programs Center, Population Division, U.S. Census Bureau, HIV/AIDS Surveillance Data Base, June 2000.
17. HIV/AIDS and Security, M Carballo and others, International Centre for Migration and Health, 2001.
18. HIV/AIDS Training Manual, Sakriya Unit, United Mission to Nepal
19. HIV/AIDS and VCT, National Guidelines for voluntary HIV/AIDS Counseling and testing NCASC, 2003
20. HIV/AIDS-The Situation in Nepal: NCASC, 2001

21. HIV Subverts National Security, Lee Nah Hsu, UNDP SE Asia HIV and Development Project, August 2001.
22. Injecting and Sexual Behaviors of Injecting Drug Users: NCASC, USAID, Impact, FHI, Pokhara, Nepal, 2004.
23. Injecting and Sexual Behaviors of Male Injecting Drug Users in Pokhara: A Focused Ethnographic Study: NCASC, USAID, Impact, FHI, August-November 2002
24. Lesson Plans For HIV, AIDS and Safer Sex, Avert, www.avert.org
25. Men's Sexual Health Matters, Healthlink Worldwide, 1998.
26. National Estimates of Adult HIV Infection Nepal 2003: NCASC, MOH, March 2004
27. National Guidelines for Voluntary HIV/AIDS Counseling and Testing: MOH, NCASC, July 2003.
28. National HIV/AIDS Strategy (2002-2006) Nepal: MOH, January 2003.
29. National Operational Plan For HIV/AIDS Control (2003-2007): MOH, NCASC, July 2003.
30. National Response to HIV/AIDS: UNAIDS, April 2004.
31. On The Front Line: UNAIDS, August 2003.
32. Peer Education Kit for Uniformed Services, Implementing HIV/AIDS/STI: UNAIDS, September 2003
33. Refugees, Displaced People and their Vulnerability to HIV/AIDS, UK NGO AIDS Consortium, 1996.
34. Review of the Legal Situation on Harm Reduction: Development Law Inc, Kathmandu, February 2004.
35. School Health Education to Prevent AIDS and STD, Handbook for Curriculum Planners, World Health Organization and United Nations Educational, Scientific and Cultural Organization, 1994
36. School Health Education to Prevent AIDS and STD, Teachers' Guide, World Health Organization and United Nations Educational, Scientific and Cultural Organization, 1994
37. School Health Education to Prevent AIDS and STD, Students' Activities, World Health Organization and United Nations Educational, Scientific and Cultural Organization, 1994
38. South Asia Region (SAR)-Nepal: The World Bank, August 2003.
39. South Asia Region (SAR)-Nepal: The World Bank, April 2004.
40. Tenth Plan (2002-2007), HMG/Nepal, National Planning Commission
41. The World Health Report 2004: WHO, May 2004.

42. Uniformed Services Programming Guide: UNAIDS, 2003.
43. UN Millennium Development Goals, UNDP, 2000.
44. Winning the War Against HIV and AIDS: A Handbook on Planning, Monitoring and Evaluation of HIV Prevention and Care Programmes in the Uniformed services, Civil-Military Alliance to Combat HIV and AIDS/ UNAIDS, 1999.
45. Women, Vulnerability and HIV/AIDS, Adriana Gomez and Deborah Meacham, Latin American and Caribbean Women's Health Network, 1998.

Web-based Search Links

1. www.fhi.org/en/aids/impact/briefs/uniformedservice.html
2. www.hiv-development.org/publicatiions/subverts-security.asp
3. http://www.unaids.org/publications/documents/sectors/military/militarypve/pdf
4. www.fhi.org/en/aidscap/aidscappdfs/civilmilitary/pdf
5. www.fhi.org/en/aids/impact/briefs/uniformedservice.html
6. www.fhi.org
7. www.unaids.org/bestpractice/collection/subject/sector/keymilitary.html www.fhi.org/en/topocs/listing/uniformedserviceslist.html
8. www.panos.org.uk
9. http://hivinsite.ucsf.edu/InSite.jsp?page=kb-08-01-08
10. www.child-soldiers.org
11. www.childsoldier.net
12. www.cdr.dk
13. www.icmh.ch
14. www.planetout.com
15. www.impactalliance.org
16. www.hivnet.ch
17. www.crisisweb.org
18. www.synerggaids.com
19. www.globalhealth.org
20. www.chinfo.navy.mol
21. www.aclu.org
22. www.cc.nih.gov
23. www.youandaids.org
24. www.avert.org
25. www.aegis.com
26. www.thebody.org
27. www.allafrica.com/aids
28. www.pso.com
29. www.fhi.com
30. www.usaid.org
31. www.dod.org
32. www.worldbank.org/aids
33. www.cs.mb.edu
34. www.ventageproed.com/aids/aidsc.htm
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