

# NATIONAL HIV/AIDS STRATEGY (2006-2011)

## NEPAL



October 2007



*Ministry Of Health & Population*  
**National Center for AIDS and STD Control**  
*Teku, Kathmandu*

# Message

The spread of HIV/AIDS is a growing threat all over the world. It is affecting individuals, families, communities, nations, and the world as a whole. We know that HIV/AIDS is a complex problem that has adverse impacts not only on health but also on various aspects of development.

As a signatory to the Millennium Development Goals and UNGASS Nepal has expressed its commitments to tackle HIV/AIDS issue and had already started strategic interventions in this regard. The first National HIV/AIDS Strategy (2002-2006) for the effective response to the epidemic was a milestone. The Tenth Five-Year Plan of Nepal has also incorporated HIV/AIDS as a crosscutting issue and as a priority programme. Government of Nepal is also dedicated towards achieving universal access for HIV/AIDS services to its people.

As such, the national responses need to be scaled up, commitment to achieving the Three Ones is to be translated into firm actions. I am very much confident that this second National HIV and AIDS Strategy (2006-2011) will guide us for the effective response in an expanded and scaled up approach for lowering the prevalence of HIV among the most at risk populations, reducing the vulnerability of young people and providing quality treatment and care to the infected as well as affected people. Ultimately, it will contribute in improving the quality of life of Nepalese people.

It is important that we understand the seriousness of the epidemic and put our sincere efforts, at all levels, from all sectors to implement this strategy in a coordinated and effective way before it is too late.

**Giriraj Mani Pokharel**  
**Minister for Health and Population,**  
**Chair, National AIDS Coordination Committee**  
**Member Secretary, National AIDS Council**

# Message

HIV/AIDS is a priority development issue for the Government of Nepal. Even though the prevalence appears to be low in the general population, major efforts are required to prevent the epidemic from spreading from high risk groups such as migrant workers, transport workers, intravenous drug users, sex workers and their clients, into the general population.

The national Strategy on HIV/AIDS (2006-2011) has strongly emphasized the importance of continuum of services from prevention to treatment and care. Expansion and scaling up of the services from prevention to care and treatment are focused in line with the government commitment towards Universal Access, leading to attaining Millennium Development Goal.

If Nepal's HIV response is to be scaled up, the country needs to focus its efforts to achieve the Three Ones. For a comprehensive and scaled up HIV/AIDS response, Nepal's current legal and policy framework needs to be revised, updated and new laws and policies to be developed for the support and protection of rights of infected and affected people. Establishment of HIV/AIDS as the development agenda and its integration into the development initiatives of non-health sectors of government and civil society is to be realised through enhanced multisectoral and decentralized programming.

This National HIV/AIDS strategy (2006-11) has taken into accounts all these issues, obstacles and the targets defined in the Universal Access document. A coverage target of addressing 70% of most-at-risk populations for HIV/AIDS prevention, treatment, care and support is envisaged for 2011. I am fully confident that this strategy will guide us to achieve MDG to halt and begin to reverse the increasing trend of HIV by 2015.

**Shashi Shrestha**  
**State Minister for Health and Population**

# Message

Worldwide more than 40 million people are living with HIV and every year the number of infected people is on rise. Since the out break of the epidemic, about 2.5 to 3 million of people are loosing their lives of AIDS every year. No country in the world is spared by the epidemic.

After the detection of first HIV case in 1988, Nepal Government started working for the prevention and control of HIV in the country. A 12 point policy on HIV/AIDS Prevention and Control was developed in 1995 and is under implementation. A five year National HIV/AIDS Strategy (2002-2006) was developed in 2002 based on the recommendations of two important studies undertaken; the Situation Analysis and the Response Analysis. This strategy was the first formal National HIV/AIDS Strategy developed in consultation with the major stakeholders and was implemented through the operational plan (2003-2007) and subsequent Annual Plans.

Now based on the lessons learned from the implementation of the first National Strategy and also taking into account of the nature of the epidemic in the country, its dynamics, existing vulnerability and risks and also existing strength and opportunities, this second National HIV and AIDS Strategy has been developed for the period of 2006-2011. The current strategy has taken into account the issues, obstacles and targets defined in the Universal Access document. The targets and appropriate strategies for achieving the Universal Access are discussed and elaborated in this National Strategic Plan. The subsequent multi year action plan i.e. National Action Plan (2006-2008) has further elaborated the specific targets and budgets.

I look forward to the successful implementation of this Strategy through the strong coordination and linkages among the stakeholders, enhanced management capacity of government and civil societies and effective multi-sectoral involvement.

Finally, Government of Nepal is fully committed to address the vulnerability, risks, threats and impact of HIV/AIDS and would like to extend its full support in the implementation of this strategy.

**Ram Chandra Man Singh**  
**Secretary, Ministry of Health and Population**  
**Chair, Country Coordination Mechanism**

# Foreword

Compared to some other countries, the prevalence of HIV in Nepal is low. However, in the South Asia region it has the second highest adult prevalence rate after India. The majority of HIV infection is among the productive age group of 15 to 49 years. If the epidemic is allowed to spread, it would further worsen the poverty scenario and will have serious negative impact on the country's economy and productivity.

Without effective interventions, it is predicted that there may be a generalized epidemic by the end of the decade with an estimated prevalence of 1-2 percent in the age group 15-49 years, making AIDS the leading cause of death in this age group.

With the implementation of First National HIV/AIDS Strategy (2002 – 2006) collaboration and support to the national response has increased over the past two years and the number of partners involved in HIV and AIDS activities has also increased significantly including the support from the organizations like Global Fund (Round II). In addition to traditional partners such as the UN and international NGOs a large number of civil society organizations and networks have become involved in different aspects of the response.

I am confident that this document will serve as a guideline to all the partners to respond to the epidemic in a coordinated and decentralized way with the maximum utilization of the existing resources. We are committed to ensure that the HIV and AIDS programme is mainstreamed in the health care delivery system for synergy and better lasting benefit for the people.

**Dr. Govinda Prasad Ojha**  
**Director General**  
**Department of Health Services (DOHS)**  
**Ministry of Health and Population (MOHP)**

# Acknowledgement

National AIDS Coordination Committee (NACC) is pleased to introduce the second National HIV/AIDS Strategy for the periods 2006-2011. Based on the experience and lessons learned from the implementation of first National HIV/AIDS Strategy (2002-2006) and keeping in view of the low coverage and access to services; insufficient focus to treatment care and support as well as inadequate link between prevention and treatment care and support, the current NSP (2006 – 2011) is designed in line with Universal Access target of 80% coverage with prevention, treatment, care and support services to Most-at-risk population and People living with HIV and AIDS.

The NSP (2006 – 2011) is developed within the broader framework of the national HIV and AIDS policy and 11 point guiding principles. This strategy has highlighted Prevention and Treatment, Care and Support as the two main programmatic components and Advocacy, Policy and Legal Reform; Leadership and Management; Strategic Information and Finance and Resource Mobilization as the four major cross cutting components. The strategy has also defined basic service packages and specialised service package for various population groups keeping in view of their vulnerability and needs.

As this strategy was developed in wider consultation with and inputs from all the concerned stakeholders from national to district level, I am confident that each and every stakeholders will own this and put their efforts for its timely and effective implementation. Based on this strategy, two years action plan (2006-008) has been developed for its implementation, which is the achievement for the country towards one of the Three Ones principle i.e. one coordinated national plan.

Development of this strategy wouldn't have been possible without the support of the number of national and international partners and donors. Acknowledgement and thanks must be given to the various organizations and individuals whose skills, resources and knowledge helped us to make this strategy possible. We all know that an endeavour such as this draws heavily upon the knowledge, skills, experience and goodwill of countless persons. NACC would like to express its sincere appreciation for their important contribution at various stages of the development process.

The National AIDS Coordination Committee (NACC) wishes to express special thanks to UNAIDS for their technical and instrumental role that enabled us to go for wider consultation with the stakeholders at the centre and at the five regions. NACC thanks all the stakeholders; EDPs, line agencies, networks and their member organizations and INGO, NGOs and CBOs for providing their time and inputs at different level, from consultation to finalization of the document. I would like to thank all the staffs of NCASC for their support and backup. NCASC would to like thank GFATM for the support in the development as well as publication of this strategy.

Lastly I look forward to the strong cooperation and collaboration of all the stakeholders for the effective implementation of this Strategy.

**Dr. Padam Bahadur Chand**  
**Member Secretary, National AIDS Coordination Committee (NACC)**  
**DIRECTOR, NATIONAL CENTRE FOR AIDS AND STD CONTROL (NCASC)**

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# Abbreviations

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ARPS	At Risk Population
ART	Anti Retroviral Treatment
CBOs	Community Based Organisations
CHBC	Community and Home Based Care
DACC	District AIDS Coordination Committee
DDC	District Development Committee
DOTS	Directly Observed Treatment Shout course
EDPs	External Development Partners
FHI	Family Health International
FSW	Female Sex Workers
GFATM	Global Fund to Fight against AIDS, Tuberculosis and Malaria
GIPA	Greater Involvement of People with AIDS
GO	Government Organisation
HMIS	Health Management Information System
IBBS	Integrated Bio-Behavioural Survey
IDUs	Intravenous Drug Users
ILO	International Labour Organisation
INGOs	International Non Governmental Organisations
M&E	Monitoring and Evaluation
MARPs	Most At Risk Populations
MDG	Millennium Development Goal
MIPA	Meaningful Involvement of People with AIDS
MoHP	Ministry of Health and Population
MSM	Men having Sex with Men
MSW	Male Sex Workers
NAC	National AIDS Council
NACC	National AIDS Coordination Committee
NCASC	National Centre for AIDS and STI Control
NGOs	Non Government Organisations
NHRC	National Health Research Council
NTC	National Tuberculosis Centre
OI	Opportunistic Infections
OVC	Orphan and Vulnerable Children
PEP	Post Exposure Prophylaxis
PLHA	People Living with HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
PPP	Public Private Partnership
SGS	Second Generation Surveillance
STI/STD	Sexually Transmitted Infection/Disease
SW	Sex Workers
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
VACC	Village AIDS Coordination Committee
VCT	Voluntary Counselling and Test

# Executive summary

National Strategic Plan (2006 – 2011) aims to contribute directly to the Millennium Development Goal (**Halt and begin to reverse the increasing trend of HIV by 2015**) through numbers of key strategies for Prevention; and Treatment Care and Support. Keeping in view of current low coverage and access to services, insufficient focus to treatment care and support as well as inadequate link between prevention and treatment care and support, the NSP (2006 – 2011) is designed in line with Universal Access target of 80% coverage with prevention, treatment, care and support services to Most-at-risk population and People living with HIV and AIDS. The NSP (2006 – 2011) is developed within the broader framework of the National HIV and AIDS Policy and 11 point guiding principles.

A country with immense cultural and geographical richness and diversity, Nepal is also home of some 23 million people (40.2% under age 15) with more than hundred ethnic and linguistic groups. These diversities also pose numerous development challenges. Basic development indicators are far from satisfactory despite some improvements marked over the period. Poverty, deprivation, discrimination are core underlying causes of poor development and vulnerability of people of Nepal. Moreover, the decade long armed conflict has had tremendous implications on the overall development in the country and vulnerability of the people.

With consistently exceeding the HIV prevalence of more than five percent among the most at risk populations (FSWs, IDUs, MSMs, Migrants and their spouse) years after years, the country has remained at a critical juncture of “**concentrated epidemic**” stage with looming threat of HIV/AIDS being a number one killer in the country. The highest burden of the epidemic rests on seasonal labour migrants followed by the clients of sex workers and rural female low risk population among the total number of 70, 256 people living with HIV in the country.

The previous National HIV/AIDS Strategy (2002 – 2006) was instrumental in accelerating the responses by expanding the partnerships; broadening the scope and opportunities for innovative yet need driven programming; and by initiating the dialogue at all level for policy and structural reformation process. In other words, the Strategy offered a strong foundation on which scaled up response mechanism could be developed in order to respond to the changing scenario of the epidemic and the need of the people. In spite of these success and innovative approaches achieved in the previous strategy period, the implementation of the Strategy encountered number critical challenges and certain commitments of the Strategy were not fully realised particularly in the areas of policy formulation, institutional arrangements, leadership commitments, donor harmonisation and resource mobilisations.

This strategy has six components with two programmatic components and four cross cutting components. For each component, component goal, detail strategies, strategic outcomes and key activities has been developed. It is envisioned that subsequent development of National Action Plan will detail out the cost and other operational aspects of the strategy including targets. The strategy has also defined basic service packages and specialised service package for various population groups based on their vulnerability and needs.

## **Programmatic components**

### **PREVENTION (1000)**

#### **Objective**

By 2011, HIV program coverage will be 70 - 80% among the MARPs and reduction of new HIV infection among general population.

#### **Strategic Outcomes:**

- Improved knowledge and safe behavioural practices of all target groups (safer sex practices and safer injecting practices)
- Increased availability and access to appropriate and differentiated prevention services

- Increased acceptance of HIV and AIDS and enhance non-discriminatory practices affecting marginalized and most at risk populations
- Reduced risk and vulnerability to HIV infection of all target populations

### **Strategies towards these outcomes**

- Strategy: 1 Expansion of Strategic Behavioural Communication .....
- Strategy: 2 Expansion of Comprehensive Programme for risk and harm reduction .....
- Strategy: 3 Facilitate and Expand Interventions for safe migration and mobility .....
- Strategy: 4 Strengthen management and control of STIs
- Strategy: 5 Expand Voluntary Counselling and Testing (VCT)
- Strategy: 6 Expand and Strengthen Prevention of Mother to Child Transmission Program
- Strategy: 7 Expand the prevention of transmission in health care delivery settings
- Strategy: 8 Develop and implement workplace policy and programs
- Strategy: 9 Prevention among people living with HIV and AIDS (Positive Prevention).....

## **TREATMENT CARE AND SUPPORT (2000)**

### **Objective**

By 2011, ensure universal access to quality treatment, diagnostics, care and support services for infected, affected and vulnerable groups in Nepal within a context of a comprehensive response to HIV/AIDS

### **Strategic Outcomes**

- Increased national capacity to provide quality diagnostic, treatment and care services
- Increased availability of appropriate and differentiated care and support services to infected, affected and vulnerable population
- Increased involvement of private sectors, civil societies, communities and family for treatment, care and support to the infected, affected and vulnerable groups
- Increased importance of the role of support groups of infected, affected and vulnerable people in treatment, care and support
- Established and monitored continuum of prevention to treatment, care and support
- Established standardised clinical care, ART, OIs and PEP services both in the public and the private sectors.
- Established impact mitigation strategies and programmes in place, adequately resourced and accessed equitably by the infected, affected and vulnerable groups

### **Strategies towards these outcomes**

- Strategy: 1 Increase access to quality treatment, diagnostics, care and support for ART, STI and OI.
- Strategy: 2 Stigma and discrimination reduction.
- Strategy: 3 Community and Home Based Care
- Strategy: 4 Paediatric Care (Including Orphan and vulnerable children) .....
- Strategy: 5 Impact mitigation programme .....
- Strategy: 6 Prevention and clinical management of OIs and HIV/AIDS related illness
- Strategy: 7 Expansion of Antiretroviral therapies
- Strategy: 8 Management of HIV related co-infections

### **Cross cutting components**

## **ADVOCACY, POLICY AND LEGAL REFORM (3000)**

### **Objective**

By 2011, comprehensive and well implemented legal framework on HIV/AIDS promoting human rights and establishing HIV/AIDS as a development agenda

## **Strategic Outcomes:**

- HIV/AIDS prioritized as national development agenda and included in 11th Five year plan as P1 program under social sector.
- Rights of infected, affected and vulnerable groups insured through effective legislative framework.
- Networks of PLWH and MARPs operational
- HIV/AIDS response decentralized and coordinated.
- Multi-sectoral response to HIV/AIDS strengthened and expanded

### **Strategies towards these outcomes**

- Strategy: 1 Establish HIV/AIDS as a development agenda  
Strategy: 2 Ensuring the rights of the infected, affected and vulnerable groups.

## **LEADERSHIP AND MANAGEMENT (4000)**

### **Objective**

Enhanced leadership and management at national and local levels for effective response to HIV/AIDS

### **Strategies towards these outcomes**

- Strategy: 1 Operationalise three ones principle  
Strategy: 2 Promote multisectoral and decentralised response to HIV/AIDS  
Strategy: 3 National capacities for expanded response strengthened.

## **STRATEGIC INFORMATION (SURVEILLANCE, M & E) (5000)**

### **Objective**

Strategic information to guide an effective response improved and used for planning and implementation

### **Strategies towards these outcomes**

- Strategy: 1 One Monitoring and Evaluation system in place and operational  
Strategy: 2 Second Generation Surveillance System strengthened  
Strategy: 3 Strategic Information System created and functional .....
- Strategy: 4 Operational Research carried out to inform gaps in the response

## **FINANCE AND RESOURCE MOBILISATION (6000)**

### **Objective**

By 2011 Sustainable financing and effective utilization of funds

### **Strategies towards these outcomes**

- Strategy: 1 Accelerate resource mobilisation within the country and outside.  
Strategy: 2 Develop and implement multisectoral policy .....
- Strategy: 3 Establish a semi-autonomous body, with a flexible financial management system and rules.
- Strategy: 4 Establish simplified, efficient and transparent financial system

# National HIV/AIDS Policy

National HIV/AIDS Policy with 12 major points on HIV/AIDS Prevention and Control was endorsed in 1995. Based on which National response has been planned and implemented.

## 12 Key Policy Statement

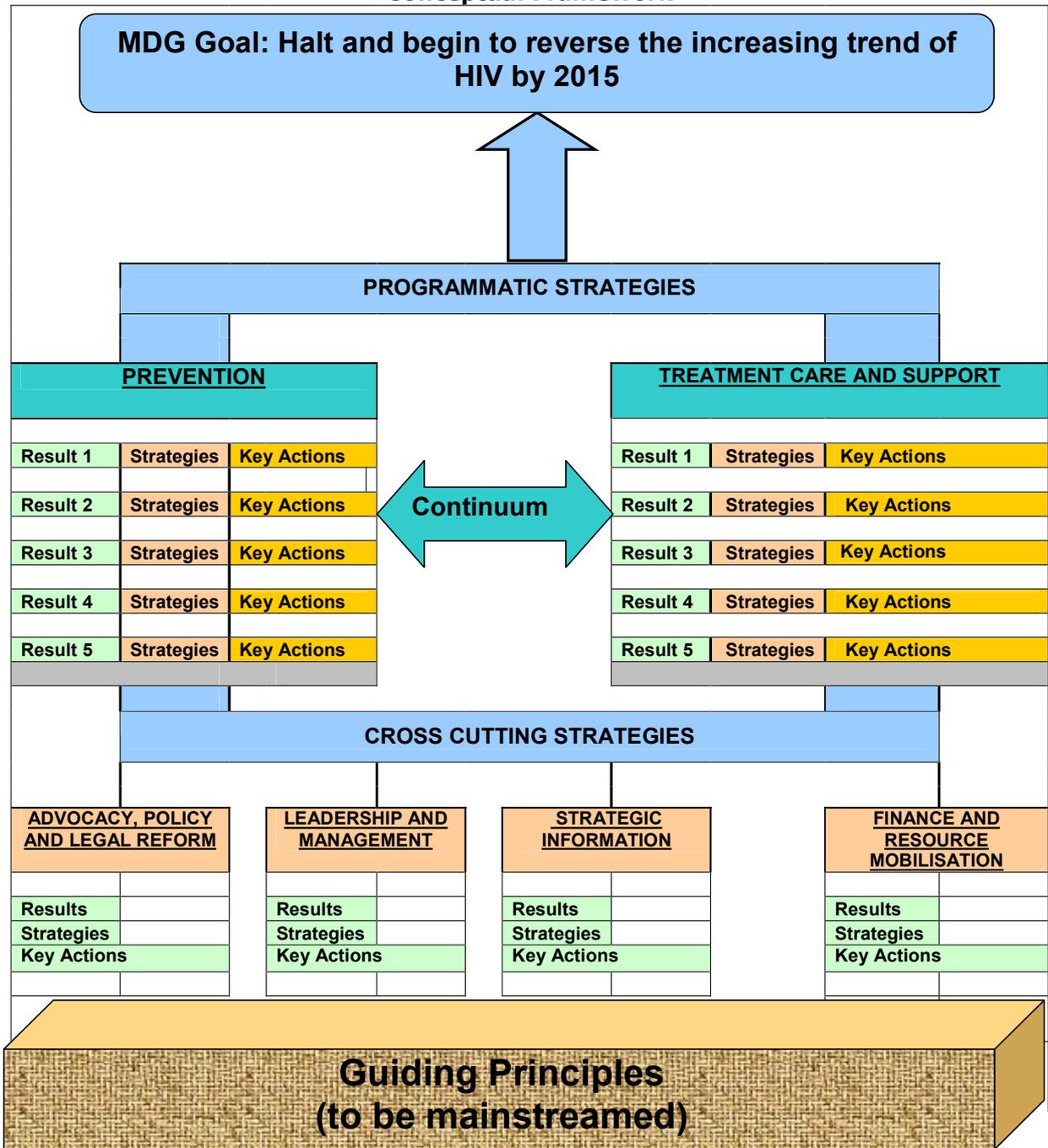
- HMG will give high priority to HIV/AIDS and STD prevention program
- HIV/AIDS and STD prevention activities will be conducted as multisectoral program
- The activities will be implemented on the basis of decentralization
- The activities will be implemented through both governmental and nongovernmental sectors
- The activities will be coordinated, followed up and evaluated in both governmental and nongovernmental sectors.
- The activities will be integrated with other program both on Governmental and nongovernmental sectors.
- Safer sexual behavior will be promoted.
- Counseling and other services will be provided to PLHAs.
- Discrimination on the basis of HIV status will not be done.
- Results of the blood test will be treated with confidentiality.
- Reports of the blood test will be made available to NCASC.
- All the donated blood will be screened before transfusion.

National AIDS Coordination Committee (NACC) under the chairmanship of Health Minister and District AIDS Coordination Committees (DACC) with the District Development Committee chairperson as the chair are the two main structures envisioned by National Policy for the policy and strategic guidance and coordination to implement national programs at the central and district level respectively.

# Guiding Principles for National HIV/AIDS Strategy 2006 – 2011

1. Since HIV/AIDS is more than a public health priority and is a complex, multifaceted problem affecting all aspects of society, **decentralised, multi-sectoral and interdisciplinary** involvement must be established for building an adequate response to the HIV epidemic. As such **commitments, responsibility and accountability** of wider health sectors and sectors outside of health will be promoted through high level political commitments.
2. The primary focus of the strategy will be on **prevention and universal access for treatment, care and support** with strong **linkages** to treatment, care and support and impact mitigation **continuum**.
3. The response to HIV/AIDS will be **rights based** with a specific focus on the rights of people infected and affected by HIV/AIDS.
4. **Gender considerations** must be central to the development of programmes and interventions.
5. **Evidence informed policy and programmes** will feature in the strategy with strategic information and best practices linked to the programme design and implementation. As such, **resource allocations** must take into consideration **defined priorities** based on the vulnerability and risk factors associated with various groups and communities ensuring adequate focus on most at risk population, vulnerable and marginalised.
6. People and communities must be **empowered to protect themselves** against HIV infection within a supportive environment. Interventions to **mitigate economic impact** of HIV and AIDS will be promoted at all levels.
7. **Equal and equitable access** to basic care and services must be guaranteed for all persons infected and affected by HIV/AIDS.
8. **GIPA** (Greater Involvement of People Living with AIDS) principle must be ingrained at all levels in the design and implementation of policies, strategies, programmes and projects.
9. The strategies, programmes and activities must take into consideration the impact of conflict and the opportunities of the **post conflict scenario**.
10. **Public Private Partnership** concept shall be developed and expanded at all levels of prevention, treatment and care programmes.
11. The strategy must emphasise the **national and international commitments** and ensure that such commitments are honoured and implemented.

**Conceptual Framework**



# COUNTRY SITUATION

A country with immense cultural and geographical richness and diversity, Nepal is also home of some 23 million people (40.2% under age 15). The density of population is 157.3 persons per sq. km with high annual population growth rate of 2.25. The rapid population growth is a major development challenge in the country. Basic development indicators are far from satisfactory despite some improvements marked over the period. Health indicators remains poor with high maternal mortality rate (539 per 100,000 live births) and infant mortality rate (under five mortality rate is 91 per 1000 live birth). Over 90% of maternal deaths are from rural areas and only 9.8% from urban areas. However utilisation of ante natal and post natal services has increased with 57 and 13 percentages respectively.

Ranked at 140 in Human Development Report (2004) with per capita income US\$ 240 (ranging from US\$ 240 to below US\$ 200), the lower socio economic status can be explained by low life expectancy (71 years national average), low literacy rate (65 for males, 42.8 for females) and a fifth of total population still without access to safe water supply and uneven inclusion of people from different ethnic and geographical background<sup>1</sup>. The national average often shrouds the geographical and ethnic variation Geographical disparity is also a major challenge in health sector. For example, the life expectancy in Mugu district is only 37 years, where as it is 74.4 in Kathmandu. Nevertheless, in 2003-04, estimated poverty headcount was 31 percent in Nepal, compared to 42 percent in 1995-96. Between 1995-96 and 2003-04, the incidence of poverty declined by 8 percentage points in rural areas (from 43 percent to 35 percent) and by 12 percentage points in urban areas (from 22 to 10 percent).

Poverty, deprivation, discrimination are core underlying causes of poor development in Nepal. Moreover, the decade long armed conflict has had tremendous implications on the overall development in the country.

Nepal is fully committed to the Millennium Development Goals (MDG). The recent MDG progress review, however, has indicated that progress has been far from satisfactory in the case of several MDGs. This calls for better alignment between the MDGs and PRSP policies and activities<sup>2</sup>.

## 1. The HIV/AIDS Situation

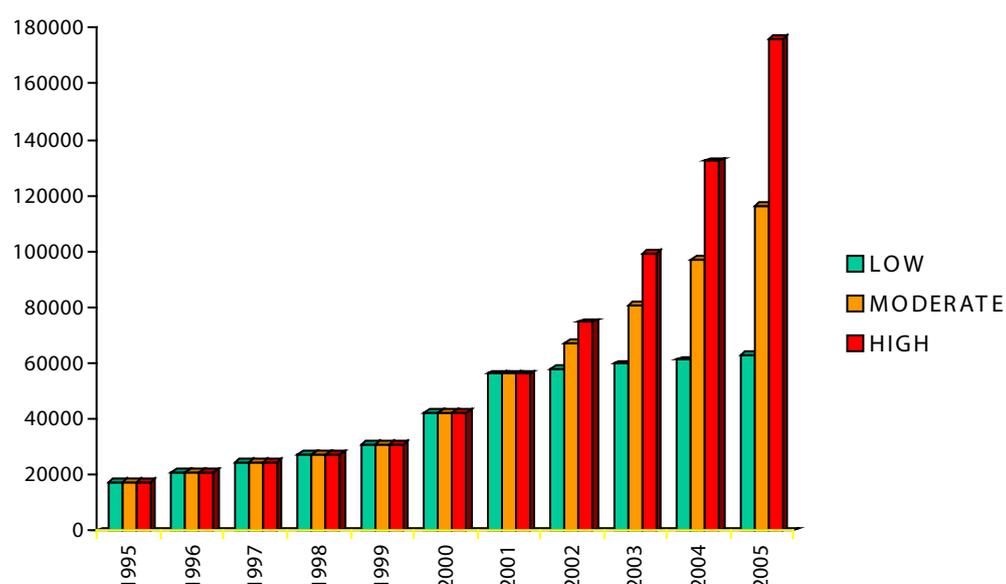
Since the identification of the first HIV+ positive case in the country in 1988, the epidemic has been gradually gripping hard on people from all walks of life. Currently, there are 70,256 people estimated to be living with virus. The projection made little earlier in 2004 highlighted three scenario based on current level of transmission and other available epidemiological evidences. One estimate made earlier with an estimated sero prevalence of 1 to 2 percent among the age group 15 to 49 (Chin 2000)<sup>3</sup>, the HIV may become the nation's number one killer among the people of that age group. With consistently exceeding the prevalence of more than five percent in certain groups (IDUs, Migrants) years after years, the country has remained at a critical juncture of "**concentrated epidemic**" stage with looming threats of epidemic spreading to the general population.

1 Gurung, H (2006), From exclusion to inclusion Socio Political Agenda for Nepal. Social Inclusion Research Fund, PO Box 1966, Kathmandu

2 GoN/UNDP (2006), Millenium Development Goals, Needs Assessment for Nepal, , National Planning Commission, Government of Nepal, Kathmandu 2006

3 Chin J. (2000). An assessment of the HIV/AIDS situation in Nepal (unpublished)

Estimated number of People Living with HIV/AIDS in Nepal



The fact that the epidemic remains extremely dynamic, growing and changing character as the virus exploits new opportunities for transmission, poses constant challenges for programme intervention and generating adequate strategic information. Recent integrated bio-behavioural surveys indicated that the HIV prevalence among IDUs is 51.6% in Kathmandu, 31.7 percent in Eastern Tarai districts, 11.7 percent in the Western Tarai districts, and 21.7 in Pokhara (New ERA/SACTS, 2005). In another group i.e. Female Sex Workers in 16 Tarai highway districts in the East, HIV infection has decreased significantly since 1999, from 3.9% to 1.5% in 2006, whereas as in Pokhara infection among FSWs has remained low and constant at 2%. In Kathmandu, infection recorded in 2006 was 1.4% compared to 2% in 2004 and 15.7% among a sub group of FSW – street based in 2001<sup>4</sup>. Besides, another sub group of population MSM for the first time recorded 3.9 percent prevalence in Kathmandu in 2005<sup>5</sup>.

The most recent national estimates (NCASC/UNAIDS/WHO/FHI 2006) of people living with virus indicated that the highest burden of HIV/AIDS rests on seasonal labour migrants followed by the clients of sex workers and rural female low risk population.

Population at higher risk	Total	% of total cases
IDUs	6493	9.2
MSMs	2517	3.6
Sex workers	1118	1.6
Clients of sex workers	13595	19.4
Seasonal labour migrant	32341	46.0
<b>Sub total</b>	<b>56064</b>	<b>79.8</b>
Population at lower risk		
Urban female low risk population	1886	2.7
Rural female low risk population	12306	17.5
<b>Sub total</b>	<b>14192</b>	<b>20.2</b>
<b>Total estimated people living with HIV</b>	<b>70,256</b>	

4 NCASC (2005). National Estimates of adult HIV infections, Kathmandu

5 Integrated Behavioural and Biological Survey (2004) among MSM population in Kathmandu Valley (Unpublished)

The country's vulnerability to HIV/AIDS and AIDS are further exacerbated by the number of factors, such as

- Geographical and ethnic diversity is a major challenge to design an intervention that reaches to un-reached groups with culturally acceptable ways.
- Wide spread poverty, inequality and illiteracy further compounds the challenge.
- Civil conflict and political instability has led to a shift in national priority.
- Increasing labour migration due to lack of economic opportunity or fuelled by the civil conflict has left women and children in more vulnerable situation.
- Girl trafficking particularly to brothels in India has been a chronic social problem for long time.
- Increasing number of young girls pushed to sex trade in major urban areas.
- Varied level of knowledge about HIV transmission among most at risk groups and young people.
- Uptake of prevention and health service very low.

## **2. Review of previous Strategy**

The National HIV/AIDS Strategy (2002 – 2006) was a milestone in national efforts to combat the epidemic in the country. The strategy was instrumental in accelerating the responses by expanding the partnerships; broadening the scope and opportunities for innovative yet need driven programming; and by initiating the dialogue at all level for policy and structural reformation process. In other words, the Strategy offered a strong foundation on which adequate response mechanism could be developed to respond the changing scenario of the epidemic and the need of the people.

Five priorities were identified for the Strategy (2002 – 2006); they were, i) prevention of STIs and HIV among the vulnerable groups, ii) prevention of new infections among young people, iii) ensuring care and support services are available and accessible for all people infected and affected by HIV/AIDS iv) expansion of monitoring and evaluation frame through evidence based effective surveillance and research v) establishment of an effective and efficient management and implementation mechanism for an expanded response. Towards its implementation, a National Operational Plan for HIV/AIDS Control (2003 – 2007) were prepared and costed to US\$ 95 million for five years.

During implementation of this strategy, the country witnessed a major political conflict impacting on all aspects i.e. political, social, economical and other development related aspects. HIV/AIDS sector was also affected by the conflict induced events and changes though to a lesser extent than other programmes, the overall achievements are mixed.

During this period, the increasing debate, discussion and responses to some of the international commitments further influenced the implementation of the strategy. Millennium Development Goals, UNGASS, Universal Access and "three ones" were the major discourses around which national responses and dialogues were structured.

Prevention activities were rapidly expanded both in scope and magnitude. Based on epidemiological data generated through surveillance and other researches new geographical areas were covered through prevention programme. Likewise, large numbers of newer partners and groups like MSMs were intimately involved in the programme design and implementation. The scope of partnership was expanded to community based organisations, constituency groups of vulnerable people and the NGOs in the regions and the districts. As a result, in 2005/06 annual plan almost 70% of total resources were budgeted to be executed through NGOs. The GFATM – II input during this period was both catalytic in stimulating implementation of the Strategy as well as filling the gaps in the resources. Towards the end of the Strategy, in 2005/2006 the resource mobilisation reached to US\$ 14 million compared to US\$ 5.4 million in 2004 and 2.5 million in 2002/03.

Prevention programme reached almost 35% of FSWs, 8.6% of IDUs, 5.4% of MSMs and less than 1 percent of migrants population<sup>6</sup>. While these results are certainly encouraging and a breakthrough in the case of MSMs who were recognised in the national strategy and responses, the overall impact of this result in changing the epidemiological scenario is not adequate. As indicated in the same report, only 3.1% of FSWs, 5.2% of IDUs, 0.03% of migrants and 0.04% of MSMs received HIV testing in the and who know the results. Clearly, service delivery is not adequate. The spark of light however are the MARPs themselves coming up in an organised way to influence the policy and programme as well as to build capacity and cater the need of their own constituency.

Treatment, care and support services were also either established or expanded to reach wider populations. VCT centres (over 100 with different capacity and coverage), ART (7 sites reaching some 500 PLHAs) sites, and PMTCT centres were expanded to many parts of the country as well as guidelines and manuals were developed. Similarly, CHBC guidelines were developed and number of training were conducted and some CHBC were piloted by networks and NGOs which offered a good experiences and information to build on it for further expansion of the activities.

In spite of these success and innovative approaches observed in the previous strategy period, the implementation of the Strategy encountered number critical challenges and certain commitments of the Strategy were not fully realised.

The quality and level of leadership and the management as anticipated in the Strategy (2002 – 2006) were not achieved despite repeated efforts and dialogue at various levels. The strategy had anticipated to set up a National Trust Fund to fight HIV/AIDS to speed up multisectoral responses. Numbers of Task Force were formed to workout the appropriate model for such institution that can operate effectively and efficiently as an autonomous body. Similarly, the national coordinating bodies e.g. National AIDS Coordination Committee, National AIDS Council and District Coordination Committee remained rather passive largely due to its structural limitations and lack of clear roles and means to influence policy/ programme decisions. Donor harmonisation and coordination is an on going challenge that requires strong commitments from policy makers, EDPs and Civil Society Partners.

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6 NCASC (2005) Status of the 2005 National Response to the UNGASS Declaration of commitment on HIV/AIDS, Nepal County Report

# 2

## UNIVERSAL ACCESS TARGETS

In response to the global efforts toward achieving universal access for HIV/AIDS prevention, treatment, care and support, the Government of Nepal has also dedicated itself towards achieving universal access for HIV/AIDS services to its people<sup>7</sup>. As such, the national responses needs to be scaled up, commitment to achieving the Three Ones is translated into firm actions; and the Global Task Team recommendations on improving institutional and donor coordination are seriously taken up at the national and international levels.

The current coverage of HIV/AIDS prevention, treatment, care and support services is limited. The national response is largely focused on prevention services and links between prevention, treatment, care and support are insufficient. The geographic distribution of services does not reach large portions of groups who are most vulnerable and most at risk of HIV infections.

There are a number of challenges to achieve a scaled up and comprehensive HIV/AIDS programme in Nepal. These included:

- An incomplete policy and legal framework to support a comprehensive national response
- Under developed multi-sectoral aspects of current strategies and plans
- A lack of a transparent system for mobilising, pooling, disbursing and monitoring HIV/AIDS funds including donor harmonisation
- Inadequate numbers and skills of human resources to provide the coverage and quality of services needed
- Weak systems for coordination, monitoring and evaluation and the supply of essential commodities
- A shortage of and poor distribution of service points
- Insufficient opportunities for partnership for all stakeholders in the national response

A coverage target of addressing 80% of most-at-risk populations' needs for HIV/AIDS prevention, treatment, care and support is envisaged for 2011. The key targets for achieving this are:

- Reformed legislation and policy to ensure protection from discrimination for vulnerable groups and improved programme access for most-at-risk groups
- A fully functional, semi-autonomous multi-sectoral national authority with decentralised bodies and systems in place
- A National Strategic Plan (2006-2011), including detailed targets, resource requirements and monitoring and evaluation systems
- Strong and broad partnerships (including public-private) where partners have capacity for strategic planning, HIV/AIDS mainstreaming, resource management, service delivery, monitoring, evaluation and reporting
- A single transparent national AIDS account and resource mobilisation and monitoring mechanism in place
- Skilled human resources available in all districts, particularly in areas where they are most needed (70% coverage)
- Expanded infrastructure and functional public and private laboratory and supply management systems

The current strategy has taken into accounts of the issues, obstacles and targets defined in the

<sup>7</sup> Universal Access Targets, Roadmaps and other details were worked out in December 2005 jointly by the Ministry of Health, National Centre for AIDS and STI Control (NCASC) and the civil society organizations including private sectors. *(Please refer to final report for further detail)*

Universal Access document. The targets and strategies for achieving them are discussed and addressed in this National Strategic Plan (2006-2011). The subsequent multi year action plan i.e. National Action Plan will further elaborate the specific targets and budgets.

**10 recommendations of the Global Task Team (July 2005):**

1. National mechanisms that drive implementation and provide a basis for the alignment of external support.
2. Macroeconomic policies that support the response to AIDS.
3. Alignment of external support to national strategies, policies, systems, cycles, and plans.
4. Approaches to progressively shift from project to programme financing, and harmonisation of programming, financing and reporting.
5. Closer UN coordination on AIDS at country level.
6. UN system-Global Fund problem-solving mechanisms at global level.
7. Clarification of the division of labour among multilateral institutions
8. Increased financing for technical support.
9. Country assessments of the performance of multilateral institutions, international partners and national stakeholders.
10. Strengthening of country monitoring and evaluation mechanisms and structures that facilitate oversight.

## 1 - Advocacy, Public Policy and Legal Framework

### ROADMAP

#### 2008

- Draft HIV/AIDS Bill, regulations, bi-laws & policies endorsed by Government Nepal
- Ministerial policy leaders and implementing bureaucrats of all relevant ministries integrate HIV/AIDS activities into their policies, plans and programmes
- A functional HIV/AIDS unit established and staffed with appropriately trained focal persons at all ministries to carry out HIV/AIDS-related activities
- Champions and leaders from diverse groups (media persons, leaders from I/NGOs, political parties, communities, transport union, trade union, sports, religious, youth & adolescents, women and other vulnerable groups) developed at different levels to incorporate AIDS activities into their plans
- Legislative frameworks and national policies regarding prevention, treatment, care & support issues established, accepted and monitored
- An active network of civil society organizations established as a pressure group to monitor the establishment and implementation of policies and programmes

#### 2010

- All laws and by-laws fully enacted and enforced
- All concerned stakeholders sensitized on HIV/AIDS laws and policies
- HIV/AIDS policies decentralised as cross-cutting development issues and supported by adequate resources within all government sectors

## 2 - Strategic Planning, Alignment and Harmonization

### ROADMAP

#### 2007- 2008

- A National Strategic Plan (2006-2011) including a single M&E framework finalized and operational (2007)
- Functional national institution to implement and monitor multi-sectoral action framework
- External development partners aligned to support national strategies, systems and planning and reporting cycles
- Capacity building package developed and implemented based on NSP and on new capacity assessment of PLWHAs, vulnerable groups, young people and other concerned stakeholders at each level

#### 2010

- Impact evaluation of national response completed based on NSP (2006-2011)

### 3 - Sustainable Financing

#### ROADMAP

##### 2008

- National financial monitoring and evaluation system developed and endorsed by stakeholders
- National AIDS Account established
- Needs assessment conducted and gaps identified for sustainable financing of HIV/AIDS Programmes at national level
- National government budget for HIV AIDS Programme allocated as a separate entity (Semi autonomous entity)
- Effective national resource mobilisation initiatives for HIV/AIDS prevention, treatment and care and support implemented
- Mechanism for disbursing district HIV/AIDS budgets identified (in accordance with the Local Self Governance Act) for the local bodies in 16 full devolution districts
- All donors/multisectoral institutions coordinate their national HIV/AIDS programme financing through simplified and efficient financial system

##### 2010

- A fully functional national AIDS Account with an appropriate M&E system
- A fully functional mechanism for disbursing HIV/AIDS funds

### 4 - Human Resources

#### ROADMAP

##### 2008

- Human resource needs (positions, number and required skills) assessed for the HIV/AIDS Programme
- Human resource development plan developed and implemented
- Mobilize private sector involvement in the treatment, care and support required for the national response
- A functional training unit for the HIV/AIDS Programme established within the government structure and aligned with NGO training facilities
- Trained human resources available in 75 districts, including:
  - 200 trained planners, managers, epidemiologists, social scientists finance managers and data processors
  - 75 District AIDS Coordination Committee members (75x11=825) trained on planning, monitoring, leadership, advocacy and resource mobilisation for HIV prevention, care and support
  - 250 physicians, 300 nurses, and 300 clinical officers on VCT, PMTCT, OI, STI and ARV therapy and monitoring
  - 600 counsellors including home based carers, 150 Lab Technicians and 100 Pharmacists trained on VCT, PMTCT, HIV testing and ARV monitoring
  - 2000 peer educators (including IDUs, PLWHAs, MSMs, sex workers) trained on BCC and HIV prevention strategies
- Prepare Training Matrix for coordinated Human resource development

##### 2010

- Service coverage and its quality, provided by the trained service providers assessed and refresher training given
- Service providers (Physicians, Nurses, Clinical Officers, Counsellors, Lab Technicians, Pharmacists) skilled to provide services on VCT, PMTCT, HIV Testing, ARV monitoring

## 5 - Organization and Systems

### ROADMAP

#### 2008

- A sufficiently empowered and resourced semi-autonomous, multi-sectoral national authority established
- District AIDS Coordination Committees and Village AIDS Coordination Committee functioning in each district and village with strong linkage to the national authority
- Policy support and capacity building for a quality system of HIV treatment, care and support developed and endorsement for public and private laboratories

#### 2010

- Fully functional semi-autonomous, multi-sectoral national authority with decentralized systems and mechanisms in place
- Fully functional District AIDS Coordination Committees in all 75 districts
- Functioning national and private laboratory and supply management systems

## 6 - Infrastructure

### ROADMAP

#### 2008

- Specialized clinical infrastructure for antiretroviral treatment, prevention of mother to child transmission and opportunistic infections established in 5 regional hospitals and all medical college hospitals.
- Completion of at least 50% of a facilities expansion programme for the provision of the following services:
  - 2 VCT centres in each of 75 districts (150)
  - 300 STI treatment centres based in primary health centres and district hospitals
  - 4 Information and counselling centres in each of 75 districts (300)
  - 25 Referral Services Centres based in Zonal and Regional Hospitals and Teaching Hospitals
  - 25 well-equipped laboratories to perform HIV/AIDS diagnosis and ARV monitoring
  - 5 regional/nodal hospitals for oral substitution treatment programmes for IDUs
- Updated protocols, manuals, guidelines, quality assurance standards and IEC/BCC materials on prevention and care accessible at all levels (and including linkages and referral systems between various facilities and services)

#### 2010

- Completion of the facilities expansion programme listed above
- Specialized clinical infrastructure on ART, PMTCT, OI at 14 Zonal hospitals
- Completion of training of facilities and community-based human resources to operate expanded services
- Fully functional VCT/STI/HIV services with referral systems at all levels

Quality assurance system in place for expanded services

## 7 - Partnerships

### ROADMAP

#### 2008

- Implementation of the national partnership framework, including formal recognition and mandate to multi-sectoral representation in the National Partnership Forum and the regular review of partners' roles and performance
- Expansion of civil society roles in the national response at decision-making and implementation levels
- Formation and operationalization of a district level partnership network
- Implementation of a partner capacity-building programme in areas of programme development, management and implementation

#### 2010

- Formal public-private partnership networks contributing to the development, implementation and review of the national HIV/AIDS response

# 3

## TARGETING SERVICE DELIVERY

In a low prevalence scenario, the needs for services vary widely with groups. All the groups may not need all the services at the same level and frequency. Therefore service package differentiated by target groups not only maximise the benefit but also is cost effective. The service package will be specifically targeted to the MARPs as per their needs. The following matrix explains the targeted and specialised service package for each group.

Service Delivery Package Targeted by Groups

SN	Strategies/service package	MARPs (and their partners)					ARPs	Vulnerable Populations	PLHA
		IDUs	Sex Workers	MSM	Migrants	STI Patients			
1	STI/OIs treatment	√	√	√	√	√	√ As per need and referral	√ As per need	√
2	Comprehensive Harm Reduction, treatment and Rehabilitation	√	√ When SWs are IDUs						√
3	Treatment (ARV, OIs)								√
4	Care and Support (Nutrition prg, clinical care, HBC)								√
5	PMTCT	√	√		√	√	√	√	√
6	TB Co-infection	√				√			√
7	Livelihood Prg	√	√					√ (OVC)	√
<p><b>Basic Minimum Package available to all groups:</b> BCI interventions (Life Skills, peer-education, health promotion, mass awareness), Condoms, VCT, STI referral, PEP, Blood Safety</p>									
<p>MARPS: Most-at-risk population ARPS: At-risk population MSM: Men having sex with men</p>					<p>SW: Sex Workers PEP: Post Exposure Prophylaxis IDUs: Intravenous Drug Users</p>				

The basic minimum package will be made available to all groups and whole population, but the certain services are available to certain groups only because of the specific need and situation of that particular group. As such, the respective MARPs will receive all the elements as a comprehensive package along with Basic Minimum Package, where as Basic minimum package will be available to all other groups and population as necessary. For the cost effective delivery

of the services and to ensure the accessibility and equity of the MARPs, a strong referral system will be established.

Besides, experiences have shown that a specialised and isolated services designed only to socially disadvantaged groups like FSW, MSM and IDUs are likely to increase social stigma. But it is of utmost importance to understand that the general services are not easily accessed by these groups because of discriminatory behaviour of service providers.

Clearly, unless the delivery system is complemented by other interventions like quality and accessible VCT services, STI treatment and reduction of stigma and discrimination, the impact of service packages will be limited. Moreover, since many socially marginalised and discriminated groups are not accessing the general health and development services because of various social and other factors, it is justifiable for specialised and targeted services. The MARPs groups are conscious that the more they establish separate (and often parallel) services the more they will be excluded from rest of the society. Therefore a conscious and balanced approach is necessary while designing the interventions and delivering it.

Besides, given the "concentrated" nature of epidemic, sectoral strategy would facilitate operationalisation of the national Strategy. Therefore based on evidences and best practices, development of sectoral strategy and detail work-plan would be encouraged.

For the better designing and targeting of the services, the MARPs and ARPS are defined and categorised as follows

MARPs	ARPs
Group with <ul style="list-style-type: none"> <li>➤ Identified risky behaviours contributing to high transmission of HIV</li> </ul>	Group with <ul style="list-style-type: none"> <li>➤ Certain risky behaviours that is highly likely to contribute to the transmission of HIV</li> </ul>
IDUs, MSM, MSWs, FSWs, Migrants and spouse, Prison population <sup>8</sup>	Youth, Uniform Services, Street Children, Trafficked Girls,

<sup>8</sup> Based on Based on international experiences Prison population is considered as MARPs. In Nepal further researched evidence is required to reconfirm the prevailing risky behaviour in Prison

**E**ffective prevention strategies are key to combating the AIDS epidemic. Prevention must continue to remain the mainstay of the HIV/AIDS Strategy in Nepal. As such, much has been learned over last two decades on strengths and weakness of prevention programmes in Nepal. There is adequate documented evidence on how different strategies and initiatives have helped improve the knowledge level on HIV/AIDS among the youth; how the harm reduction services can be accessed by IDUs; and how the other most at risk populations (MARPs), for example, sex workers (SWs), migrants and men who have sex with men (MSM) can be empowered to improve their access to information and services focusing on specific behaviour change intervention programs. While the achievements made at certain intervention areas so far are encouraging, the overall epidemiological impact at the national level is not adequate

It is a globally established fact that the rising trend of the AIDS epidemic can only be reversed if effective HIV prevention programmes are intensified in scale and scope. In concentrated epidemics like that of Nepal, it is absolutely important to design, scale-up and expand targeted intervention programs aiming at the most at risk populations in order to curb the epidemic. The prevention strategies for the coming period (2006 – 2011) therefore will put emphasis on the intensification both in scale and scope of the programme, focusing on the MARPs as the main targets.

Lesson learned globally has shown that when prevention strategies are linked with treatment, care and support service delivery programmes, there is a greater impact on the epidemic. Subsequently, the protection, promotion and respect of human rights (related to people living with and affected by HIV/AIDS (PLHA) and other vulnerable populations) are essential prerequisites to effective planning, programming and implementation of HIV prevention activities and thus, maximum efforts should be made to frame and implement prevention strategies within the human rights framework. Among all these, special attention must be also given to prevention of HIV and AIDS among positive persons through comprehensive positive prevention service delivery packages.

HIV prevention, if adequately resourced can also have a major impact on other national priorities including control of sexually transmitted infections (STIs) and treatment for tuberculosis co-infection, as well as addressing gender equality, health promotion and education, drug issues and improving health services. In doing this, there is a need for all national stakeholders to come together in strong coordination, backed up by a conducive and supportive policy environment to scale-up prevention programs.

### **Objective:**

By 2011, HIV program coverage will be 70 - 80% among the MARPs and reduction of new HIV infection among general population.

### **Strategic Outcomes:**

- Improved knowledge and safe behavioural practices of all target groups (safer sex practices and safer injecting practices)
- Increased availability and access to appropriate and differentiated prevention services

- Increased acceptance of HIV and AIDS and enhance non-discriminatory practices affecting marginalized and most at risk populations
- Reduced risk and vulnerability to HIV infection of all target populations

## Targets and indicators

Prevention programme coverage targets<sup>9</sup>

	2006-08		2009		2010		2011	
	%	Nos.	%	Nos.	%	Nos.	%	Nos.
IDU	40	7940	55	10917.5	65	12903	80	15880
MSM (including MSWs)	40	51400	50	64250	60	77100	80	102800
Female Sex workers	75	22312.5	60	17850	70	20825	80	23800
Clients of sex workers	2	24780	50	619500	60	743400	70	867300
Migrants	20	247800	30	371700	60	743400	80	991200
Prison	50	2840	60	3408	70	3976	80	4544

## Indicators

	Indicators	UA Targets for 2008 2011	
		2008	2011
1	Percentage of female sex workers reporting the use of a condom with their most recent client	40	80
2	Percentage of men reporting the use of a condom the last time they had sex with a male partner	35	80
3	Percentage of IDUs who have adopted behaviours that reduce transmission of HIV i.e. who both avoid sharing nor sterile injecting equipment and use condoms, in the last month	50	80
4	Percentage of MARPs who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission ( <i>By MARPs, Age and Sex</i> )	80	80
5	Percentage of young people who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV ( <i>By age and sex</i> )	90	90
6	% of HIV+ pregnant women receiving a complete course of ARV prophylaxis to reduce the risk of MTCT	50	80
7	% of orphan and vulnerable children (OVC) who received a basis external support package (e.g. School fee, shelter and food)	50	80

## Strategy: 4.1 Expansion of Strategic Behavioural Communication

Strategic Behavioural Communication (SBC) is a process for promoting and sustaining positive or risk-reducing behaviours in individuals and communities by distributing tailored health and HIV/STI prevention messages in a variety of communication channels.

<sup>9</sup> **Coverage of Prevention programme (UNGASS definition).** Number of respondents who have participated in at least one of the HIV/AIDS prevention programme in the last 12 months. 1. Peer Education. 2. Exposed to targeted mass media. 3. STI screening and treatment. 4. Exposed to counselling and Testing. 5. Exposed to substitution therapy and safer injection practices

SBC is vital to confront cultural ideals — and the practices that clash with them and can set the tone for compassionate, responsible interventions. It can also produce insights into the broader socio-economic impacts of the epidemic. SBC strategies in HIV/AIDS aim to create a demand for information and services relevant to preventing HIV transmission, and to facilitate and promote access to care and support services.

An SBC strategy that is woven into the overall program and based on sound formative assessment can influence community discussion, social norms, and—when services and commodities are in place—individual and community behaviours. SBC should not be viewed as a collection of different, isolated communication tactics, but as a framework of linked approaches that function as part of an integrated, ongoing process.

It is estimated that between 6 and 9 billion condoms are distributed around the world every year. Quality-assured male latex condoms, when properly used, are a proven effective means of preventing the sexual transmission of HIV, some STIs and pregnancy. Since the beginning of the AIDS epidemic, condom distribution has greatly increased. As a result of increasing awareness about AIDS and STIs, many people in longer-term relationships are changing their sexual behaviours. Some people are abstaining from sex until after they are married; many have decided to remain faithful to their partners, and others have started using condoms regularly and consistently for protection. However, large numbers of people have yet to adopt safer sexual behaviours through correct condom use. The spread of AIDS would be slowed if more people used condoms.<sup>10</sup>

In Nepal, since the HIV intervention, ad-hoc studies have shown that there is an increase in the numbers of condoms being used but few studies have also shown that there is a lack of appropriate knowledge and misconceptions about appropriate and correct use of condoms. In most urban areas of Nepal, and in many rural communities, while men (and fewer women) can obtain good-quality a condom free or at low cost, there is still a growing but unmet demand for male and female condoms. Female condoms can serve as an effective method to help women have control over their sexuality.

Besides, increasingly reported risky behaviours among prison inmates coupled with repressive or non liberal attitude of the administration in the prison, need for an extra attention at the prison has become even more important than ever before. In totality, Nepal's population of sexually active men and women needs more condoms and lubricants.

## **Strategic Results:**

- 4.1.1 Improved health seeking behaviour and adoption or maintenance of healthy life styles (including abstinence and being faithful, as appropriate) by target groups**
- 4.1.2 Improved and continued safe sexual practices**
- 4.1.3 Enhanced responsibility and capacity for the prevention of HIV of all sectors of government, civil society and INGOs/NGOs**
- 4.1.4 Increased knowledge and social acceptance of HIV and AIDS issues among the general population**

## **Key actions:**

1. Utilize and expand peer-education approach to promote HIV prevention education for most- at-risk population and at-risk-population based on evidence and national needs
2. Expand the condom/lubricants provision, increase condom coverage specially in high

11 UNAIDS, World AIDS Campaign, 2001

- risk areas (hot spots) and continue marketing condom/lubricants through non traditional outlets (pan pasal etc)
3. Design and expand programs on health promoting lifestyles and health seeking behaviours for specific targeted groups
  4. Promote and create demands for voluntary counselling and testing (VCT), prevention of mother to child transmission (PMTCT) prevention services, and care and support for orphans and vulnerable children (OVC)
  5. Utilize and expand life-skills interventions for developing safer sexual behavioural practices and increasing access to services with special emphasis to young people and adolescents
  6. Continue vigorous campaigns (including media), community dialogue and mobilisation to create public awareness on HIV/AIDS/STIs
  7. Build management and leadership capacity of GOs, civil society organizations and MARPs for an effective prevention service delivery
  8. Promote condom and lubricants (male/female) use as fashionable, acceptable and responsible, and as an essential part of HIV/AIDS, sexual health and sex education among all populations, especially MARPs, women and young people
  9. Make condoms more widely available, ensuring privacy and confidentiality at the point of acquisition and, where appropriate, use peer distribution.
  10. Promote social marketing of condoms, lubricants needle/syringe and other commodities as a means for sustainable supply of commodities complementing supply through public services.
  11. Advocate condom availability in bars, nightclubs and hotels, prisons, barracks, lodging, etc. -- wherever people gather to have a good time or people are kept confined for long periods of time
  12. Ensure the production and distribution of high-quality condoms
  13. Encourage national and international reproductive health, family planning and AIDS programs, as well as donor agencies, to include condom provision and distribution in their programming and funding priorities

**4.1.5 Social marketing of condoms, lubricants, needle and syringes and other commodities established as strong and viable strategy**

**4.1.6 Increased availability and accessibility to both male and female condoms**

**4.1.7 Increased awareness and acceptance on appropriate and correct use of condoms by all populations including prison population**

**Strategy: 4.2 Expansion of Comprehensive Programme for risk and harm reduction**

In public health, 'Harm Reduction' is used to describe a concept aiming to prevent or reduce negative health consequences associated with certain behaviours. In relation to drug injecting, 'harm reduction' components aim to prevent transmission of HIV and other infections that occur through sharing of non-sterile injection equipment and drug preparations.<sup>11</sup>

In a country like Nepal where HIV infection among the Injecting Drug Users (IDUs) is 52% in Kathmandu, comprehensive harm reduction strategies carry a significant HIV prevention potential for both IDUs and the general population, especially since HIV transmission through sharing of non-sterile injection equipment is augmented by sexual transmission both among IDUs and between IDUs and their sex partners. Additionally, interventions for IDUs that reduce HIV risks also have the potential to engage drug users in drug dependence treatment services that may ultimately lead to abstinence from drug use. Finally, such programmes can help to avoid other

11 WHO, Harm Reduction Approaches to IDUs, 2006

harmful consequences of drug use, including hepatitis B/C infections and overdose deaths.

Successful harm reduction is based on a policy, legislative and social environment that minimizes the vulnerability of IDUs to HIV infection. Harm reduction for IDUs primarily aims to help them avoid the negative health consequences of drug injecting and improve their health and social status. Harm reduction approaches recognize that for many drug users total abstinence may not be a feasible option in the short term, and aim to help drug users reduce their injection frequency and increase injection safety.

### **Strategic Results:**

- 4.2.1 Increased and continued safe injecting as well as safe sexual practices**
- 4.2.2 Improved access and availability to commodities related to safe injecting and sexual practices**
- 4.2.3 Improved access and availability to quality services for drug treatment and rehabilitation including Oral Substitution Therapy (OST)**
- 4.2.4 Enhanced supportive environment and policy and legal framework to protect the rights of IDUs (*should also reflect in policy/advocacy component*)**
- 4.2.5 Reduction in number of IDUs**

### **Key Actions:**

1. Utilize and expand needle exchange programs (including disinfections programs)
2. Expand peer-outreach programs aiming at HIV prevention education and harm reduction of drug use (i.e. IEC materials and condom distribution)
3. Expand mass media campaigns to encourage condom use and safer injecting practices
4. Expand condom and other commodity distribution outlets through non-traditional places, especially targeting MARPs
5. Provide and increase quality drug treatment and rehabilitation services
6. Expand Drug Substitution Therapy (*Pharmacotherapy*)
7. Expand the provision of quality rehabilitation facilities in all affected areas and programs aiming at healthy lifestyle development
8. Establish functional referral mechanisms and linkages between drug treatment services and HIV prevention, care and treatment related services
9. Expand the partners and provide capacity building of (health) service providers/care-takers in counselling and drug-treatment related issues to IDUs
10. Increase community mobilization and partnership among families as well as private businesses (i.e. pharmacy) to create a supportive environment and promoting services for harm reduction
11. Promote family reintegration programme

## Consideration needs for Treatment Care and Support for IDUs

Estimates suggest that there are over 13 million IDUs worldwide (Aceijas et.al. 2004) and that globally, 5-10% of all new HIV infections can be attributed to injecting drug use (UNAIDS 2004). Nepal follows similar pattern with a high prevalence of HIV among IDUs.

Injecting drug use can also result in infection with hepatitis B (HBV), C (HCV) and D, and result in other health problems, including overdose, venous thrombosis and severe bacterial infections. Furthermore, some IDUs have a long history of mental illness without proper diagnosis or treatment. Many IDUs face social problems including stigma and discrimination associated with drug use and HIV and/ or hepatitis status. The economic pressure of supporting drug dependency and resulting crime, mean that a large proportion of drug users are periodically incarcerated, which results in additional negative social and health consequences.

Thus special considerations will be placed for HIV-positive IDUs to have equitable and universal access to ARV therapy on both public health and human rights grounds.

A comprehensive response for HIV among IDUs will combine prevention, treatment and other support services to ensure maximum uptake of services as early as possible.

In addition to HIV, IDUs have an increased incidence of drug dependence, several other blood-borne infections and injecting-related health issues

## Strategy: 4.3 Facilitate and Expand Interventions for safe migration and mobility

Migration and population mobility has always been a major economic activity in Nepal and is likely to remain a major source of income for the foreseeable future. While all types of mobility require adequate attention in terms of minimising the risk of HIV/AIDS transmission, special attention is required to those whose movements are likely to encounter risk and activities associated to risk (i.e. trafficked women and girls).

Migration is one of the structural factors associated with HIV infections. Migrant populations are at higher risk of contracting HIV because of their situation – in particular poverty, exploitation, and separation from families and partners - that put them at risk. Migrant populations are often working individuals, subject to poor and unstable living and working conditions. Such conditions usually mean that they have limited access to reliable and culturally appropriate information on HIV/AIDS and health services.

Many migrants live in legal limbo, having no stay or work permit in the host country and live in constant fear of deportation and therefore are difficult to reach. This factor combined with the hardships of daily life makes providing HIV testing, care, support and treatment particularly challenging for these populations. Additionally, migrants are subject to compounded forms of discrimination and stigmatisation, within and outside their own communities because of factors like HIV status, ethnic origin, religious beliefs and practices, socio-economic condition and more. This is especially true for those young girls, women and boys who are trafficked to India and other countries.

In Nepal, the numbers of those travelling to other countries has significantly increased. Many of them are returning with the infection and the impact is widely visible with their spouses and children being infected. In districts like Achham, in the Far Western Region, majority of households have either a person living with HIV and AIDS or are headed by the children of parents who have died because of AIDS related illnesses.

Additionally, mobility must address issues related to forced migration or events leading to human trafficking (i.e. abduction of children for labour, sex industry, trafficked women and girls/boys). Development of regional level policies and cross-border programs are required to protect their rights, provide services as well as integrate them back into mainstream society. Human trafficking particularly to Indian brothels has remained a chronic problem in the country compounding the vulnerability to HIV infections.

### **Strategic Results:**

#### **4.3.1 Improved health seeking behaviour and healthy life styles**

#### **4.3.2 Increased awareness on HIV and AIDS and adoption of safer sexual practices, including human trafficking**

#### **4.3.3 Increased access to and availability of support services and health services related to HIV and AIDS**

#### **4.3.4 Enhanced cross-border linkages and provision of services related to prevention, treatment, care and support**

### **Key Actions:**

1. Develop and expand programs utilizing returned migrants and their families to create awareness (including IEC materials) on HIV and AIDS and create demand of AIDS related services for those who are likely or planning to migrate
2. Increase the use of mass-media to disseminate and stimulate dialogue among community members and families on STIs, HIV and AIDS, vulnerabilities and possible risk-factors associated to migration, human trafficking and other mobility related events
3. Establish linkages to services, coordination and referral systems to provide social and health services in both Nepal and destination countries for HIV prevention, care and support and treatment
4. Expand awareness programmes on trafficking and HIV/AIDS and ensure the rehabilitation of trafficked women with easy access to quality care, support and treatment services
5. Utilize and expand pre-departure orientation and counselling on arrival programs on HIV prevention, care and support for abroad and seasonal migrants

### **Strategy: 4.4 Strengthen management and control of STIs**

Management and control of STIs involves designing programs and providing treatment services related to the treatment of STIs among MARPs. Testing and treatment of STIs can be an effective tool in preventing the spread of HIV. Individuals who are infected with STIs are at least two to ten times more likely than uninfected individuals to acquire HIV if they are exposed to the virus through sexual contact. In addition, if an HIV-infected individual is also infected with another STI, that person is more likely to transmit HIV through sexual contact than other HIV-infected persons.

Early detection and treatment of curable STIs should become a major and explicit component of comprehensive HIV prevention programs at all levels as well as in hospitals, laboratories and clinics. Encouraging STI patient for VCT and risk reducing counselling should be a part of STI services. HIV and STI prevention programs, together with private and public sector partners, should take joint responsibility for implementing these strategies through a standardized STI treatment guideline and packages involving various healthcare workers (HCWs).

## Strategic Results:

- 4.4.1 Increased capacity for effective and high quality syndromic management of STIs in the private sector and public sector health care settings**
- 4.4.2 Increased access to STI treatment and management for all target populations, and specifically targeted to MARPS at free or affordable cost**
- 4.4.3 Increased supplies and STI treatment related drugs in all health service delivery points in collaboration and coordination with private drug stores and pharmaceuticals**

## Key actions

1. Integrate VCT and HIV risk reduction component in STI services and or STI services within existing public and private health facilities including strong referral linkages
2. Integrate STI syndromic management into medical or graduate nursing schools and pre-service training or induction programs
3. Expand quality STI service delivery points for MARPS and clients of SWs.
4. Expand the distribution and utilization of STI treatment guidelines in all health care delivery settings
5. Expand mobilization of the health sector in utilization of the traditional medicine and working with traditional healers and traditional medical practitioners (Ayurvedic, homeopathic)
6. Expand the provision of appropriate and quality mobile health facilities (through *Haat Bazaars, Melas*, etc.) and outreach services in providing STI care/treatment services for specific user groups, especially among MARPs
7. Initiate capacity building of all health service providers in STI management and control

## Strategy: 4.5 Expand Voluntary Counselling and Testing (VCT)

VCT, or voluntary counselling and testing, refers to the process of giving people professional counselling before and after an HIV test. The process helps people prepare for and understand their test results. Those who test negative can learn ways to avoid becoming infected, and those who are positive can learn how to live longer, healthier lives and prevent transmission to others.

Best practices have shown that VCT offers an important entry point to care and support and is an essential component of comprehensive HIV/AIDS programming.

Effective counselling helps people reflect on issues related to sexual behaviour, drug use, and necessary individual change in behaviours to prevent HIV, STIs and unintended pregnancy. Those who have sought counselling can share the knowledge and services with their peers and increase awareness. Therefore, VCT is a powerful tool that can equip people with knowledge and skills for sustainable healthy behaviour.

Scaling up access to VCT is key for successfully implementing antiretroviral therapy. HIV status must be known before treatment can commence or before decisions can be taken about future prevention needs, such as in preventing mother-to-child transmission. Knowing one's status following pre and post counselling enables people to initiate or maintain behaviour to prevent the acquisition or further transmission of HIV.

VCT services should be easily available, accessible and affordable. Global best practices have shown that integrated VCT services in multiple-service delivery settings such as Youth Friendly

Services (YFS), Antenatal Care (ANC), Primary Health Care Services, Private Clinics, and community based centres services yield better outcomes than the standalone VCT centres.

Considering the role of VCT services and its limited availability in the country, scaling up is a top priority if we are to halt the epidemic.

In accordance with international principles, in addition to VCT, HIV testing and pre/post-test counselling should also be routinely offered:

- Where medically indicated as part of clinical care;
- As part of services for preventing HIV infection among mothers and their infants;
- In TB treatment settings;
- As part of the management of other sexually transmitted infections (STI).

Thus HIV testing and counselling will be offered in health care settings to everyone who might benefit from knowing their HIV status. **Provider-initiated approaches** in clinical settings will be promoted in a context in which the provision of, or referral to, effective prevention and treatment services is assured.

Depending on country context and stage of epidemic, a range of innovative service delivery models can be applied. These include variation on integrating within the existing service outlets (health facilities, private clinics, freestanding as run by NGOs or CBOs or even mobile service). The important aspect is its accessibility and affordability and quality service.

## **Strategic results**

- 4.5.1 Increased capacity of health service providers to deliver and manage VCT services**
- 4.5.2 Upgraded infrastructure and condition of VCT service centres including management of products and supplies related to providing VCT services**
- 4.5.3 Established, systematic referral and linkages between routine testing, care and treatment, especially for all MARPs**
- 4.5.4 Increased availability and access to quality VCT services, especially for all MARPs through different settings (YFS, ANC, etc)**
- 4.5.5 Established indicators for quality of testing and counselling applied at the programme level;**

## **Key actions**

1. Integrate VCT services in existing health facilities (i.e. hospitals, private clinics, prison clinics etc.) and non-traditional health service centres (i.e. youth friendly service, community based health centres)
2. Establish a functional referral mechanism at all the VCT sites linking to different health services (especially care, support and treatment services)
3. Develop and expand VCT services for hard to reach populations, MARPs through non-traditional methods (i.e. mobile VCT centres for street children, SWs, prison population etc.)
4. Develop/update standard operating procedures for integrating testing and counselling into clinical care sites, including in and outpatient, TB, STIs, antenatal and family planning services and services targeting IDUs, MSMs and sex workers
5. Support operations research to assess the optimal integration of testing and counselling into clinics
6. Establish and ensure quality control mechanisms at all VCT centres

## **Strategy: 4.6 Expand and Strengthen Prevention of Mother to Child Transmission Program**

Worldwide, the transmission of HIV from mother to child is responsible for over 90% of infections among children under the age of 15. The effects are dramatic. AIDS is beginning to reverse decades of steady progress in child survival. But effective and feasible interventions to reduce mother-to-child transmission are now available and could save the lives of thousands of children each year.

Comprehensive programmes to address mother-to-child transmission include strategies to prevent HIV transmission to women; to provide reproductive health care to women living with HIV; to prevent HIV transmission during pregnancy, labour and delivery; to minimise HIV transmission through safer infant feeding practices; and to provide care, support and treatment services to women, infants and their families. Lessons learned globally have shown that prevention of mothers-to-child transmission serves as an important strategy to halt the spread of HIV and AIDS to the general population. PMTCT also serves as a key entry point to reach majority of HIV negative women and children for primary prevention education and services.

In the context of Nepal, the National PMTCT program provides an important platform to reach marginalized and vulnerable women who are at the highest risk of HIV infection through their sexual partners, mostly husbands, and stop transmission from these women to their children. While the country's prevalence rate of 0.55% no longer depicts the trend towards a generalized epidemic in some districts like that of Achham and Syangja, effective and comprehensive PMTCT programs will certainly help to halt the further spread of HIV among women and children as well as to mitigate the socio-economic burden of AIDS..

### **Strategic Results:**

- 4.6.1 Reduced transmission of HIV infection to newly born**
- 4.6.2 Increased decentralised coverage and access to PMTCT at district level in collaboration with private sectors, communities and NGOs**
- 4.6.3 Increased health seeking behaviours among pregnant women and women of child-bearing age and safe sexual practices**
- 4.6.4 Increased knowledge, acceptance and demands of PMTCT program among communities, families and targeted pregnant women.**
- 4.6.5 Strengthened linkage between PMTCT services and HIV treatment/care and support services to ensure that ART programme fast tracks women in PMTCT programmes into ARV treatment plans followed by care and support services ensure**
- 4.6.6 Increased capacity of health service providers for effective management and delivery of PMTCT services**

### **Key Actions:**

1. Develop and implement a national PMTCT strategy and costed national scale up plan (5 years: 2006-2011) with realistic targets
2. Expand the distribution, dissemination and utilization of the national PMTCT guidelines in all service delivery points
3. Integrate and expand PMTCT programme (comprehensive information, counselling services including rapid HIV testing and ART) into existing reproductive health service programme including all ANC programs, and through private sectors, community and NGOs

4. Build capacity of the health service providers in management and delivery of PMTCT programs including capacity to assess all pregnant women for their eligibility for treatment (e.g. CD4 count)
5. Establish effective supply chain management of the range of PMTCT related products, equipment and drugs
6. Promote community sensitisation and mobilization on gaining acceptance and utilization of PMTCT programs as well as promote safe sexual practices among women of child bearing age.
7. Organise mobile ANC services including HIV counselling, testing and referral for those who do not access ANC services at the clinic
8. Promote post natal care attendance, especially of children treated for MTCT
9. Establish and ensure quality control mechanisms at all PMTCT sites
10. Decentralize PMTCT programme at district level, expand PMTCT sites in high-risk district hospitals, Zonal hospitals and private hospitals (through promoting public-private partnership)
11. Train community health workers, skilled birth attendants in management and delivery of PMTCT interventions at community level

### **Strategy: 4.7 Expand the prevention of transmission in health care delivery settings**

Current scientific data suggest that the occupational risk of acquiring HIV infection in the health care setting is low. However, the possibilities of HIV transmission depend on the degree to which universal precautions are followed by health care workers. In most developing nations like that of Nepal, health care providers are not adequately trained on universal precautions. This is compounded by lack of adequate supplies (latex gloves, clean syringes, dental/eye related equipment, etc.) in these settings. To prevent HIV infection among health care providers (whether in hospitals or home based care settings), it is important to ensure that universal precautions are in place and that there are adequate supplies including post exposure prophylaxis (PEP) available.

A greater threat to transmitting HIV results from blood transfusion. Globally, the number of HIV infections caused due to transfusion of infected blood is on the rise. Therefore, prevention of HIV in health care delivery settings includes addressing issues related to universal precautions and protection of rights of all health service providers, providing appropriate treatment services (PEP) for any exposure to HIV infection as well as ensuring a safe system of blood screening and transfusion for all clients.

#### **Strategic Results:**

- 4.7.1 Reduced transmission of infection among health care providers and health service seekers**
- 4.7.2 Ensured screening of all donated blood and organs**
- 4.7.3 Increased knowledge and attitude on mode of transmission and methods of prevention among all health service providers**
- 4.7.4 Implemented and regularly monitored Blood Safety policy (*should be also reflected in policy and advocacy*) in all health care settings**
- 4.7.5 Improved access and availability of necessary quality supplies (Gloves,**

**needle destroyers, Sharps disposal containers, etc)**

**4.7.6 Increased access, availability and awareness of PEP services**

**4.7.7 Increased knowledge and awareness on universal precautions**

**4.7.8 Increased availability and promoted use of safe and screened blood**

### **Key Actions:**

1. Adopt, disseminate, orient and utilize standard guidelines on universal precaution, PEP service and blood safety
2. Ensure availability of high quality supplies and equipment related to universal precautions in all health care delivery settings
3. Establish linkages between HIV prevention services in health care delivery settings and treatment, care and support services
4. Ensure effective management of logistic systems and routine monitoring
5. Strengthen capacity of blood banks.
6. Increase availability of quality PEP services and related counselling for health service providers
7. Establish monitoring and quality assurance system to ensure safe blood and surgical/ medical equipment are supplied and used in all health care delivery settings

### **Strategy: 4.8 Develop and implement workplace policy and programs**

The labour market in Nepal has shifted as a result of urbanisation and changing economic activity to non-traditional and highly vulnerable workplace environments such as industries and factories. Subsequently, with increasing mobility as well as vulnerability that rises due to workplace situations and environment, there is increasing number of persons being infected with HIV within the workplace.

Global lessons learned on workplace policy on HIV and AIDS has shown that effective workplace policies not only create a safer environment for the employees but also ensure the enterprises continued economic growth and mitigating measures against the impact of HIV/AIDS. Workplace programs uniquely help to identify gaps in human resource policies and to advocate for political and procedural reforms with regards to the occupational health safety, rights, and well being of individuals.

Workplace programs include information and education on preventive measures, VCT services, and non-discriminatory terms of employment and services and referral linkages to care/support and treatment services as well as health insurance schemes where applicable.

### **Strategic Results:**

**4.8.1 Formulated and operationalised national workplace policy on HIV and AIDS (*should also reflected in policy and advocacy*) in all sectors**

**4.8.2 Increased access to and coverage of quality workplace programs in all major industries and factories as well as government organizations**

#### **4.8.3 Enhanced linkages between preventive education measures (including VCT) in workplaces and existing care, support and treatment services available locally**

#### **4.8.4 Increased acceptance of HIV and AIDS and reduced discriminatory practices related to HIV and AIDS in workplaces**

### **Key Actions:**

1. Adopt, disseminate, orient and implement national guidelines and protocols on HIV and AIDS and workplace issues (including health care settings)
2. Expand HIV and AIDS prevention education and awareness campaigns in the workplace settings, especially high-risk workplace settings (factories, industries)
3. Utilize peer-education approach to educate on workplace issues, including methods of HIV prevention, risk and vulnerable situations as well as on VCT services, PEP, Universal Precautions
4. Establish systematic referral and linkages of the workplaces with locally existing VCT services for counselling, treatment and care
5. Promote activities (campaigns, drama/functions, etc.) related to reducing HIV and AIDS related stigma and discrimination at workplaces

More than 40 million worldwide are now living with HIV and AIDS. This not only has an emotional impact on the nearest family and friends of those who are positive, but also bears serious consequences for the nation's socio-economic growth. As globally the HIV and AIDS movement is slowly moving towards increasing care, support and treatment services to people living with HIV and AIDS, there is a global concern about failures of current prevention strategies not being able to target intensive prevention efforts for those who have been diagnosed with HIV.

From an epidemiological point of view and public health perspective, the most important group to target for HIV/STI prevention programs are people living with HIV and AIDS. This is particularly important for countries with low-prevalence like Nepal where the epidemic is contained in certain core populations and spread through them to others. Additionally, knowing one's HIV status is important for prevention strategies with people with HIV -- 90% of the people living with HIV in developing nations do not know about their status and have very little means to find out about their status. Therefore, prevention strategies play an important role in providing services to people with HIV and controlling the spread of the epidemic. These strategies include helping people find out their HIV status by increasing their access to VCT, and enabling those who already know about their HIV status to reduce their risk of onward transmission of HIV.

Subsequently, prevention-treatment-care continuum reinforces rationales for supporting HIV prevention strategies for people living with HIV. For example, when people living with HIV access medical care and psychosocial support, it not only improves their health status, but also builds their skills for adapting and maintaining safe behavior. In many countries the programs based on the continuum of prevention to care has proven to be effective in reducing the impact of HIV spread. The challenge for Nepal will be to implement these programs within an ethical framework – without subjecting PLHA to increased stigma and discrimination and without eroding their human rights to treatment, care and support.

## **Strategic Results:**

- 4.9.1 Increased availability and access to comprehensive harm-reduction and treatment programs**
- 4.9.2 Reduced risk behaviours of people living with HIV and AIDS**
- 4.9.3 Increased incidence/cases of beneficial disclosure**
- 4.9.4 Increased number of activists among PLHA**

## **Key Actions**

1. Promote VCT programs to sero-discordant couples
2. Develop and implement prevention care management and risk reduction counselling programs to increase knowledge and use of treatment (ARV programs), care and support services as well as building risk reduction skills including safe sexual/ injecting practices, and social skills of positive people
3. Promote and expand outreach programs among people living with HIV and AIDS to increase beneficial disclosure<sup>12</sup> and utilization of prevention, treatment and care services
4. Expand coverage and quantity of comprehensive harm reduction and treatment programs
5. Develop and implement focused campaigns among people living with HIV and AIDS for establishing peer-support groups, living positively, etc.
6. Mobilize PLHAs, communities, health service providers and families to reduce stigma and discrimination related to HIV and AIDS through advocacy and awareness campaigns
7. Expand livelihood support programs

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<sup>12</sup> Beneficial disclosure could be when a person with HIV status chooses to inform their partner (sexual/injecting) of his/her status, or informs their families, community or health care giver in order to obtain care, support, and treatment and prevention services. (AIDS Alliance, Positive Prevention Background Paper. 2006)

# 5

## TREATMENT CARE AND SUPPORT (2000)

**T**reatment Care and Support are critical and essential components of the response to HIV infection and AIDS-related morbidity in Nepal. These core components of the national strategy focus on providing standardised quality support services for HIV infected individuals and their families with the aim of improving their quality of life. This in turn will be beneficial in the further prevention of HIV and AIDS in the country.

As people infected with HIV progress to recurrent illness the services they need change. Providing comprehensive care across a continuum from home and community to institutional services and back will ensure that the specific needs of clients and their families are met. Functioning health systems are fundamental to successful, equitable and sustainable delivery of a continuum of HIV/AIDS prevention, treatment, care, and support.

Treatment Care and Support efforts are more effective when the programme and activities are integrated into existing infrastructures both at public and private sectors. Integrated intervention approach focusing on providing standard quality support services targeted to HIV infected and affected population with an aim of improving their quality of life will have direct bearing on the prevention efforts. Widespread access to antiretroviral treatment could bring millions of people into health care settings, providing new opportunities for health care workers to deliver and reinforce HIV prevention messages and interventions. Simultaneous and aggressive expansion of both HIV prevention and AIDS treatment in a truly comprehensive approach can halt and begin to reverse the epidemic<sup>13</sup>.

In Nepal access to treatment, care and support services is still extremely low owing to the inadequate health delivery system, inaccessible private health care, less developed community and home based care and inadequate capacity of support groups (including NGOs, CSOs) for service delivery and expansion.

Providing antiretroviral therapy, prevention and other health services along the continuum necessary for a comprehensive health-sector response to HIV/AIDS requires that all levels of the health system are functioning and are working together. Obtaining greater access to better services requires strengthening human resources planning and management, drug procurement and supply chain systems, financing mechanisms, health facility planning, patient tracking, social and political analysis and community and private sector involvement.

### Strategic Outcomes

#### Objective:

By 2011, ensure universal access to quality treatment, diagnostics, care and support services for infected, affected and vulnerable groups in Nepal within a context of a comprehensive response to HIV/AIDS

- Increased national capacity to provide quality diagnostic, treatment and care services
- Increased availability of appropriate and differentiated care and support services to infected, affected and vulnerable population

13 UNAIDS (2004), 2004 Report on the global AIDS epidemic

- Increased involvement of private sectors, civil societies, communities and family for treatment, care and support to the infected, affected and vulnerable groups
- Increased importance of the role of support groups of infected, affected and vulnerable people in treatment, care and support
- Established and monitored continuum of prevention to treatment, care and support
- Established standardised clinical care, ART, OIs and PEP services both in the public and the private sectors.
- Established impact mitigation strategies and programmes in place, adequately resourced and accessed equitably by the infected, affected and vulnerable groups

### Universal Access targets

	Indicators	UA Targets
1	80% of eligible people living with AIDS to be receiving antiretroviral combination therapy	30% (2008) 80% (2010)
2	HIV+ pregnant women receiving a complete course of ARV prophylaxis to reduce the risk of MTCT	20% (2008) 50% (2010)

### Strategy: 5.1 Increase access to quality treatment, diagnostics, care and support for ART, STI and OI.

Current National capacity for treatment, diagnostics, care and support is not optimal. While the public health care outlets beyond the district hospital level and below to primary and community care level are designed for preventative services with limited treatment and care facilities, the access of infected, affected and vulnerable populations to such outlets and district hospitals is extremely low. Moreover, the quality of services in many health facilities (confidentiality, non discrimination, cost and rational use of drugs and diagnostic tools) has often been an issue. Despite an increase in private health care facilities, accessibility and affordability for PLHA and vulnerable groups to such facilities is also extremely low. Moreover, concentration of such facilities in the urban areas makes it more inaccessible to rural poor, vulnerable, deprived and marginalised groups.

Access is the ability of an individual to utilise the available services when needed. Establishment of service outlets alone often do not guarantee utilisation by people who need them. Therefore, in order to design interventions that are accessible and affordable, it is crucial to understand the factors that influence access. Apart from physical factors like distance, cost, and presence or absence of care providers, other important factors that discourage the access to services are a) stigma and discrimination leading to fear, anxiety and depressed psychosis; b) lack of information about the available service; and c) service (health) seeking behaviour.

It has been reported that despite an increase over the past several years in the number of service outlets for VCT, PMTCT, condoms, IDUS, MSM, ART, the overall coverage is far from adequate<sup>14</sup>. Therefore it is essential that such services are scaled up to the level that would be accessible and affordable.

14 NCASC (2005) Coverage of essential HIV/AIDS services in Nepal, 2005, NCASC/Futures Group/ Policy Project USA

## Strategic Results:

- 5.1.1 Assured availability of drugs, supplies and commodities related to treatment, diagnostics, care and support**
- 5.1.2 Increased capacity to provide quality clinical treatment, diagnostics (CD4, viral load, lymphocytes) and care services as well as monitoring drug resistance at national level**
- 5.1.3 Trained care providers delivering services at various level (i.e. family, community and establishment)**
- 5.1.4 Increased number of certified (pre-qualified) service delivery points with comprehensive<sup>15</sup> treatment and care services (scaling up the services)**
- 5.1.5 Increased availability of differentiated care and support interventions and services to reflect broad range of needs of infected, affected and vulnerable groups through a multi-disciplinary and multi-sectoral approach**

## Key Actions:

1. Establish or upgrade infrastructures and diagnostic facilities in all district hospitals and other sites for diagnostic, treatment and care
2. Develop a National HIV/AIDS Training Plan and provide quality training to care providers at all levels (e.g. government, private care providers, civil society and support groups) based on the National HIV/AIDS Training Plan and nationally approved curriculum.
3. Develop national systems for certification of health workers and care providers in scaling up of ART
4. Update, develop and widely circulate information and guidelines on treatment, diagnostics, care and support.
5. Develop National HIV/AIDS Diagnostics Plan.
6. Strengthen partnership programme and linkages between private and public sector for treatment, diagnostics, and care services.
7. Strengthen the National Public Health Lab to function as a key referral lab for quality assurance and supervision.
8. Develop standardized minimum package of services to be provided at each level of health care and settings for various groups<sup>16</sup>.
9. Ensure that laboratories have the equipment and trained staff necessary for monitoring, including CD4, TLC, viral load counts and the detection of the opportunistic diseases, infections and malignancies commonly associated with HIV/AIDS
10. Adopt decentralized approach for service delivery and procurement ensuring

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15 Comprehensive Package (Basic Minimum Package plus additional services as defined in **section 3 (TARGETING SERVICE DELIVERY)**)

16 A minimum package should include 1) medical care for opportunistic infections, 2) antiretroviral therapy, 3) ongoing monitoring for HIV positive people; and 4) psychosocial support

participation of local communities and adequate information about available services.

11. Ensure access to facilities for crisis care, rehabilitation services and re-integration services as an integral component of the support system for PLHA, MSM, SWs and their families in need.
12. Promote and strengthen support groups (communities, CBOs, NGOs, self help groups) and networks for treatment, care and support activities.

## **Strategy: 5.2 Stigma and discrimination reduction.**

One of the serious obstacles in HIV/AIDS programming is the stigma and discrimination that exists at all levels of society. The form in which stigma and discrimination are expressed varies enormously and depends on the level of knowledge among individuals and communities about HIV/AIDS. Stigma is an inner feeling of disliking which is expressed in various ways like, fear of getting infected, avoidance, discrimination in behaviour, hate, humiliating and dishonouring. Discrimination is visible expression of stigma, superior feeling and rejection of the individual. Reduction of stigma and discrimination has posed a serious challenge for activists and implementers alike. The implications of stigma and discrimination have multiple effects. It ranges from denial of services and support to not accessing the service for the fear of being stigmatised and denied. Because of stigma attached to HIV/AIDS and discriminatory behaviour of service providers, people living with HIV often do not come forward to access the service.

This has created a complex situation in many ways. Firstly, the service that is most essential for health and minimising the impact of the disease is not fully utilised. Secondly, the participation and views of infected and affected individuals, essential for designing appropriate policy and services, is often lacking. Thirdly, the magnitude of impact on individuals, families and society is not known, thus making immediate and effective action difficult. It is known often at late stage where corrective action is too difficult to initiate.

It is therefore crucial that reduction of stigma and discrimination feature strongly in this HIV/AIDS strategy. Stigma and discrimination reduction is both a prevention strategy and a treatment and care strategy.

### **Strategic Results:**

- 5.2.1 Code of conduct developed and enacted for service providers and health care workers**
- 5.2.2 Ensured involvement of PLHA, IDUs, MSM and SWs in key decision making regarding treatment, care and support**
- 5.2.3 Increased professional level PLHA involvement in HIV/AIDS related activities**

### **Key actions:**

1. Develop and enforce code of conduct for Health Care Providers/Setting
2. Design stigma and discrimination reduction advocacy and sensitisation programmes.
3. Engage national leaders and key prominent figures and celebrities in HIV/AIDS campaigns, programmes, manuals and IEC materials.
4. Strengthen capacity of PLHA so that they can be a role model in the society.
5. Promote GIPA principle and ensure such principle is acted upon

## **Strategy: 5.3 Community and Home Based Care**

Antiretroviral therapy can only be effective if provided as part of a continuum of HIV/AIDS care and support interventions and services that address the broad range of needs of people living with HIV/AIDS, including those that are not purely biomedical. Comprehensive care and support require a multidisciplinary and multisectoral approach involving many different community elements for effective delivery. Chronic care over the course of a lifetime is best provided as close as possible to where people live. For people living far from treatment and care facilities who do not have access to transport or whose mobility is otherwise restricted, providing care in the home and community is critically important.

Community and Home Based Care (CHBC) offers an opportunity of care within an environment where people are most comfortable and get love and support (better quality of life), and at the same time lessen the burden on an already stretched health system. The added value to CHBC is normalisation of HIV and AIDS which contributes to prevention as well as reduces the stigma.

In a low prevalence country like Nepal, CHBC model can take various forms and include many innovative ideas e.g. impact mitigation activities, stigma reduction, nutrition supplement programme, TB/HIV intervention and prevention education.

CHBC is an emerging concept in Nepal and requires an innovative approach and concerted effort. For CHBC to be effective and acceptable, strong community outreach and support systems are necessary along with referral linkages. Outreach work is cost intensive and requires trained and skilled community workers.

### **Strategic results**

- 5.3.1 Increased number of trained community workers, volunteers and family members in CHBC**
- 5.3.2 Established Linkages developed between health facilities and CHBC workers and programmes**
- 5.3.3 Increased availability of integrated and comprehensive services at the community level**

### **Key actions**

1. Ensure policies, strategies, guidelines and manuals for incorporating home-based care into overall national health systems
2. Ensure core training competencies and curricula for community health workers and treatment supporters
3. Endorse national guidelines for home care services, including basic palliative care by family members and community volunteers
4. Mobilise and build capacities of communities (including local support groups) and families for providing care and support services to the infected and affected
5. Define comprehensive package for CHBC and ensure that services are adequately delivered and used and that the quality of care is maintained
6. Promote herbal and yoga for healthy living
7. palliative care, nutrition supplementation and food security into CHBC programmes with adequate resources
8. Ensure psychosocial support
9. Set monitoring and support systems for community based treatment supporters and care providers

## **Strategy: 5.4 Paediatric Care (Including Orphan and vulnerable children)**

As the epidemic progresses, it leaves children orphaned and vulnerable. Globally, the number of AIDS orphans has reached a figure of more than 15 million, posing serious challenges to existing social system and government service delivery mechanism. Experiences elsewhere have indicated that multisectoral, collaborative and coordinated responses are essential for care of orphans and vulnerable children.

Capacity of existing social system, involvement of NGOs and CBOs are most crucial aspects of P/OVC strategy.

### **Strategic results**

- 5.4.1 Improved access of children living with HIV/AIDS to quality care, support and treatment and ensure that at least 15% of people receiving ARVs are children**
- 5.4.2 Strengthen capacity of government and partners to provide paediatric ART services**
- 5.4.3 Improved access to and management of drugs and diagnostic supplies, including paediatric formulations and early infant diagnosis**
- 1.1.4 Social safety net to support OVC established**

### **Key actions**

1. Develop and implement a national Paediatric ART strategy and costed national scale up plan (5 years: 2006-2011) with realistic targets
2. Guidelines and manuals developed
3. Coordinate with organisation working on eliminating child labour and child exploitation (ILO), child welfare committees
4. Decentralize Paediatric ART in high prevalence districts and expand sites to private hospitals (through promoting public-private partnership)
5. Coordinate and joint programming with Ministry of Education for equal access to education
6. Strengthen family and social ties
7. Health professional at Hospitals and Health Posts trained on paediatric care to reach HIV positive children with adequate medical attention
8. Community based care system developed, piloted
9. Develop national and district level duty bearers' capacity (including NGOs and community-based support groups) to plan and provide services to orphans and vulnerable children
10. Prepare inventory of and coordinate with existing orphanage

## **Strategy: 5.5 Impact mitigation programme**

As the epidemic matures, the impact on people infected and affected by the virus increases. Socioeconomic status of affected families and individuals may decline due to loss of earning power either through illness, job loss, stigma and discrimination or other reasons. Specific, focused and well designed impact mitigation programmes are necessary to support and sustain PLHA and their families particularly the housewives. Housewives in many part of the country are

doubly disadvantaged because of low socio economic status and limited access to preventive and curative services. Besides, increasingly housewives have also emerged as care provider in many rural settings. Impact mitigation programmes not only strengthen the socio economic status of PLHA but also complements other prevention, treatment and care interventions.

## **Strategic results**

**5.5.1 Micro-enterprise and income generation (economic development activities) policy, guidelines and programmes developed and implemented specifically targeting PLHAs and infected/affected housewives**

**5.5.2 Ensured benefits for PLHAs from impact mitigation programmes**

## **Key actions**

1. Assess socio economic impact of the HIV epidemic on PLHA
2. Formulate policies on impact mitigation for HIV epidemic focused on PLHA and housewives
3. Explore and implement alternative microfinancing mechanism targeted to PLHAs.
4. Establish linkages between HIV programmes and micro financing institutions so that PLHA and housewives are benefited
5. Provide marketable skills training to PLHA
6. Mobilize the private sector for increased job opportunity and job security for PLHA
7. Coordinate and collaborate to assure children's rights to education and livelihood.

## **Strategy: 5.6 Prevention and clinical management of OIs and HIV/AIDS related illness**

Treatment of Opportunistic Infections (OIs) is an essential component of a comprehensive service package to reduce the AIDS related morbidity and mortality. Best practices show that proper interventions for OI management result in significant gains in life expectancy and quality of life for PLHA. With prompt diagnosis and management most OIs are treatable. It is therefore important not only to have the drugs and medications but also the infrastructure and trained human resources in place and universally accessible.

## **Strategic results**

**5.6.1 Reduced AIDS related morbidity**

**5.6.2 Increased access to OI services**

**5.6.3 Increased availability of diagnostic and management facilities at the district level**

## **Key actions**

1. Develop OI guidelines and protocols and incorporate into national treatment guidelines (HIV co-infections with other serious diseases like TB, Hepatitis B).
2. Implement OI prophylaxis and treatment preparedness activities

3. Provide prophylaxis/suppression for specific HIV opportunistic infections as needed e.g., PCP, candidiasis, cryptococcosis, toxoplasmosis, MAC, CMV.
4. Forecast, procure, store and distribute sufficient supply of OI drugs
5. Establish effective clinical/treatment monitoring system
6. Train health workers on OI management

## **Strategy: 5.7 Expansion of Antiretroviral therapy**

AIDS has now become a manageable chronic illness because of ARV therapy (ART). The availability of ART has not only lessened the suffering of an individual, but has also contributed to restoring economic and social productivity. The challenges, however, are access to ART for the people who need it; continued supply of the ARVs at affordable prices; and the capacity of the health system to monitor and support its use. It is therefore important that the minimum infrastructure is in place before initiating ARV on a massive scale.

In November 2003, in Lusaka, Zambia, WHO and UNAIDS hosted an International Consensus Meeting on Technical and Operational Recommendations for Emergency Scaling-Up of Antiretroviral Therapy in Resource-Limited Settings which made recommendations for rapid scale up of ART and on the essential package of care and prevention services necessary to support ART.

One recommendation was that ART should be initiated in facilities at all levels of the formal health care system as soon as the following minimum conditions are available:

- HIV testing and counselling;
- Personnel trained and certified to prescribe ART and follow up recipients clinically;
- An uninterrupted supply of antiretroviral drugs; and
- A secure and confidential patient record system.

A supporting recommendation to the above being that, adherence support and community mobilization and education on ART must be made available at all levels of the health system concurrent with (and following) the introduction of ART.

Given the late initiation of ART in Nepal<sup>17</sup>, the national strategy must prioritize building or upgrading the infrastructure required to scale up ART. This includes scaling up VCT services; diagnostic and monitoring facilities; clinical monitoring services (detection of drug toxicity, ART for drug users because of drug interaction, etc); training, supervision and support to health professionals; procurement and supply system; and resources to pay for long term treatment.

Furthermore, given the high prevalence and risk taking behaviours among IDUs, a comprehensive response for HIV among IDUs combining prevention, treatment and other support services is essential to ensure maximum uptake of services as early as possible.

## **Strategic results**

### **5.7.1 Increased access to ARV**

### **5.7.2 Increased/maintained immune function of PLHA**

### **5.7.3 Established programmes for a comprehensive response to HIV among IDUs combining prevention, treatment and other support services to ensure maximum uptake**

17 ART was started in 2004 on a very limited scale solely by the government with no donor funding

#### **5.7.4 Established diagnostic and OI management facilities in district hospitals**

#### **5.7.5 Available external and internal resource commitments for long term treatment including ARV drugs**

### **Key actions**

1. Develop/revise treatment guidelines and manuals for comprehensive care of IDU with HIV
2. Develop suitable delivery mechanisms for IDUs, MSM and SWs
3. Train and certify health care providers to prescribe ART and follow up clinically;
4. Ensure an uninterrupted supply of ARVs and substitution drugs for drug dependence
5. Strengthen the National Public Health Laboratory as a reference laboratory for clinical monitoring
6. Strengthen regional and district networks for laboratory support both for private and public laboratories
7. Establish HIV testing and counselling services
8. Establish community support services through support groups and self help groups
9. Establish linkages between treatment sites and other HIV-related services
10. Promote involvement of private sectors in ARV (can be included in treatment certification process)
11. Provide adherence support, community mobilization and education on ART at all levels of the health system concurrent with (and following) the introduction of ART
12. Ensure close linkages between harm reduction and HIV treatment programmes to enable the rapid referral of IDUs testing HIV positive for care, better monitoring and resolution of drug interactions
13. Train counsellors on the needs of IDUs (IDUs) requiring ART

### **Strategy: 5.8 Management of HIV related co-infections**

The AIDS pandemic presents a massive challenge to the control of tuberculosis (TB) at all levels. Tuberculosis is already a serious public health threat in Nepal. It is reported that 45% of the total population is infected with TB, out of which 60% are in the productive age group. According to the National TB Centre (NTC), every year 44,000 people develop active TB of whom 20,000 have infectious pulmonary disease<sup>18</sup>.

TB is also one of the most common causes of morbidity and one of the leading causes of mortality in PLHA. As one of the first OIs to appear in PLHA, TB may be the earliest sign of HIV infection. While addressing TB offers the opportunity for early HIV intervention, VCT services offer an opportunity for referral and early detection and treatment of TB. Therefore combining TB and HIV services is an effective strategy in reducing morbidity and mortality related to the co-infection.

18 NTC (2002), **Annual Report of Tuberculosis Control Programme**, Government of Nepal, National Tuberculosis Centre/Community Tuberculosis and Lung health Project (JICA), Kathmandu

## **Strategic results**

- 5.8.1 Integrated TB and HIV services in VCT and DOTS centres for universal access to ARV**
- 5.8.2 Established coordination mechanism between National TB programme and HIV/AIDS programme**
- 5.8.3 Established system for the management and monitoring of co-morbidity of TB and HIV**

## **Key actions**

1. Develop joint TB/HIV/AIDS plan for integration at DOTS/VCT centres
2. Develop and disseminate National Protocols on Hepatitis B, Hepatitis C and TB co-infections including specific tools and guidelines for use at various levels (e.g. district hospitals, private hospitals, central hospitals)
3. Implement collaborative TB/HIV interventions at different levels of the health care system following national policies and guidelines
4. Establish clear referral linkages for TB HIV co infection
5. Strengthen public awareness about TB/HIV co infections
6. Build capacity at all levels for management of co infections (including DOTS and VCT workers training on co infections and its management)
7. Establish linkages between CHBC and TB HIV co infection activities

# 6

## ADVOCACY, POLICY AND LEGAL REFORM (3000)

**I**gnorance and misconceptions related to HIV and AIDS are the major causes for the prevailing stigma and discrimination which often leads to violation of basic human rights of the infected, affected and vulnerable groups. Such violations enhance the risk of HIV infection as in such an environment people are less willing to seek education, counselling and advice, to test for HIV, or to admit their HIV positive status and seek treatment and support.

National response to HIV/AIDS in Nepal is guided by the National Policy on AIDS and STD Control, 2052. The main emphasis of the National Policy is priority to HIV/AIDS and STD prevention programmes; the need for a multi-sectoral and decentralized response; services for people living with HIV/AIDS; a non-discriminatory approach; and confidentiality for test result. Based on the National Policy, two National HIV/AIDS Strategic Plans covering the periods 1997 to 2001 and 2002 to 2006 have been developed and implemented.

HIV/AIDS and Human Rights: A Legislative Audit carried out for the first time in Nepal in 2003 indicated the gap between international obligations and the legal system practiced in the country and suggested a need for law reform so that the legal system makes a more positive contribution in controlling the further spread of HIV, and protects the rights of PLHA. Out of a possible maximum score of 100, the Nepalese legal system has scored 39.98. As per the recommendation of the study, Nepal has drafted an HIV and AIDS (Treatment, Prevention and Control) Bill and also amendment proposals on existing laws which are in the process of endorsement. Advocacy is also underway to promote the development of the UNAIDS Three Ones Principle—One National Action Plan; One National Management Structure; and One National Monitoring and Evaluation Plan. These documents are already in process with an inclusive development process that involved a wider and active consultation of all the concerned stakeholders.

Committed and sustained leadership in the government sector is essential for sound policies and legal system in place as well as for the management of a national response in a multisectoral and decentralized manner. This strategy promotes the understanding of the policy makers and planners about the negative impact of HIV/AIDS on development and human rights and advocates for the inclusion of HIV/AIDS as one of the priority areas on the development agenda. It will ensure the formulation of an appropriate legal framework and support services to guarantee the rights of the infected, affected and vulnerable groups. A detailed advocacy plan will be developed and implemented to raise awareness of leaders and champions in all sectors and at all levels who will support in mobilizing the public and private sector and the community in response to HIV and AIDS.

### **Objective:**

By 2011, comprehensive and well implemented legal framework on HIV/AIDS promoting human rights and establishing HIV/AIDS as a development agenda.

### **Strategic Outcomes:**

- HIV/AIDS prioritized as national development agenda and included in 11th Five year plan as P1 program under social sector.

- Rights of infected, affected and vulnerable groups insured through effective legislative framework.
- Networks of PLWH and MARPs operational
- HIV/AIDS response decentralized and coordinated.
- Multi-sectoral response to HIV/AIDS strengthened and expanded

### **Universal Access Targets**

- 1) Resources mobilised by government (both domestic and international sources) fully meets the prevention and treatment targets, or at least 3 times increase from that in 2005
- 2) Enabling environment
  - a) Civil society engagement in National AIDS Coordinating body who represent sectors of civil society
  - b) National legislation to address AIDS related Stigma and Discrimination, and rights of infected and affected population

### **Strategy: 6.1 Establish HIV/AIDS as a development agenda**

To generate an effective response to HIV/AIDS from each sector, detailed advocacy plans will be developed and intensive advocacy will be carried out to increase the understanding of the government, political and social leaders and law makers about the impact of HIV/AIDS on development and the importance of timely action to mainstream it into all sectors of development. Policy makers and planners will be sensitized, advocated and supported to include HIV/AIDS as P1 program under social sector of coming 11th National Five year plan because as a cross cutting issue it seems less attended and also for developing multisectoral guideline to mainstream HIV/AIDS in each sector as a development agenda.

Advocacy will be carried out for the politicians, high level bureaucrats and law makers for effective operation of three ones i.e. one authority, one plan and one monitoring framework and for also fulfilling the national (11<sup>th</sup> Plan) and international commitments expressed as a signatory to the UNGASS, MDGs and other commitments (WTO, TRIPS).

#### **Strategic results:**

- 6.1.1 Established national semi autonomous body for an expanded response to HIV and AIDS**
- 6.1.2 Established functional national and local coordinating bodies (e.g. NAC, DACC) and decision making mechanism inclusive of MARPs and civil society organisations**
- 6.1.3 Established one coordinated national multisectoral plan operational at all levels.**
- 6.1.4 Committed government leaders and champions (sports, youths, media) to follow the national and international obligations**

## **Key actions:**

1. Advocate political leaders, bureaucrats and law makers for the prioritization of HIV/AIDS in the national development agenda and for multisectoral and decentralised response.
2. Advocate for having the functional “three ones” in place
3. Develop multisectoral guideline by advocating key sectoral ministries to plan and implement HIV/AIDS programme in their respective sectors.
4. Review, update and comply with existing National HIV/AIDS policies, Acts, rules ( Local governance act, Planning guide) and structure (NACC, DACC, VACC) for effective coordinated, decentralized and multisectoral programming at all levels.
5. Develop appropriate policies, guidelines and reports to comply with international obligations

## **Strategy: 6.2 Ensuring the rights of the infected, affected and vulnerable groups.**

Advocacy for the endorsement and enactment of draft HIV/AIDS bill and laws amendment proposal will be carried out. Needed laws and by laws will be formulated, endorsed and disseminated. A mechanism to monitor the violation of the rights of the infected, affected and vulnerable groups will be established and regular monitoring will be carried out. Mechanism for the punishment in case of rights violation will be established and strengthened. Most at risk groups like SWs, MSM, IDUs etc will be empowered to form support groups and networks so that they can advocate on behalf of their own issues and work as pressure groups for gaining access to preventive, curative and supportive services. Best practices have shown that to promote and ensure the rights of PLHA, MARPS and vulnerable people social mobilisation of all the sectors of the society at all levels creates a lasting benefit.

### **Strategic results:**

- 6.2.1 Favourable policies (e.g. Blood safety policy, workplace policy, youth policy, sports policy and so on) and laws in place**
- 6.2.2 Enacted HIV/AIDS bill and supporting laws and by laws.**
- 6.2.3 Established mechanism to monitor human rights violations so that rights of PLHA, MARPS and vulnerable people are promoted and protected**
- 6.2.4 Established functional networks of PLHA, SWs, MSM and other MARPs and civil society organisations**
- 6.2.5 Increased contribution of private sectors in prevention and treatment, care and support (harm reduction, workplace programming, drug supply, socio economic support etc)**
- 6.2.6 Increased participation of faith based organisations**

### **Key Actions:**

1. Revise and explore the implications of international commitments like UNGASS, MDG, WTO, TRIPS etc
2. Review and amend discriminatory act

3. Enact HIV/AIDS bill and supporting laws and bylaws to promote rights
4. Promote GIPA principle through encouraging infected, affected and vulnerable groups to be actively involved in developing and implementing HIV/AIDS policies, strategies, and programmes.
5. Form an independent National Watch Dog for monitoring implementation of policies and laws
6. Increase community mobilization and partnership among families, faith based organisations as well as private businesses (i.e. pharmacy) to create a supportive environment.
7. Create, strengthen and promote "leadership forums" of different constituency groups (e.g. Media, Youth, Sports, Celebrities, Women, Business coalition etc as well as nominating "Goodwill Ambassador")
8. Conduct issue based advocacy for the effective prevention and supporting treatment, care and support and management (e.g. reduction of stigma and discrimination, rights based services, drug supply from private sector, public private partnership, workplace interventions)
9. Raise public awareness through appropriate IEC strategies and interventions.

# 7

## LEADERSHIP AND MANAGEMENT (4000)

**S**trong leadership at all levels of society is crucial for an effective response to the epidemic. Leadership involves personal commitment and concrete actions. Inspiring and empowering leadership at all levels is needed to transform the national response to HIV and AIDS from a plan into action.

HIV/AIDS has been a priority of the Nepal government reflected as a crosscutting issue in the Tenth Five year Plan. Furthermore, HIV/AIDS is an important component under the Millennium Declaration. Nepal is a party to the UNGASS declaration which is clearly reflected as a policy commitment of the government. Due to the political instability in the country, the continuity, consistency, and commitments of the leadership to take forward the plan and commitments into actions have been less than optimal.

Similarly, although various structures to coordinate the HIV/AIDS response have been established from national to district level, with some exceptions, these coordinating mechanism are not functioning to their optimal level<sup>19</sup>.

Until now the focus of the strategic interventions for leadership and management has largely been in the area of strengthening the institutional mechanism both within and outside of NCASC. Still, an effective national structure to manage and coordinate the national response to HIV/AIDS is lacking. The location and mandate for this national structure is very crucial as it should be able to overcome the current anomalies and promote multisectoral response to the epidemic. A broad coalition of stakeholders across all sectors must define their strategic roles and take the lead in proactively contributing to the goal of increasing access to HIV and AIDS services.

### **Objective:**

Enhanced leadership and management at national and local levels for effective response to HIV/AIDS

### **Strategic Outcomes:**

1. Operationalized national strategy through the National Action Plan
2. Active champions and leaders at the societal, institutional and individual levels for the HIV/AIDS response
3. Mainstreamed HIV/AIDS programs in all development sectors
4. Enhanced social inclusion, equitable access and gender equality to AIDS services
5. Coordinated and decentralized response to HIV/AIDS

<sup>19</sup> Current coordinating mechanism are as follows: - A high-level National AIDS Council (NAC), chaired by the Prime Minister for multisectoral policy and guidance; a National AIDS Coordination Committee (NACC) under the Health Minister for guiding the implementation of the national plan; a Steering Committee, chaired by the health secretary for program monitoring and review; National Centre for AIDS and STD Control (NCASC) for the overall implementation coordination and management; and District AIDS Coordination Committees (DACC) in all 75 districts for coordinating the HIV response at local level

## **Strategy: 7.1 Operationalise three ones principle**

At present in Nepal there is only one component of the UNAIDS three ones principle that is functional: the one national action plan. The remaining two components—one national authority and one monitoring and evaluation framework—are still in development. The institutional entity must be established with clear Terms of Reference that delineate its lines of authority, responsibility and coordination, and operational guidelines. Its mechanisms and processes must promote public and private sector partnerships by ensuring full participation from government, private sector, and civil society, including PLHA and vulnerable groups, in all aspects of governance and in the implementation of the NSP and the National Action Plan. Its operations must be guided by two basic principles: participatory governance and accountability for resources and results.

The Multi-year National Work Plan will act as the fundamental framework for the national response. It will reflect priority programmes based on evidence and decided upon by consensus among key stakeholders. The National Action Plan will have costed activities and indicate comparative advantages and contributions of players.

The National M&E system and framework will set forth the system for tracking the patterns of the epidemic (surveillance), the progress of activities in the National Action Plan (monitoring) and the effectiveness or outcomes of strategies (evaluation). M&E indicators should reflect changes in the needs of target populations for prevention and treatment, care and support services.

### **Strategic results:**

**7.1.1 Established and functional semi-autonomous entity to manage and coordinate the national response**

**7.1.2 Established national monitoring and evaluation system to effectively monitor and evaluate the national response and implementation of "Three ones"**

**7.1.3 Implemented multiyear National Action plans**

### **Key actions:**

1. Establish and support multi-sectoral management entity with Public Private Partnership (PPP), autonomy, representation of PLHA, women and vulnerable groups at national and district levels
2. Develop and implement multi year (2-year) National Action Plan for the operationalisation of the national strategy
3. Establish and strengthen single coordinated National Monitoring and Evaluation system

## **Strategy: 7.2 Promote multisectoral and decentralised response to HIV/AIDS**

Activation, strengthening and restructuring of NAC, NACC and DACC is essential with clear roles, responsibility and accountability to promote multisectoral and decentralised response. Civil society, the business community and the private sector must be strengthened for the full and active participation to complement and supplement the national response to HIV and AIDS. Advocacy is necessary to influence the policy makers at all levels and to develop active champions and leaders at each level for the multisectoral, decentralized and coordinated programming. The structure at the local level (e.g. DACC) should be strengthened and its scope and mandate widened so that the local response to the epidemic is more effective.

## **Strategic Results:**

- 7.2.1 Functional coordinating bodies at national and local level (e.g NACC, DACC)**
- 7.2.2 Developed sectoral plans and resource allocated for central line ministries and local plans for local governance bodies to mainstream HIV/AIDS into the regular development plan**
- 7.2.3 Increased multisectoral involvement and HIV/AIDS reviewed as an priority agenda at National Planning Commission and Ministerial review meeting**
- 7.2.4 Established functional HIV/AIDS unit in the line ministries to integrate HIV/AIDS programs**
- 7.2.5 Increased and meaningful involvement of private sector**

## **Key actions:**

1. Form/reform and legalize NAC, NACC and DACC with clear roles and responsibilities and with clear linkage to NCASC and semi autonomous body.
2. Develop leaders and champions at all levels and sectors (media persons, politicians, communities, ports, religious, youth, and women) for decentralized response.
3. Support the development of sectoral and local plans to mainstream HIV/AIDS
4. Ensure resources to implement sectoral and local polices and plans
5. Strengthen sectoral units /focal points/local bodies to implement sectoral plans
6. Foster inter-ministerial collaboration through NAC/NACC and semi autonomous entity

## **Strategy: 7.3 National capacities for expanded response strengthened.**

Capacity building of partners and stakeholders is an important strategy to enhance the performance and quality of services. NGO capacity for managing the scale up and decentralization of activities will be systematically developed to increase the effectiveness of the implementation of HIV/AIDS interventions on prevention, treatment, care and support programs. It is important to maintain the NGO advantage of community-level effectiveness while building their capacity for increased coverage of the services they provide. Their leadership skills must also be tapped to catalyze other organizations to integrate HIV and AIDS services within their existing scopes, as a way of reducing costs and increasing efficiency. Coalition building and knowledge sharing will be essential elements in the capacity development programme. Allocation of funds for capacity building will be insured from the very beginning. Areas and skill for capacity building will be identified and capacity building plan will be developed and implemented based on the needs assessment.

A pool of master trainers will be developed for replicating the training as needed. Partners and stakeholders will also be supported in establishing effective management systems with the development of procedures, guidelines and tools for the delivery of quality services. Special focus will be given to build the capacity for commodity and service delivery of the health sector in collaboration with private partners. Accountability and transparency among the funding and implementing partners, stakeholders, and beneficiaries will be established and coordination and linkages will be strengthened and enhanced.

## **Strategic Results:**

- 7.3.1 Enhanced program management capacities of civil societies and government**
- 7.3.2 Strengthened commodity supply and regulation system to support diagnostic, clinical and treatment services**
- 7.3.3 Strengthened networks and coalitions including grass roots organisation to expand reach and scope of programme**
- 7.3.4 Strong public private partnership developed for prevention, treatment and care and support programs**
- 7.3.5 National Training Plan (Matrix), Guidelines and certification system developed to accredit and standardise the training practices and system in the country**

## **Key actions:**

1. Ensure funding for organisational development and capacity building of partners and stakeholders.
2. Develop and implement partner-defined capacity building package for public, private sectors and civil societies for resource mobilization, planning and management of HIV interventions.
3. Develop a pool of master trainers to replicate the capacity building training.
4. Document and disseminate best practices
5. Enhance capacity through exposure visits and knowledge sharing.
6. Provide technical, material, financial support for networking and coalition building.
7. Up graded management capacity of health infrastructures for AIDS services at all levels, in collaboration with private sector.
8. Develop capacities of marginalized groups for accessing prevention, treatment, care and support services
9. Build leadership and management capacity of civil society organizations for an effective prevention service delivery

The HIV/AIDS epidemic in Nepal is evolving from low-level to concentrated epidemic among some of the groups at highest risk of infection, with a prevalence above 50% among Injecting Drug Users. Heterosexual transmission is a significant contributing factor and a prevalence of 2-3% was found among sex workers in two sites in 2004 (16% in Kathmandu in 2001). Evidence from Integrated Bio-Behavioural Surveillance (200) also shows HIV prevalence of 8-10% among vulnerable populations such as migrant or mobile workers, who in turn contribute to the transmission of HIV through their spouses to the general population.

Support to the national response has increased over the past two years and the number of partners involved in HIV and AIDS activities has also increased significantly. In addition to traditional partners such as the UN and international NGOs, a large number of civil society organisations and networks have become involved in different aspects of the response. The benefits of the expansion in contributing to the response are evident but also highlight the need to strengthen Monitoring and Evaluation, as well as Surveillance, the "Third One".

Second Generation Surveillance is a key element which contributes to tracking the evolution of the epidemic as well as the impact of efforts on it. Information generated by Monitoring and Evaluation contribute to national-level and internal programming and quality assurance, provide information to ensure that the most effective interventions are selected and importantly help to ensure that the use of resources and efforts is maximised.

The following outcomes and strategies have been identified as essential to provide policy-makers, programme managers and implementers involved in the response with the necessary information for planning and resource allocation.

**Objective:**

Strategic information to guide an effective response improved and used for planning and implementation

**Strategic outcomes**

1. Trends and changes in HIV prevalence and HIV and STI related risk behaviours among different risk groups tracked over time and across regions in Nepal
2. Effectiveness of HIV prevention and care interventions and activities monitoring and evaluated
3. All aspects of key programme service delivery areas effectively monitored and evaluated
4. Programme coverage and service delivery assessed by target group
5. Resources inputs and outputs contributing to the programme monitored

**Targets: by end of 2011**

1. One Monitoring and Evaluation System operational and supporting the response with impact, outcome and programme (output and process) data

2. All elements of Second Generation Surveillance system implemented
3. One Strategic Information Unit operational, collating and analysing data and sharing it with partners
4. Operational Research carried out according to gaps identified

## **Strategy: 8.1 One Monitoring and Evaluation system in place and operational**

The National Monitoring and Evaluation strategy and framework for HIV and AIDS is closely linked to the National Strategy for HIV/AIDS and to the Operational Plan developed for Nepal. An overarching framework for HIV/AIDS/STD interventions in Nepal exists in the 5-year National Strategy on HIV/AIDS in Nepal and in the Operational Plan linked to it. The Objectives and Priorities developed for 2002-2006 are currently under review for 2006-2011 and cover Targeted Prevention, Treatment, Care and Support as well as cross-cutting areas of work in support of the response such as Policy, Legal reform and Advocacy, Leadership and Management and Resource Mobilisation.

A comprehensive M&E strategy and system are required to inform the National programme and stakeholders involved in the response, of evolutions in the epidemic and on progress made in responding to the spread and control of HIV as well as in caring for those infected and affected. The National Monitoring and Evaluation framework for Nepal follows a hierarchy of objectives in line with the National Strategic and Operational Plans.

### **Strategic results**

- 8.1.1 National Monitoring and Evaluation strategy for HIV and AIDS and guidelines developed and shared**
- 8.1.2 Central Monitoring and Evaluation unit established and operational**
- 8.1.3 Use of surveillance, monitoring and evaluation data advocated to policy-makers, donors and implementing partners**
- 8.1.4 Size estimation of key target groups updated regularly through participatory process**
- 8.1.5 Technical tools and guidance for M&E developed**
- 8.1.6 Strengthening capacity of monitoring and evaluation built**
- 8.1.7 HIV and AIDS service delivery, quality of services and coverage mapped**
- 8.1.8 HIV data integrated into HMIS**

### **Key Actions**

1. National Monitoring and Evaluation strategy and guidelines (including tools) developed and shared
2. Capacity of M and E unit strengthened by setting up system and with appropriate training
3. A joint M and E team and HMIS (at Ministry of Health and Population) formed to workout the modality to include HIV data into HMIS
4. Ensure monthly flow of data at the national Unit that also provides timely feedback

## **Strategy: 1.1 Second Generation Surveillance System strengthened**

Although some quality surveillance activities are being carried out, there is currently no overarching, continuous surveillance framework or system at the national level in Nepal. The existing HIV & AIDS sentinel surveillance was initiated in 1991 and covered five sub-populations (female sex workers, patients with sexually transmitted infections, IDUs, antenatal care attendees, and tuberculosis patients) and six surveillance sites (Kathmandu, Pokhara, Nepalgunj, Mahendranagar, Damak and Birgunj). Surveillance was due to take place at six-month intervals. However, the sites, intervals between the rounds, and the sub-groups targeted were changed after a few rounds. The NCASC, with support from WHO/USAID will be reviewing its entire surveillance strategy with the aim of strengthening the Second Generation Surveillance system in Nepal.

### **Strategic results**

- 8.2.1 Standardised national guidelines for Second Generation Surveillance in Nepali and English available**
- 8.2.2 Standard Operating Procedures and protocols for SGS system developed and shared**
- 8.2.3 SGS reviewed on a regular basis to ensure it remains appropriate to the epidemic**
- 8.2.4 Data generated by SGS from different sources integrated in one location and utilised by the programme implementers**

### **Key Actions**

1. Prepare standard national guideline and translate into Nepali
2. Organise orientation and dissemination of standard guidelines to key organisations involved in research and data collection
3. Organise regular training to team involved in surveillance

## **Strategy: 8.3 Strategic Information System created and functional**

The National Coordinating Authority, currently the NCASC, will work with all stakeholders to collect data in their relevant areas of activities to support national-level Monitoring & Evaluation of the national response. In order to facilitate the data flow, the capacity in M&E will be strengthened at central, regional and pilot district levels by creating a network of "strategic information units".

In the initial stage of the implementation of this system and network, the central strategic information unit will establish and maintain a direct link with donors to centralise the Surveillance and M&E information received from different implementing partners supported by them.

## **Strategic results**

- 8.3.1 Donors and development partners sensitised on the role of the NCASC in surveillance, monitoring and evaluation.**
- 8.3.2 Strategic information system established and functional (periodic dissemination by National Unit)**
- 8.3.3 Technical capacity for M&E strengthened**
- 8.3.4 Working groups on Monitoring, Evaluation and surveillance integrated and streamlined**

## **Strategy: 8.4 Operational Research carried out to inform gaps in the response**

While Surveillance allows evolutions in the spread of HIV and in risk behaviours among specific population groups to be followed, there are clearly areas where emerging needs will arise and which need to be assessed and documented. These are areas of research and information that are not or cannot be provided through on-going monitoring and evaluation data. For example as the number of AIDS deaths grows, the needs of orphans and vulnerable children in Nepal will need to be assessed for possible inclusion into policy and programming decisions. Researches carried out will be closely coordinated and consulted with **National Health Research Council (NHRC)** for quality, ethical assurance and to decide the most appropriate areas for research that will have national and international importance.

Although it is beyond the scope of the Strategy to detail these areas, three broad areas of operational research have been identified and include:

- Studies related to treatment outcomes and modalities (e.g. documenting start-up, scale up and treatment outcomes of ART programme)
- Studies on quality of services (e.g. Health facility surveys to assess both quality of treatment and access or user-friendliness for vulnerable population groups such as sex workers, young people etc...)
- Undocumented aspects of the epidemic (e.g. population groups and geographical areas where vulnerability, risk of infection or impact of the epidemic is increasing)

## **Strategic results**

- 8.4.1 Drug resistance studies carried out to ensure treatment guidelines remain up-to-date**
- 8.4.2 Collaboration with programme implementers (GOs, NGOs and INGOs) and research institutes for studies and small scale research**
- 8.4.3 Research on Ayurvedic and traditional medicine for HIV prevention, treatment and care carried out**
- 8.4.4 Rapid studies and small scale research on HIV Policies and risk behaviours in groups and geographical locations where information is lacking.**

## Key Actions

1. Study priorities and topic agreed in consultation with wider team
2. Stock check of existing knowledge base of Ayurvedic and traditional medicine performed in collaboration with civil society organisations, research organisation and government units (e.g. Ayurvedic Department of Ministry of Health)
3. Capacity to do research on modern and traditional system improved through a collaborative effort (training, documentation, flow of information)

Please note that this concept needs to be amended and further elaborated based on workshop discussions, field assessment and decentralisation plan of the government:

- A central strategic information unit will be established at the NCASC with a full time coordinator, statisticians and assistants. This unit will compile and analyse information received by the regional and district levels and ensure the effective use of information including its dissemination.
- Although the reinforcement of all District Public Health Offices (DPHO) for HIV/AIDS M&E is questionable in view of the large number of districts (75) and the capacity building required to strengthen an effective national M&E system, strengthening will be considered for high-prevalence districts with a good number of partners are active. A phased process will be more appropriate, with the establishment of an M&E team in pilot DPHO, high risk districts with a good number of activities. The team will be in charge of compiling and analysing data received and collated from public services and other partners in their respective district. The team will then transmit aggregated information to the regional and central level on a quarterly basis.
- At regional level, the Regional Health Directorate (RHD) is responsible for monitoring and supervision and administrative and financial management. The capacity of the 5 RHD will be strengthened regarding HIV/AIDS M&E. Reinforcement is crucial to support districts where an M&E team is not present at this stage. The RHD will be directly in charge of compiling and analysing data from public services and partners in districts under their remit and of transmitting aggregated data to the central level. In districts where an M&E team is present, the RHD will provide support to the districts in their M&E efforts, including compilation and analysis of data from the districts and transfer of aggregated data to the central level. Data will be transmitted quarterly.



Recently budgets for Nepal's HIV/AIDS response have increased dramatically and Nepal is taking HIV/AIDS response in a more collaborative and coordinated way. The EDP pledged budget has increased from US\$2.5 million in 2003/04 to US\$14.5 million in 2005/06. Similarly the government direct contribution to HIV/AIDS has also increased in 2005 but still it is less than one percent of the total HIV/AIDS budget<sup>20</sup>.

In order to maintain the current resource flow for multi-year action plan there is a clear need of having a transparent, accountable and flexible resource flow mechanism. Since Nepal is already scaling up its responses and is committed to the MDGs, it is extremely important to have a sustainable financing mechanism in place. A successful access to funding opportunities depends on its reliable structure, transparent resource mobilization mechanism and realistic programming. This need is very much linked with the need of having a strong institutional framework with a strong functional financial unit to carry out the necessary actions to ensure a sustainable fund flow for the HIV/AIDS program.

### Objective:

By 2011 Sustainable financing and effective utilization of funds

### Strategic outcomes:

1. Hundred percent funding mobilized for the implementation of Multi-year National Action Plan from the Government, EDPs and Pvt./NGOs Sector
2. By 2009, government investment in AIDS activities will be at least 5% of the total HIV and AIDS program budget, and by 2011, at least 10%.
3. Appropriate multi-sectoral resource allocation under relevant line ministries
4. Efficient and coordinated Financial Management System
5. Timely and improved resource flow
6. Improved accountability at all levels (Govt., EDPs, implementing partners)

### Strategy: 9.1 Accelerate resource mobilisation within the country and outside.

Despite increased level of spending on HIV/AIDS programmes in Nepal, the coverage and intensity of the programme is still inadequate to the level to create epidemiological impact.<sup>21</sup> One of the reasons is under financing of the HIV/AIDS programme in Nepal. Moreover, the national

20 However, the non-direct spending e.g. expenses for treatment of STIs and other opportunistic infections through regular health service delivery system; spending of Ministry of Education in preparing curricula and delivering lessons at the secondary schools throughout the county and other similar costs have not been calculated under the HIV/AIDS budget (National UNGASS report 2006).

21 According to UNGASS National Report, Indicator (# 4), the % of most at risk population reached by the prevention programme is very low ( FSWs 35.2%, IDUs 8.6%, Migrants 0.04%, MSMs 5.4%)

allocation for HIV/AIDS programme has been very small and is mostly externally financed. Effective advocacy and policy is required not only to increase internal allocation but also to draw external funding for the programme.

## **Strategic results**

### **9.1.1 National work plans adequately financed**

### **9.1.2 National absorptive capacity improved**

### **9.1.3 Transparent budget tracking and reporting system established and functional**

## **Key actions**

1. Conduct high level advocacy to make the case and generate evidence to help argue for prioritizing HIV program
2. Leverage EDP resources to increase GON allocation
3. Support local and central bodies to analyze, prioritize and allocate resources for HIV
4. Explore incentives mechanism (e.g. tax incentives) for corporate sector for their effective involvement in HIV programme in workplace
5. Mobilise private sector for HIV and AIDS funding

## **Strategy: 9.2 Develop and implement multisectoral policy**

While involvement of non health sectors in HIV/AIDS programme has been increasing over the period, the continuity, consistency and expansion has been very limited. Some of the reasons for such slow involvement are lack of critical understanding about the epidemic, perception that it is a health problem, limited capacity and financial resource. The bulk of resources are still channelled through the health framework. Different sectors have specific advantage and role that can have profound impact on the spread disease, mitigating the socio economic impact, reducing stigma and discrimination and improving care and support. Policy and technical support is necessary to enable the line ministries to prioritize and integrate AIDS activities in their respective planning and budgeting cycles.

## **Strategic results**

### **9.2.1 Multisectoral guidelines and financial plan developed**

### **9.2.2 Programme and budget line in non health line ministries established**

### **9.2.3 Donor assistance to sectoral ministries mainstream HIV and AIDS as an essential element of assistance**

## **Key actions**

1. Include HIV/AIDS in annual/period planning cycle as a regular activity rather than an extra activity.

2. Provide technical support to non health sector for preparing and integrating HIV/AIDS programme in their respective sectors
3. Develop capacity of line ministries to argue for adequate and appropriate allocation of resources

**Strategy: 9.3 Establish a semi-autonomous body, with a flexible financial management system and rules.**

While the national strategy and annual work plan form a single frame of reference for all actors involved in HIV control in Nepal, and recently there has been some improvements in the utilization of GFATM and other resources, the most important impediment to a stronger, more effective response has been identified as the lack of an appropriate institutional mechanism with sufficient multi-sectoral partnership, civil society involvement, bureaucratic flexibility, adequate authority and capacity. Therefore it is important the effort is continued to set up an institutional mechanism that address the problems and impediments facing national programme.

**Strategic results**

**9.3.1 By 2009, at least 10 ministries (and by 2011, all relevant ministries) will have separate budgets for HIV/AIDS activities**

**9.3.2 Pooled funding mechanism advocated**

**9.3.3 Public Private Partnership established to mobilise resources**

**Key actions**

1. Establish and strengthen district and local level funding mechanism
2. Establish a task force to workout appropriate public private partnership mechanism for HIV/AIDS programme including treatment, care and support.
3. By 2009, at least 10%, and by 2011, at least 20% of private sector enterprises will have workplace HIV and AIDS programme in their enterprises
4. Budget review process established and functional
5. Financial information analysed regularly and shared widely among the stakeholders

**Strategy:9.4 Establish simplified, efficient and transparent financial system**

The rate at which the epidemic is progressing, the system and procedure with "business as usual" is not adequate to halt or reverse the progression. A more efficient system is necessary for the entire sector to act swiftly. The current financing and grant allocation system is not very efficient particular to the grass roots organisation, self help groups and other informal organisations who are in remote areas. Moreover, the process currently being adopted both at the government and at the donors level are too slow, cumbersome and complex to access and disburse the fund particularly at the grass roots level.

## **Strategic results**

- 9.4.1 Donor coordination and harmonisation mechanism established**
- 9.4.2 Simplified (and transparent) financial and grant allocation system developed**
- 9.4.3 Accountability and transparency for HIV/AIDS program at all levels (and with all partners, Government, Donors, NGOs) established**
- 9.4.4 By 2009, at least 50% and by 2011, at least 60% of donor support to the national program will be pooled.**

## **Key actions**

1. Use simplified financial procedures for the semi-autonomous entity – especially for rapid flow of fund to the grass-roots organizations
2. Earmark resources to central and community-based civil society organizations and vulnerable groups and disburse accordingly
3. Simplify and harmonize donor conditionality and procedures
4. Code of conduct developed for accountability and transparency

## **Annexes**

### **Annex 1: Targets for universal Access by 2010**

#### Low and Concentrated Epidemic Countries in Asia and Pacific region

1. 80% of most-at-risk populations reached by prevention programmes (e.g. Outreach services, condom promotion, drug substitution treatment, needle exchange, etc)
2. 60% of behavioural change of most-at-risk populations
  - a) Percentage of most-at-risk populations who both correctly identify ways of preventing the transmission of HIV and rejects major misconceptions about HIV transmission
  - b) Percentage of female and male sex workers reporting the use of a condom with their most recent client
  - c) Percentage of men reporting the use of a condom the last time they had anal sex with a male partner
  - d) Percentage of injecting drug users who have adopted behaviours that reduce transmission of HIV, i.e. who avoid using non-sterile injecting equipment or use methadone substitution treatment and use condoms, in the last 12 months (for countries where injecting drug use is an established mode of HIV transmission)
3. 80% of eligible people living with AIDS to be receiving antiretroviral combination therapy. Follow up with second and third line ARVs to be fully covered.
4. Resource mobilized by Government (both from domestic and international sources) fully meets the prevention and treatment targets, or at least 3 times increase for that in 2005
5. Enabling environment
  - a) Civil society engagement
    - i. Percentage of members in National AIDS Coordinating body who represent sectors of civil society
    - ii. Percentage of national AIDS response budget earmarked for programmes pertaining civil society, including capacity building and management support
  - b) Fight against AIDS related Stigma and Discrimination
    - i. National legislation to address stigma, discrimination, rights of infected and affected population.
6. % of HIV+ pregnant women receiving a complete course of ARV prophylaxis to reduce the risk of MTCT
7. % of orphan and vulnerable children (OVC) who received a basic external support package (e.g. School fee, shelter and food)
8. Reduction of new infections in the next five years as an outcome

Note: No. 1-3 are non-negotiable quantitative targets as agreed in the Regional Consultation on Universal Access at Pattaya in February 2006 and the civil society consultation in August 2006 in Bangkok

## Annex 2: Monitoring and Evaluation Framework

### Monitoring and Evaluation Framework for HIV in Nepal: Baseline & Targets for NSP

Monitoring and Evaluation Framework for HIV in Nepal: Baseline & Targets for NSP									
Standard Indicators (inc. UNGASS in blue shaded)	Indicative standards	Reference Yr Denominator ( <i><b>(national)</b></i> )	Add reference (Year)	Baseline (Year)	Add data (Year)	Suggested Targets (Universal Access...)			
						Jul 2007-Jul 2008	Jul 2008-Jul 2009	Jul 2009-Jul 2010	Jul 2010-Jul 2011
Prevention 1. HIV-related risk and transmission among Sex Workers reduced									
<b>Impact/Outcome Targets</b>									
% of female sex workers that are HIV infected (E Terai)		10,150	3% (2003)	1.5% (2006)			1.5%		1.5%
<i>% of female sex workers that are HIV infected (KTM)</i>		7,500	2% (2004)	1.4% (2006)			1.4%		1.4%
<i>% of female sex workers that are HIV infected (W Terai)</i>		3,250	0% (2003)	1.5% (2006)			1.5%		1.5%
<i>% of female sex workers that are HIV infected (Pokhara)</i>		600	2% (2004)	2% (2006)			2%		2%
% of female sex workers that have an STI (syphilis) (E Terai)		10,150	4.25% (2003)	5% (2006)	9.8% (GC2006)		4% (GC8%)		3% (GC6%)
<i>% of female sex workers that have an STI (syphilis) (KTM)</i>		7,500	6% (2004)	3% (2006)			3%		3%
<i>% of female sex workers that have an STI (syphilis) (W Terai)</i>		3,250	3% (2003)	4% (2006)	3.5% (GC2006)		4% (GC 3.5%)		3% (GC 3.5%)
<i>% of female sex workers that have an STI (syphilis) (Pokhara)</i>		600	2% (2004)	3.5% (2006)			3%		2%
% of female sex workers that report the use of condom with most recent client (E Terai)	80%	10,150	53.3% (2003)	68% (2006)			75%		80%
<i>% of female sex workers that report the use of condom with most recent client (KTM)</i>	80%	7,500	74% (2004)	77.2% (2006)			80%		80%
<i>% of female sex workers that report the use of condom with most recent client (W Terai)</i>		3,250	50% (2003)	43% (2006)			50%		60%
<i>% of female sex workers that report the use of condom with most recent client (Pokhara)</i>	80%	600	64.5% (2004)	75% (2006)			75%		80%

Output/Coverage Targets									
Female sex workers reached with targeted HIV prevention (eg. BCC with OE/PE or DIC or STI Clinics or community events / trainings - 2006) in Eastern Terai	80%	10,150	N/a	85.3% (2006)		85%	85%	85%	85%
Female Sex workers reached with targeted HIV prevention (eg. BCC with OE/PE or DIC or STI Clinics or community events / trainings - 2006) in KTM		7,500	N/a	85.2% (2006)		85%	85%	85%	85%
Female Sex workers reached with targeted HIV prevention (eg. BCC with OE/PE or DIC or STI Clinics or community events / trainings - 2006) in W Terai		3,250	N/a	70% (2006)		75%	77%	80%	80%
Female Sex workers reached with targeted HIV prevention (eg. BCC with OE/PE or DIC or STI Clinics or community events / trainings - 2006) in Pokhara		600	N/a	57% (2006)		61%	68%	74%	80%
Number of female sex workers receiving HIV test results & post-test counselling	80%	30,000	4% (2006)	1,206 (2006)		20%	40%	60%	80%
Condoms distributed or sold (in millions)		23,000,00		16,000,00		20,000,000	23,000,000	26,000,000	29,000,000
Prevention 1: HIV-related risk and transmission among MSM reduced									
Impact/Outcome Targets									
% of MSM* that are HIV infected (KTM)		13500*		3.6% (2004)		3%		2%	
% of MSW that are HIV infected (KTM)				4.8% (2004)		4%		3%	
% of MSM that have a STI (syphilis)				1.5% (2004)	3.6% (GC2004)	1.5% (3% GC)		1.5% (3% GC)	
% of MSW that have a STI (syphilis)				2.4% (2004)	12% (GC2004)	2% (10% GC)		2% (5% GC)	
% of condom use by MSM at last anal sex	80%			55.9% (2004)		65%		80%	
% of condom use by MSW at last anal sex	80%			66.7% (2004)		75%		80%	
Output/Coverage Targets									
MSM reached with targeted HIV prevention (eg. BCC & condom, STI treatment)	80%	129,000	36% (KTM 2004)	14115 (2006)	22%	40%	50%	60%	80% (MSW focus)
Number of MSM receiving HIV test results & post-test counselling	80%	32,250	-	77 (2006)	-	40%	55%	70%	80%

Prevention 1: HIV-related risk and transmission among IDUs reduced									
Impact/Outcome Targets									
% of IDU that are HIV infected (E Terai)		3,550	35.1% (2003)	31.6% (2005)	28%		24%		
% of IDU that are HIV infected (KTM)		5,750	68% (2001)	51.6% (2005)	45%		35%		
% of IDU that are HIV infected (Pokhara)		950	22% (2003)	21.7% (2005)	18%		14%		
% of IDU that are HIV infected (W Terai)		2,650	-	11.7% (2005)	10%		8%		
% of IDU that avoid sharing injecting equipment in last ( <i>week</i> ) month (E Terai)	80%	3,550		67.8% (2005)	75%		80%		
% of IDU that avoid sharing injecting equipment in last ( <i>week</i> ) month (KTM)	80%	5,750		78.3% (2005)	80%		80%		
% of IDU that avoid sharing injecting equipment in last ( <i>week</i> ) month (Pokhara)	80%	950		65% (2005)	72%		80%		
% of IDU that avoid sharing injecting equipment in last ( <i>week</i> ) month (W Terai)	80%	2,650		69% (2005)	75%		80%		
% of condom use by IDU at last sex (E Terai)	80%	3,550	64.3% (2003)	71.4% (2005)	76%		80%		
% of condom use by IDU at last sex (KTM)	80%	5,750	60% (2001)	75% (2005)	80%		80%		
% of condom use by IDU at last sex (Pokhara)	80%	950	79.8% (2003)	74.4% (2005)	80%		80%		
% of condom use by IDU at last sex (W Terai)	80%	2,650	-	59.4% (2005)	70%		80%		
Output/Coverage Targets									
IDU reached by Harm Reduction programme	80%	20,000		3,000 (2006)	(=15%)	40%	55%	67%	80%
Number of IDU receiving HIV test results & post-test counselling	80%	20,000		1,353	(=6.7%)	20%	30%	40%	50%
Needles distributed to IDU's	80%	21,900,000		987,433 (2006)	4.5% (2006)	7665000	10950000	14235000	17520000
Number of IDU on OST (BP or MMT)		20,000		0 (2006)		240	600	900	900
Prevention 1: HIV-related risk and transmission among Mobile populations (migrant workers, truck drivers etc..) reduced									

Impact/Outcome Targets									
% of clients of female sex workers that are HIV infected (proxy: Truck drivers) (22 districts)		660,000 (2005)	1.75% (2005)	1% (2006)			1.75%		1.75%
% of migrant workers that are HIV infected (West)		1,240,000 (2006)		1.1% (2006)			1%		1%
% of migrant workers that are HIV infected (Far West)				2.8% (2006)			2%		1%
% of clients of FSW (Truckers) that have an STI (syphilis) (22 districts)		1,240,000 (2006)	1.8% (2003)	1.75% (2006)			1.5%		1.5%
% of clients of FSW (Truckers) reporting the use of condom at last sex (22 districts)			84.7% (2003)	89.8% (2006)			90%		90%
% of Migrant workers that report the use of condom at last sex (West)	80%			63.6% (2006)			70%		80%
% of Migrant workers that report the use of condom at last sex (Far West)	80%			71% (2006)			75%		80%
Output/Coverage Targets									
Migrant population reached with targeted HIV prevention (eg. BCC with OE/PE or DIC or STI Clinics or community events/trainings - 2006)	80%	1,240,000	27.5% (Truckers, Terai 2006)	85,597(2006)		248000	372000	744000	992000
Migrant population receiving HIV test results & post-test counselling	80%	310,000	1.2%	3,861		10%	30%	50%	70%
Prevention 1: HIV-related risk and transmission among Institutionalized population reduced									
Impact/Outcome Targets									
Output/Coverage Targets									
Prisoners reached with HIV prevention (including health education, condoms & STI treatment.)	80%	5680 (2006)		0		20%	40%	60%	80%
Number of prisoners receiving HIV test results & post-test counselling	80%	F(risk behaviour)'		n/a					
Prevention 1: HIV-related risk and transmission among Uniformed services reduced									
Impact/Outcome Targets									
% of condom use by uniformed services		F(risk behaviour)'		-					
Output/Coverage Targets									

Uniformed personnel reached with HIV prevention (BCC, PE, Condom & STI Treatment)	188,000	-	11,410 (2006) or 6%						
Prevention 1: HIV-related risk and transmission among Young people reduced									
Impact/Outcome Targets									
% of condom use by young people at last paid sex (15-24 y/o)	80%		-	37-66% (2005)	50%	60%	70%	80%	
% of youth who correctly identify the three common ways of preventing HIV transmission & who reject misconceptions	95%	-	-	27-50% (2005)	65%	75%	85%	95%	
Output/Coverage Targets									
Out of school youth (15-24) reached by prevention programme	20%		-	14706 (2006)					20%
In-school youth (10-16) reached by life-skills programme	45%		-	15214 (2006)					45%
(%) No of schools with teachers who have been trained in life-skills-based HIV education and who taught it during the last academic year	45%		1501 Teach trained	1231					45%
Prevention 1: HIV-related risk and transmission among men and women of reproductive age reduced									
Output/Coverage Targets									
Men and women of reproductive age reached by prevention programme	0%	11,360,000	-	-	-				0%
Reproductive age receiving HIV test results & post-test counselling each year (excluding targeted pop)	1%								1%
% of people with STI appropriately diagnosed, counselled and treated	75%	n/a	-	-		75%	75%	75%	75%
Number of patients treated for STI	-	568,000	-	2% (Syph2005)	5% (GC+2005)	250,000	350,000	450,000	600,000
Number of service delivery points providing STI treatment (incl NGO & govt serv)	-		-	74 (2005)	-				
Treatment and Care 2: Availability & access to Treatment, Care and Support for PLWH improved									
Treatment, care and support with & without ARV									
Impact/Outcome Targets									
% adults & children alive at 12 months after initiation of ART		-		WHO/NCASC					
Output/Coverage Targets									

Number of People with Advanced HIV Infection receiving ARV ( <i>all</i> )		10,538	4.5%	472 (2006)		10%	15%	20%	15%
Number of Children with Advanced HIV Infection receiving ARV (<15 yrs)		400	4%	17 (2006)					
Number of people living with HIV receiving Cotrimoxazole as prophylaxis (>15y/o)		3688		529 (2006)	14%				
Number of PLWH diagnosed & treated for TB									
Number of people receiving palliative care & support ( <i>without ARV</i> )				1245 (2006)					
Number of health facilities with the capability to provide advanced HIV & AIDS clinical care & psychosocial support, including ARV combination therapy			3 (2005)*	7+3 (2006)*		15	15	15	15
Number of service delivery points providing counseling & testing for HIV (exclud. PMTCT)				65 (2006)		65	65	65	65
Prevention of Mother to Child Transmission									
Impact/Outcome Targets									
% of infant born to HIV infected mother that are HIV infected ( <i>national</i> )		28 (2006)	-	UNICEF (Jan07)					
Number of exposed infants on Cotrimoxazole ( <i>proxy for above</i> )			-	55					
Output/Coverage Targets									
Pregnant women receiving HIV test results & post-test counselling ( <i>PMTCT districts</i> )*	80%	144,482		17.86%		25%	40%	60%	80%
Pregnant women receiving HIV test results & post-test counselling ( <i>PMTCT sites</i> )*	80%	31,786		81.17%		85%	87%	90%	90%
% of mother- baby pair receiving a complete course of ART prophylaxis for PMCT		4,950		0.57%					
Number of service delivery points providing PMTCT	low in conc epidemic	N/a		7 (2006)		16	16	16	16
3-5: Policy, Leadership, Strategic Information and Resource mobilisation strengthened									
Impact/Outcome Targets									
Output/Coverage Targets									
% of districts implementing HIV test with no stock out of HIV test kits	100%					100%	100%	100%	100%

Proportion of HIV testing laboratories participating in EQAS for HIV serology	100%								100%
Proportion of transfused blood units screened for HIV (last year)	100%	82,677				100%	100%	100%	100%
Amount of national funds disbursed by government of Nepal for HIV and AIDS				146,657					
National Composite Policy Index (Prevention, care & support, human rights, civil society involvement, monitoring and evaluation)									
Amount of bilateral and multilateral financial flows (commitments and disbursements) for the response to HIV and AIDS in Nepal									
% of large enterprises who have HIV/AIDS workplace policies and programme	3%			Survey to be conducted					3%
* 3 ART sites 2005: Teku, Dharan, Nepalganj									
* 7 ART sites 2006: Teku, Dharan, Nepalganj, TUTH, Pokhara, Mahendrenagar, Birgunj, + 3 community sites in Kathmandu: Sparsa, Navakiran+, Maiti Nepal									
* New ARTsites for 2007: Dangadhi (Sedi Zonal Hospital), Surkhet, Bhutwal, Chitwan, Hetauda, Doti, Jhapa.									