National HIV/AIDS Srategy 2011-2016

Government of Nepal
Ministry of Health and Population
National Centre for AIDS and STD Control
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ACRONYMS AND ABBREVIATION

AAA	Accra Agenda for Action
ART	Anti Retroviral Therapy
CABA	Children Affected by AIDS
CBOs	Community Based Organisations
CCWB	Central Child Welfare Board
CHBC	Community and Home Based Care
CSO	Civil Society Organisation (interchangeably used with NGO)
DACC	District AIDS Coordination Committee
DCWB	District Child Welfare Board
DDC	District Development Committee
DOTS	Directly Observed Treatment Short course
EDPs	External Development Partners
EQAS	External Quality Assurance System
FSW	Female Sex Workers
GAVI	Global Alliance for Vaccine Initiatives
GESI	Gender Equity and Social Inclusion
GFATM	Global Fund to Fight against AIDS, Tuberculosis and Malaria
GIPA	Greater Involvement of People with AIDS or HIV
HMIS	Health Management Information System
HSS	Health System Strengthening
HTC	HIV Testing and Counselling
IBBS	Integrated Bio-Behavioural Survey
ICPD	International Conference on Population and Development
IDUs	Injecting Drug Users
INGOs	International Non Governmental Organisations
M&E	Monitoring and Evaluation
MACC	Municipal AIDS Coordination Committee
MARPs	Most At Risk Populations
MCH	Maternal and Child Health
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 STD Control
NGOs	Non Government Organisations
NHSP	Nepal Health Sector Programme
NSP	National Strategic Plan
OI	Opportunistic Infections
OST	Oral Substitution Therapy
PEP	Post Exposure Prophylaxis
PITC	Provider Initiated Testing and Counselling
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission of HIV
PPP	Public Private Partnership
SGS	Second Generation Surveillance

SRH	Sexual and Reproductive Health
STI/STD	Sexually Transmitted Infection/Disease
SWAP	Sector Wide Approach to Programme
TG	Third Gender
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
VACC	Village AIDS Coordination Committee
VDC	Village Development Committee
WHO	World Health Organization

ACKNOWLEDGEMENTS

EXECUTIVE SUMMARY

HIV in Nepal is characterized as concentrated epidemic. More than 80 percent HIV infections spread through heterosexual transmission. People who inject drugs, female sex workers (FSWs) and men having sex with other men (MSM) are the key populations at higher risk spreading the epidemic. Male labour migrants (particularly to HIV prevalence areas in India, where labour migrants often visit female sex workers) and clients of female sex workers in Nepal are acting as bridging populations that transmit infections from higher risk groups to lower risk general population. As the epidemic is maturing (after the first HIV case reported in 1988), increased number of infections are being recorded among low risk general men and women. However, the epidemic has never maintained through heterosexual transmission in the general population in Nepal, rather driven by the infections among higher risk populations and their sexual partners.

It is estimated that about 55,626 people are living with HIV in Nepal in2010. Majority of infections are occurred among adult (15-49) male (58%) women of reproductive age group (28%) populations, while 8% of infections are occurred among children under 15 years of age. The key populations at higher risk (IDUs, FSWs, MSM, male labour migrants and clients of FSWs) shared 58% of all adult HIV infections. Highest number of infections is estimated is in the age group of 25-49 years who are economically productive and sexually active. The younger stratum of population below the age of 15 has lowest number of infections and most are due to mother to child transmission.

Recent results of reduced new HIV infections are attributed to effective prevention interventions, particularly among key high risk population groups such as IDUs, FSWs and their clients. However, the rate of new infections has increased among MSM/TG in Nepal. In overall, the adult (15-49) HIV prevalence has started declining slowly, while the prevalence has been declining more rapidly among young populations (15-24). This demands for a continued effective prevention efforts to be sustained among key populations at higher risk, especially among young and new entrants into the risk behaviours. There were significant achievements in the last 5 years. The HIV prevalence is moving to a downward trend and it is at 0.33% in 2011.

The National HIV/AIDS Strategy is a national guiding document and a road map for the next five years. for all sectors, institutions and partners involved in the response to HIV and AIDS in Nepal to meet the national goal; to achieve universal access to HIV prevention, treatment, care and support with two major programmatic objectives (i) reduce new HIV infections by 50% and (ii) reduce HIV-related deaths by 25%, by 2016. The strategy delineates the central role of the health sector and the essential roles the other sectors play, in response to the HIV epidemic.

The current national HIV/AIDS Strategy, therefore, builds two critical programme strategies: (i) HIV prevention and (ii) treatment care and support of infected and affected. To ensure the achievements of programme outcomes, cross-cutting strategies are devised to supports (i) creating enabling environment: health system strengthening, legal reform and human rights and community system strengthening (ii) strategic information (HIV and STI surveillance, programme monitoring and evaluation and research).

The strategy is linked with the national development plan, sectoral plans such as Nepal Health Sector Plan – II that is for the overall health development in Nepalese people. The plan is specifically aimed to reduce poverty and achieve millennium development goals through universal access and coverage to free essential health care services and reduce new HIV infections and reduce AIDS related deaths. The strategy has built on to timely accomplish the national and global commitments such as the United Nations General Assembly Special Session on AIDS (UNGASS), Millennium Development Declaration, the Universal Access to prevention, treatment, care and support, and recently in June 2011, Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS, that have direct or indirect bearing on the HIV response in Nepal. Nepal being a party to the Paris Declaration (2005) and Accra Agenda for Action (AAA 2008), the strategic directions are envisioned to align the principles of emphasizing ownership, alignment, harmonisation, results and mutual accountability for allocation and utilizing development assistance.

Building on the achievements, lessons learned and experiences gained of the past five years of implementing HIV/AIDS strategy 2006 to 2011, the current strategy focus on the followings:

- Addressing complete dimensions of prevention to treatment care and support continuum
- Effective coverage of quality interventions based on the epidemic situation and geographical prioritization
- Health system and community system strengthening
- Integration of HIV services into public health system in a balanced way to meet the specific needs of target populations
- Strong accountability framework with robust HIV surveillance, program monitoring and evaluation to reflect the results into NHSP-II and National Plan

The estimated budget for National HIV/AIDS Strategy 2011- 2016 is US$ 167,483,892.

CHAPTER I: INTRODUCTION AND SITUATION ANALYSIS

INTRODUCTION

National HIV/AIDS Strategy, 2011-2016

The National HIV/AIDS Strategy is a national guiding document for all sectors, institutions and partners involved in the response to HIV and AIDS in Nepal. It sets national goals and specifies key strategies required from each sector in order to achieve the results. The Strategy covers the central role of the health sector and the essential roles the other sectors play, in response to the HIV epidemic. It calls on all actors to initiate and scale up their efforts to fight HIV and AIDS, and transform their approaches to ensure effective national as well as local response.

The previous National Strategic Plan 2006–2011 aimed to contribute directly to the Millennium Development Goal 6 "To halt and begin to reverse the spread of HIV by 2015" and was designed in line with the universal access target of 80% coverage of prevention, treatment, care and support services for most-at-risk population (MARPs) and people living with HIV(PLHIV). The NSP 2006-2011 clearly emphasised the expansion of service outlets and coverage while broadening the scope and opportunities for partnership. The strategy offered a strong foundation on which a scaled up response mechanism could be developed in order to effectively respond to the changing scenario of the epidemic.

There were significant achievements in the last 5 years. The HIV prevalence is moving to a downward trend. This year, 2011, it is at 0.33%. Moreover, the Universal Access Progress Report 2010 indicated that the coverage for prevention services for MARPs was close to, or exceeded 80% in many of the program sites. The same report showed that the country is likely to achieve the majority of the UA indicators against the targets set in the NSP 2006-2011. The National Planning Commission in 2010 had reviewed the progress of MDG in Nepal and reported that Goal 6 target 7 is likely to be achieved.

In spite of the successes and innovative approaches achieved in the previous strategy period, the implementation of the Strategy encountered a number of critical challenges and certain elements of the Strategy were not fully realised particularly in the areas of policy formulation, institutional arrangements, leadership commitments, donor harmonisation and resource mobilisation.

A review of the NSP 2006-2011 found considerable gaps in reaching migrant workers to India and their spouses, low rates of utilization of VCT services and PMTCT services, policy variations in initiation of ART, lack of mainstreaming of HIV into other sectoral plans, lack of coordination and unclear roles at the highest levels of government as well as the national coordinating bodies in the HIV response, limitations in civil society capacities, continuing discrimination against transgender persons, and almost complete dependence on external sources of funding for HIV/AIDS.

Building on the achievements, lessons and experiences of the past five years, the strategy (2011-2016) will focus on the following key points:

a) Addressing the all dimensions of continuum of care from prevention to treatment care and support
b) Effective coverage of quality interventions based on the epidemic situation and geographical prioritization
c) Health system and community system strengthening
d) Integration of HIV services into public health system in a balanced way to meet the specific needs of target populations

e) Strong accountability framework with robust HIV surveillance, program monitoring and evaluation to reflect the results into NHSP-II and National Plan

Linkages with sectoral plans (NHSP and others)

National Plan

The National Development Plan of Nepal has accorded HIV as a priority one (P1) programme. The P1 status in the national plan allows line ministries to plan HIV and AIDS related interventions, and the National Planning Commission and the Ministry of Finance to give high priority in allocating and approving resources accordingly.

National Health Sector Implementation Plan (NHSP - II)

The National Health Sector Plan is a five year plan that provides strategic and planning direction for the health sector. The NHSP–II 2010-2015 includes a plan to halt or reverse the HIV prevalence[1] and has made the commitment to scale up current level of intervention through the health sector under the essential health care package and within the broader framework of communicable diseases. It has also recognised the need to scale up sexual and reproductive health services and integrate HIV into SRH services. This will provide the Ministry of Health and Population and its divisions clear initiative to mobilise additional funding to scale up the intervention as well as integrate HIV related services into operations of the respective divisions. NSHP II also strengthens partnership with international and national non-governmental organizations as the implementation modality. This current strategy is in line with the NHSP IP-II which incorporates components like Health System Strengthening (HSS), Integration, Gender Equality and Social Inclusion (GESI), and Human Resource development.

Other Sectoral Plans

A number of sectoral plans such as National Drug Control Strategy (Ministry of Home Affairs), Education for all, SSRP (School Sector Reform Plan - 2009 -2015", Ministry of Education), National Youth Policy (Ministry of Youth and Sports) are in place and some are more explicit on HIV linkages. Some of the national initiatives such as poverty alleviation programme; social security and foreign labour employment will have important implications for HIV prevention, treatment and care. As part of mainstreaming effort the opportunity and space available in such plan will be fully explored and utilised through this strategy.

International and Regional Commitments

Nepal has made number of international commitments and is party to international instruments that have direct or indirect bearing on the HIV response. For example, the United Nations General Assembly Special Session on AIDS (UNGASS), Millennium Development Declaration, the Universal Access (UA) to prevention, treatment, care and support, and recently in June 2011, the Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS- all have direct commitments to HIV and AIDS.

On the other hand, the country is also a signatory to, or a party to the following which have commitments that indirectly address HIV.

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[1] NHSP IP –II result framework talks about HIV prevalence among pregnant women aged 15-24 years

- International Conference on Population and Development or ICPD (Cairo convention);
- Convention on Rights of Children (CRC) , and optional protocol;
- Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW);
- Elimination of Discrimination (Employment and occupation) Convention, 1958 (No. 111);
- Convention on Worst forms of child labour 1999; and
- International Health Partnership (National Compact)

Furthermore, Nepal is also party to the Paris Declaration (2005) and Accra Agenda for Action (AAA 2008) which both complement each other, emphasizing ownership, alignment, harmonisation, results and mutual accountability for allocation and utilizing development assistance. AAA further builds on Paris Declaration and in addition puts focus on the need for predictability and strengthening country systems. On the regional front, Nepal is among SAARC Member States committed to ensuring protection, care and support for children affected by HIV/AIDS (CABA) as articulated in the 2008 SAARC Regional Strategic Framework on the protection, care and support of CABA.

Such linkages to other sectors as well at the international commitments have allowed the government to make more focused and integrated policies and programmes as well as participate in international advocacy processes for a better international response and donor harmonisation. Moreover, the inbuilt and well established monitoring mechanism involved with these commitments at national, regional and international level has allowed the country not only to monitor the achievements and track the HIV epidemic in the country, but also to improve the strategic information system in the country and expand the understanding on the unfolding and evolving realities of HIV and AIDS.

Country Overview

Nepal has a population of about 26.7 million with an annual rate of growth of 1.94 percent (Preliminary findings of Census, 2011). About 48% of which are between the age of 15-49 years which is a vulnerable age for acquiring and transmitting HIV infection. Administratively the country is divided into five development regions and 75 districts however, it is moving towards a federal structure.

Significant progress towards key national health goals, particularly the Millennium Development Goals 4 and 5, has been made. Besides, the MDG goal 3 talks about gender equality and empowering women will have direct implication to women and HIV issue in the country. Under five mortality and maternal mortality has also improved significantly with some disparity between rural and urban women. After the introduction of free essential health services at health post and sub health post levels, utilisation of health services and equity is reported to have improved.

There has been remarkable progress in health in Nepal, especially in decreasing child mortality and maternal mortality in the past years. The health system has a wide network and delivery outlets up to the ward level through mobilizing various levels of human resources. About 49,000 female community health volunteers who act as interface between the health system and the community is a strength of the health system. They act as motivators and communicators for delivery of health services, especially maternal, child health and family planning services.

Table 1: **Health Facilities and Health Human Resource under Ministry of Health and Population**

Health facility under MoHP	Value
1. Total Health Institutions under MoHP	4396
Hospitals(Central, Regional, Sub-regional, Zonal and District)	94
Health Center	5
Primary Health Center (PHC)	218
Health Post	699
Sub-Health Post	3104
Ayurvedic Health Institution	293
2. Total Hospital Beds	6944
Health human resource under MoHP	
Doctors	1457
Nurse/ANM	11637
Paramedic/Health Assistant	7491
Village Health Worker	3190
MCHW	3985
Ayurvedic Physician	394
Baidhya	360
Health Volunteers	
Female Community Health Volunteer including Trained Traditional Birth Attendants	63326
Total Health manpower	91840
Life Expectancy at birth (2009)**	
Male	67.8
Female	66.4
Adult Literacy rate (2009)**	
Female	43.6
Male	70.3
Primary Enrollment gross (M/F)**	127/126
Secondary Enrollment (gross) M/F**	45/41
Health expenditure , Public (% of GDP)**	1.6
Access to improve drinking water sources**	89
Human Development Index (value) 2011	0.458
Human Development Index (rank) 2011	157
Human Poverty Index(2008)	24.7
Ranking of Human Poverty Index (2008)	88
Prevalence of HIV in adult population 15-49 Yrs (%)	0.33

**** State of world population 2009, UNFPA**

Source: http://www.mohp.gov.np/english/about_moh/fact_sheet.php

*****Population below poverty line by country", CIA World Fact books 18 December 2003 to 28 March 2011.*

Health system in Nepal

The health delivery system is extensive with at least one health facility (Sub Health Post or Health Post) in each Village Development Committee in the country primarily emanating from the principles

of a primary health care approach. Female community health volunteers have uniquely strengthened the health delivery system in Nepal over the last two decades. Sub Health Post, Health Posts, Primary Health Care Centres, District hospitals, Zonal hospitals, Regional hospitals and Central hospitals are subsequent layers of higher level service providing facilities with provision of specialised diagnosis and treatment.

Health sector reform in Nepal has been an ongoing process for several years. The most recent addition is the 10 point policy guidelines adopted in 2007 and the NHSP – I (2004 – 2009) and NHSP –II (2010-2015) which sets out strategic and programmatic directions for the health sector. The current health sector programme is implemented under a sector-wide programme approach (SWAP) focusing on results through quality service and policy reform. Supported by several development partners, it is implemented with an agreed set of performance indicators and policy reform milestones.

There are a number of international and national NGOs working in the health sector and their roles are appreciated in supporting and complementing the government's efforts.

Private sector health care providers working for profit are widespread in Nepal. They provide diagnosis and management of diseases, and are a major recipient of out-of-pocket spending by all income groups[2]. Although, some private sector inputs are included in the national reporting system, but much room is available for improvement. For HIV, the challenges for the health system is to be able to meet the ever increasing demand for diagnostic and treatment related services and integrating them in existing health delivery system particularly in those divisions responsible for providing wider services such as family health programme, child health programme, curative and diagnostic services including Health Management Information System(HMIS).

Review recommendations

During the implementation of the National Action Plans (2006-2008; 2008-2011) of the NSP 2006-11, a mid-term review in 2008 was carried out, and an End-review in 2011.

The major recommendations of the NSP 2006-211 reviews include the following:

Prevention

- There is a strong need of harmonization and coordination of programs implemented by various partners. Establish a Central Data Bank and share data based on the national M& E guideline.
- Re-assess the utilization of existing HIV Counselling and Testing (HTC) centre's and their locations for optimal utilization and also possible integration with the existing health services. Broader linkage of HTC with other relevant health services should be established and expanded for making it sustainable.
- The Oral Substitution Therapy (OST) program is seen primarily as a HIV prevention strategy and this program should fall under the domain of health sector. Therefore, OST program should be integrated with the existing Health System Strengthening (HSS). Medical doctors need to be further trained for expanding the services on a pilot basis in few districts. The government will have to take over the programme to ensure sustainability of entire OST program.
- There is a need to significantly expand prevention and develop better strategies to reach larger numbers of Nepali migrants working in India. While the coverage needs to be improved, it is

[2] In 2005/2006, out of pocket spending was 50% of the total health expenditure in the country (National Health Account, MoHP 2009)

important to recognize that all migrants are not at equal risk. Hence, it is necessary to clearly define migrants who are at risk of HIV and how will they be approached for HIV prevention.
- The WHO and UNAIDS trial results which show that antiretroviral therapy is 96% effective in reducing HIV transmission in discordant sex partner, need to be evaluated in Nepalese context to carefully address in the future National HIV/AIDS Strategy.
- The future National HIV/AIDS Strategy considers the mapping and size estimation exercise of MARPs for evidence based program planning.

Treatment, Care and Support

- All treatment, care and support program enhancement are seen and has yielded positive impact in the community with some obvious gaps and challenges in the treatment. All the contributing factors for the treatment gaps need to be collated, reviewed, analyzed and addressed at the earliest. There is a need of expansion of the ART services, but prior to that there is need of scaling up the case detection capacity through various strategies like awareness raising, HTC expansion, incentives provision, and sigma and discrimination reduction.
- Scaling up of the ART should be done on the basis of needs assessment and geographical MARP mapping data. To make the treatment service more accessible, strategies to bring services closer to the population in need is to be explored.
- At least one Institution each for ART, STI and Lab services needs to be strengthened as national referral centre / centre of excellence. Clear guidelines and criteria are required to be developed and accordingly capacity built up.
- There is a need to surge the capacity for ART and STI management at the public sector but more private sectors involvement need to be sought and supported. The laboratory service capacities also need to be expanded; through high levels of technical skills, constant maintenance and quality control. In parallel, strategies like transport of samples (not patients) are also need to be incorporated.
- The general lack of adequate human resources, overburdening on existing staff, and the frequent transfer of the staff should be addressed. Apart from strengthening the public sectors, one way to overcome this challenge is to encourage the modality of public- private partnership. Continuous training programs need to be conducted for updating the information and also for training the new staffs. Private sectors need to be mainstreamed at least in some pilot districts.
- Overall training programs related to HIV/ AIDS need to be integrated and mainstreamed in the existing health system, so that the trainings would be quality assured and cost effective. National Health Training Centre (NHTC) has the institutional capacity for conducting training on health topics, including HIV and AIDS, since year 1994-1995.
- Strong linkage and coordination between ART centers and existing CBOs /NGOs /CHBC /DACC need to be developed for monitoring process. Quality control mechanisms need to be established including the HIV drug resistance strategy.
- Co-infection of Hep B and Hep C need to be incorporated in the strategy with costed intervention including provision of vaccinations for at risk population.
- Linkages and integration with other program services (HTC, TB, HIV, PMTCT, ANC, Safe motherhood, family planning, etc.) should be fostered and strengthened to assure comprehensive management of patients and future sustainability.
- Institutional codes of conducts for health care providers need to be developed and implemented in a planned way at all levels(with existing strong and amended policy to support it) and needs to be implemented in a planned way and at all levels.
- Knowledge and tools for Universal Precautions (UP) and Post Exposure Prophylaxis (PEP) need to be widely advocated and enforced at all levels of health care facilities both in private and public. Their implementation needs to be monitored.

- The partnership with associations of PLHIV and CBO should be strengthened not only for the promotion of services, but for the key role that these entities can play in enhancing the continuum of care for patients through Community Home Based Care (CHBC).
- Need for developing joint collaborative TB/HIV/AIDS plan for integration of DOTS / HTC centers at different levels. Joint training program along with community sensitization about the TB HIV co-infection is to be conducted. All HIV patients should be systematically screened for TB while all TB patients should be offered HIV testing. At the same time two-way referral strategies between TB and HIV services should be in place with close collaboration between National Tuberculosis Center and NCASC.
- Mitigation and elimination of Stigma and Discrimination is possible only through massive and consistent awareness raising campaigns which need to be scaled up round the year with the greater involvement of PLHIV, CBOs, NGOs, faith groups and media personnel. The national advocacy plan needs to be widely implemented in different settings. There is a need of developing agreed "code of conduct" for health care providers and health care facilities to making them PLHIV friendly.
- An early initiation of ART in discordant couples for reduction of HIV transmission (by 96%) to uninfected sexual partner is recommended to be studied in our context.

Policy, Advocacy and Legal Reform

- HIV/AIDS has been considered as a National Development Agenda, and has been given the priority one category in the national plan and its issues have been clearly reflected in the Millennium Development Goals (MDG). Hence, it is NOT only the responsibility of MoHP, rather shared responsibility of other ministries as well. As a result, the multi sectoral response should be strengthened, and line ministries should be mainstreaming the process. Advocacy to enhance mult-sectorality beyond health is pertinent in this regard.
- Create an effective advocacy implementation to reach the strategy's goals. To this end come together to identify problems and solutions; get the facts; Identify the target audience; determine what and where opportunities are for influence; establish the system to celebrate accomplishments – small and large.
- Establish a system to enable Most At Risk Population (MARPs) and People Living with HIV (PLHIV) to address the issue of stigma and discrimination and other violations of their rights.
- Use the example of the NPA GBV to promote inter-sectorality in the HIV response, sectoral priority ministries to ensure the HIV focal points/units and make guarantee they have a role in strategic planning in both the HIV programme and main stream HIV at local government level.
- HIV National Strategy Plan – II be drafted, among other things, in line with new policy and proposed provisions in HIV bills and needs to be ensure the action point for district mapping to identify the real targeted populations.

Leadership and Management

- The roles and responsibilities of National AIDS Council (NAC), HIV STD Control Board HSCB), National Centre for AIDS and STD Control (NCASC), and local level coordinating committees should be clearly defined and coordination should be maintained.
- Capacity of both supply of and demand for services should be strengthened to ensure the participation of community organizations in the response; to make more decentralized system, and improve the rights of Meaningful Involvement of People with AIDS(MIPAs).
- NAC should be functional and responsive, to this end, there should be established provision of precedent at least one or two meetings in a year.
- GON should provide a minimum grant to run the HSCB office and NAC Secretariat. For the additional grant, operational autonomy should be given.

- Management capacity of NCASC needs to be sustained with increasing resources; and continued support to maintain it, through adopting decentralized planning and timely implementation.
- Multi sectoral involvement and HIV/AIDS program should be scaled up throughout the MARPs population and improve the response.
- Self monitoring mechanism and self sustainability of Networks to response HIV should be developed.
- The mechanism to improve the quality response, supply of commodities, and training procedures should be strengthened in both public and private providers.
- The existing provision of partnership forum on HIV AIDS under HSCB, which was formed in 2009 should be strengthened for HIV response.
- There should be national training plan and technical support plan based on need assessment. Evidences based on policy should be developed through action research.
- Bottom up approach of planning mechanism and implementation capacity need to be strengthened

Strategic Information

- Role and responsibilities of HSCB and NCASC need to be further clarified and implemented in practice. Broadly the NCASC need to play role in monitoring and evaluating the programmatic and technical components. Whereas HSCB should be focusing on policy related and multisectoral engagements related issues.
- There is an apparent need to strengthen the DACCs / MACCs / VACCs to perform their M&E roles effectively at the district level programs and develop linkage with the higher body.
- A Continuous capacity building process need to be institutionalized for making M & E an ongoing activity at all level.
- In the long run the M & E system need to be integrated with the national HMIS, therefore phase wise approach need to be initiated.

Finance and Resource Mobilization

- Strong advocacy is needed to get increased budget allocation from the government, and pooled funds under NHSP IP - II.
- To minimize the risk of funding gap against the NAP, at least 80 % financing must be ensured during the planning time. All HIV accounts must be consolidated and green paper needs to be published for maintaining transparency and make sure the future planning is near to correct.
- Budget absorption capacity should be increased and at least 80 % planned budget should be utilized to maintain the HIV as a priority agenda. It should be matched between planning and budgeting; a single plan should be accepted from all, and mutual accountability should be maintained.
- Sufficient funding should be maintained for the capacity building of sectoral ministries on HIV program needs to be improved, and focus should go on development of system, minimum infrastructure; and training of human resources, skills and tools development for HIV sensitive planning and response.
- Every working partners and NCASC should focus on timely implementation of the program.
- Empower and strengthen the HSCB in terms of financial autonomy**,** provide minimum funding for recurrent expenses, to pay for the utilities bills; and promote performance based financing for multi sectoral response and HIV sensitive plan implementation.

Recommendation from DFID Evaluation 2010

Furthermore, in May 2011, an External Evaluation of DfID-support to the National HIV/AIDS Program 2005-2010 was carried out. The following were the major recommendations summarized below.

Greater coordination and connection among NCASC, HSCB and DACC in the districts to manage and oversee the program (both health and non-health) is required. It requires a full development of HIV and AIDS monitoring and evaluation system; broader participation in planning and gradual integration of government and NGO services along with sufficient deputation of human resource for health up to the district level.

- There should be full utilization of feedback channels and recording/reporting system. IBBS along with different researches that will guide for effective implementation.
- Multi- sector collaboration and mainstreaming of HIV and AIDS related activities beyond the health sector should be broadly expanded to enhance and bring additional resources to the overall national response.
- Drug abuse should be addressed across the full continuum from demand reduction to harm reduction, rehabilitation and re-integration with greater emphasis as well on preventing non-injecting drug-users from becoming IDU.
- In the current resource environment NGOS and networks focused on PLHIV should continue to reevaluate the most important and demanded services of community care centers and modify the activities of these facilities and their linkages with hospitals and the community accordingly. Further work on bringing counselling and other community care services into hospital wards dealing with opportunistic infections (OIs) should be carried out by NGOs in collaboration with hospitals.
- Additional emphasis should be placed to STI and HIV prevention activities focused toward migrants including those moving to overseas destinations for longer periods of time and their families.
- Following necessary review and operational research, national protocols on HTC and STI diagnosis and treatment should be considered for revision in the direction of consolidating these services by NGOs and thereby reducing costs.
- The Strategy should note an effective strategy for social change communication that adheres to up-to-date models and lessons learned nationally and internationally. Development of this strategy and related guidelines should be a priority in the first year of implementation and the strategy and guidelines should be integrated into activities through publication of guidelines and training during the second year.

Recommendations from External Assessment of National Response to HIV/AIDS in Nepal 2008

The assessment findings largely validated the approach taken in Nepal's strategic plan(NCASC, 2008). The current focus should be maintained and intensified. The NCASC and partners have established a footprint in many areas most affected by HIV/STI epidemics – interventions and services are present, though not strong in many areas. Two key recommendations would facilitate moving from a footprint to a strong presence: 1) enhanced coordination through DACC strengthening and 2) a much higher level of capacity building that is currently in place. Other few of the major recommendations are as follows:

- NAC and NACC need to be revitalized so as to translate high level commitments into meaningful action.
- A policy guidelines needs to be adopted for rationale implementation of the spirit of public private partnership (PPP) at every level of prevention to care of HIV/AIDS
- Strengthen public sector logistics and supply management
- Clarify role of HSCB in facilitating implementation of the national response. It should play pivotal role in improving multisectoral engagement, decentralization and donor coordination and include efficient mechanisms for channeling resources
- Greater amount of authority in decision making process need to be delegated to NCASC/HSCB
- At the district level, funding provision should be channelized through DACC so as to strengthen decentralization process

- Comprehensive program for most at risk population should be expanded to increase geographical coverage
- The peer education should be strengthened and communities (particularly FSWs) engaged more in planning, implementation and monitoring activities jointly with the NGOs
- Interventions for migrant labors should not be stand alone
- Access to services like HTC, STI should be expanded through integration with other reproductive and primary health care services
- Greater focus on condom promotion, STI management, partner treatment should be promoted
- Strategies to increase access to STI services should be developed
- There should be involvement of public health sector in providing STI services linked to NGOs and CBOs outreach

Current Situations and Issues

Condom Promotion

As indicated in the table below in the previous years over 32 million male condoms were distributed in Nepal for HIV programme (UNGASS, 2010). Of these condoms, 70% were distributed through social marketing by private sectors. Female condom is not yet part of national HIV programme.

Table 2: Trend of consistent condom use among MARPs (percentage)

MARPs	2002	2004	2005	2006	2007	2008	2009	2010	2011
FSW with their clients		58		53		52			74
MSWs with non-paying male anal sex partners		44			70		65		
IDUs (with FSWs)	54		35		68		49		76
Migrant workers last time they had sex with non-regular sexual partners in India (Far-Western and Mid-Western)				61*		74*		53	

*Note: The consistent condom use reported by MARP's in this table is from Kathmandu cluster of IBBS taken as a proxy to reflect the trend. *unweighted average*

Male condom use is high at over 70% among the clients of female sex workers as reported by the sex workers. Condom use among the clients of male sex workers has risen in the last several years from under 40% to over 90%. About three quarters of men report condom use on the last anal sex with a male partner and a little over half of injecting drug users had condom-protected sex at last intercourse with any partner.

Female Sex Workers

The response to the epidemic in the country has so far been successful in controlling the epidemic among female sex workers. HIV prevalence among female sex workers is recorded less than 3% over the years. Consistent condom use with the last client in the past year was reported high at over 75% (IBBS 2011). About 60% FSWs were reached by HIV prevention programmes during 2010 in Kathmandu.

Men who have sex with men (MSM) and Third Gender (TG)

HIV prevalence among MSM is 3.8% and 5.2% among male sex workers. Reported condom use with the last client among male sex workers is 90%. About three quarters of MSM reported condom use on their last episode of anal sex.

Male Labour Migrants and their Spouses

Integrated Bio Behavioural Survey (IBBS) shows that all migrants are not at equal risk to HIV. The recent IBBS conducted in mid and far western clusters (2010) recorded weighted HIV prevalence of 4.5%. The data on prevalence among wives of migrants shows that 0.8% of wives of migrants in four western districts.

Male labour migrants to India can only be reached in Nepal before they migrate or during their visits to their home districts when they return and before they re-migrate. Their spouses left back home can be reached relatively easily than their migrating partner. All activities proposed will take place in priority districts of Nepal.

Injecting Drug Users (IDUs)
Sentinel serosurveillance has demonstrated a significant reduction in prevalence among IDUs from 68% in 2003 to 6.3% in Kathmandu in 2011.

Over ninety per cent of users reported that they used sterile equipment the last time they injected. Evidence also suggests that there are risk overlaps particularly among those FSW who inject drug or female drug users who also sell sex.

Prevention of Mother to Child Transmission (PMTCT)
In 2010, 96 mothers and 112 babies received antiretroviral prophylaxis to prevent mother to child transmission. PMTCT sites have been scaled up to 22 by 2011 with 3 Community Based PMTCT districts. Progress has been made to initiate coordination between family health division (FHD) and NCASC to integrate and establish strong linkages between HIV and reproductive health services. Nepal has adopted 'WHO option B' recommendations (triple ARV prophylaxis for mothers and nevirapine for the infants)

Prevention of HIV Transmission in Health Care Settings

Nationwide application of safe injecting practices and universal precaution has been in practice in the country. Moreover, 100% of collected blood is screened for HIV and Hepatitis B and C. PEP has been made available in all ART, PMTCT and some of the HTC sites.

HIV Prevention in Workplace

Government of Nepal has issued National Policy on HIV/AIDS in the Workplace (2007) which incorporates principles of ILO code of practice on HIV/AIDS and the world of work, such as accepting HIV/AIDS as workplace issue, prohibiting discrimination, internalizing gender equality, creating a health working environment, promoting social dialogue, prohibiting HIV/AIDS tests with an objective to remove from employment or work, respecting the right of infected people to confidentiality, guaranteeing the continuity of employment until one cannot perform a normal work, preventing and treating this infection as far as possible and supporting those living with HIV (source: National workplace policy 2007).

Uniformed Services

The uniformed service in Nepal consists of Nepal Army, Nepal Police, and Nepal Armed Police. For the uniformed services, the priority is to protect the cadre from HIV and AIDS transmission and provide full range of prevention, treatment and care services without any stigma, discrimination and prejudiced attached to perceived or real HIV status of an individual. Nepal Police is updating its current HIV and AIDS Strategy to take into account of new challenges and opportunity – which will complement and supplement this strategy.

Prison Settings

Data about risk behaviours and vulnerability within the prison setting is generally lacking, but recent programme data from service sites (HTC, ART support) in certain selected prison indicated that number of people in need of ART is increasing and HIV positive tests are reported from HTC located at prisons. Stigma among inmates has become a barrier to access HIV related services.

HIV Testing and Counselling

The growth in the number of testing and counselling service provision sites has been rapid and over two hundred sites now offer HIV counselling and testing nationwide. However, there the people served by different sites indicating underutilization at some sites due to higher concentration of service sites in some places. There is need for harmonization and coordination in the HTC sites run by different programs, at the same time integrating into the health system. Provider initiated counselling and testing is being initiated from ANC, STI and TB clinics.

Anti Retroviral Therapy

ART services have scaled up and there are 36 service sites providing ART in the country. There is no waiting list and currently more than 5,876 PLHIV on ART till July 2011. There is a good linkage between the HTC and ART sites. Nepal has adapted to WHO recommendation of initiating ART below CD4 count of 350. More teaching institutions involvement needs to be sought and supported for ART and STI management along with public sector.

Community and Home Based Care (CHBC)

Community and Home Based Care has been mainly run by the NGOs in Nepal. There have been good linkages between the ART and CHBC services. CHBC has been instrumental in following up the clients on ART. The progress has been made to standardize these services in the country by development of National guidelines and standard training curriculum.

Children Affected by AIDS (CABA)

There are estimated 24, 000 CABA in 2010 (Size Estimation of Children Affected by AIDS in Nepal, 2011, NCASC). However, with the support from the GFTAM CABA initiatives are to be implemented in targeted districts through developing a National package for CABA.

Stigma and Discrimination

Despite continuous efforts during previous strategic period, stigma and discrimination has remained a major impediment to openly access the information and services by disclosing one's HIV status as

well as risk behaviour and sexual orientation. Rejection to services, education, social events and often delayed response to treatment are other associated issue around stigma related to HIV. Women and children are often more affected. Evidences have suggested that in an open and stigma and discrimination free settings (health care and others) utilisation of services has improved substantially.

Strategic Information

After having a National HIV AIDS M&E guidelines with core set of defined indicators, a systematic mechanism has been initiated to collect analyze and use of data generated through HIV surveillance, program monitoring and research. NCASC has been capacitated in terms of human resource , system set up and preparation national M&E package which includes national recording and reporting tools, M&E training curricula and modules, data review and verification protocol. 35 districts have been capacitated with tools and systems through DACC. Quality control mechanisms need to be established including the HIV drug resistance strategy.

Nepal has been adopting the second Generation Surveillance System to collect HIV surveillance data. Routine case reporting and IBBS among high risk population are key components of SGS that has functioned over a decade. Scientific methods of estimation of HIV infections have started since 2003 that helped target settings for programming.

Resource Mobilisation

Despite marked improvement of government spending to health sector, allocation and spending in HIV is low. HIV financing has heavily relied on external assistance. While it is essential to access external financing for HIV, it is equally important to increase national financing and ownership of programme and resources. The resource mobilisation strategy will be guided by following key principles. Increase domestic financing for HIV and AIDS related activities more specifically on treatment and drug procurement; Increase government ownership and donor harmonisation; and Value for money and mutual accountability

Structural Factors impacting on HIV

Structural factors related to social, economical and political aspect of public health interventions and approaches at individual, institutional and societal levels are invariably associated with increased risk of HIV transmission and access to HIV services.

Poverty, unemployment and low education are by far the most critical structural factor making people vulnerable to the risk of HIV infection. Poverty and unemployment is a strong push factor for many young men and women for labour migration in India and Gulf countries. IBBS study revealed that about 31% of FSWs are illiterate and while 35-43% FSWs are new entrants in the sex trade moving away from their home town (IBBS 2011). Certain social norms such as patriarchal structure of society have caused gender discrimination and gender based violence.

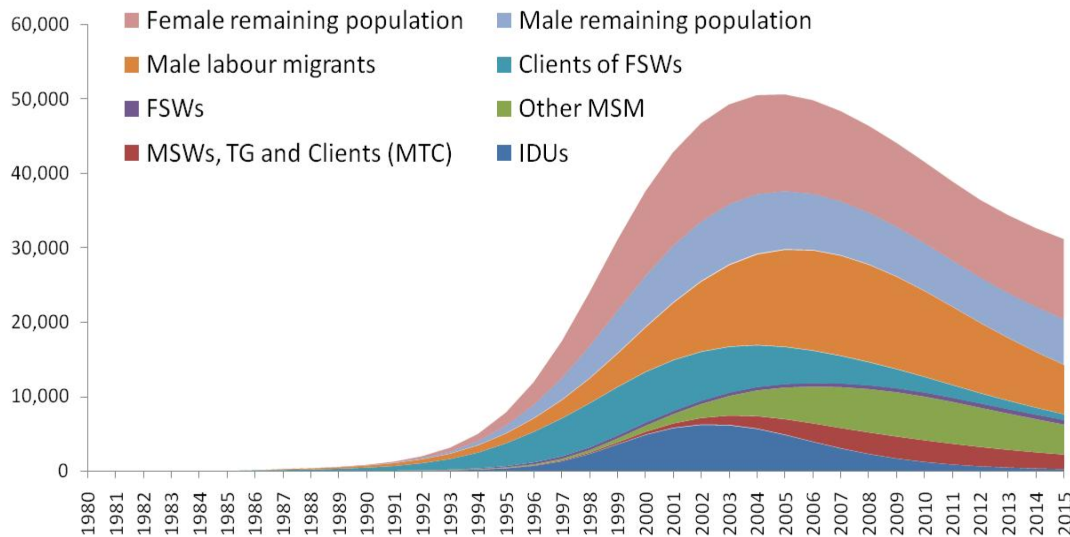
The country's vulnerability to HIV and AIDS has largely been due to numerous structural factors, social values and norms, economic and other development policies and practices. Geographical and ethnic diversity is a major challenge to design an intervention that reaches to un-reached groups in culturally acceptable ways. Furthermore, illiteracy and gender inequality are also the factors fuelling vulnerability to HIV transmission in Nepal.

Increasing labour migration due to lack of economic opportunity or fuelled by the post conflict uncertainty and declining employment opportunity has left women and children in more vulnerable situation.

Overview of the HIV epidemic

HIV in Nepal is characterized as concentrated epidemic. More than 80 percent HIV infections in are transmitted through heterosexual transmission (NCASC, 2011)[3]. People who injects drugs, men having sex with other men and female sex workers are the key high risk population groups spreading the epidemic. Male labour migrants (particularly to India, where labour migrants often visit female sex workers) and clients of female sex workers in Nepal are acting as bridging population groups that transfer infections from high risk groups to low risk general population. As the epidemic is maturing (about 23 years after the first HIV case reported in 1988), more and more infections are being recorded among low risk general men and women populations. However, the epidemic has never maintained through heterosexual transmission in the general population in Nepal, rather driven by the infections among high risk populations and their sexual partners (Figure 1).

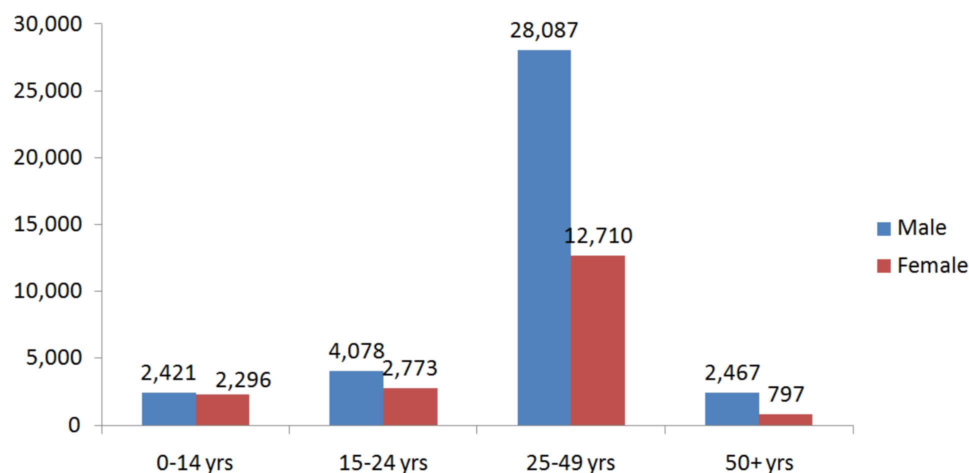
Figure 1 Distribution of Adult (15-49) Estimated HIV Infections among Risk Groups: 1980-2015



The 2010 estimation of HIV infection in Nepal was about 55,626 (NCASC, 2011). As shown in Figure 2, majority of infections are occurred among adult (15-49) male (58%) women of reproductive age group (28%) populations, while 8% of infections are occurred among children under 15 years of age.

[3] NCASC (2011) National Estimates of HIV Infections in Nepal, 2011. September, 2011

Figure 2 Estimated HIV Infections by Age Group, 2010



The high risk population groups (IDUs, MSM, FSWs, male labour migrants and clients of FSWs) shared 58% of all adult HIV infections (Table 3). The low risk general male and female population shared about 42% of all estimated infections. Highest infection is estimated is in the age group of 25-49 years who are economically productive and sexually active. The younger stratum of population below the age of 15 has lowest infections and most are due to mother to child transmission.

Table 3: Estimated HIV infections by Population Groups, 2010

Population Groups	Estimated HIV Infections (15-49 years)	Share of Total HIV infections (%)
Injection Drug Users (IDUs)	1,367	2.9
Male Sex Workers, Transgender and their Clients	3,345	7.0
Other MSM who do not sell and/or buy sex	6,724	14.1
Female Sex Workers (FSWs)	650	1.4
Clients of FSWs	2,440	5.1
Male Labour Migrants	13,219	27.7
Male Remaining Population	7,378	15.5
Female Remaining Population	12,522	26.3
Total	**47,645**	**100.0**

Nepal has produced evidence (NCASC, 2011) that effective prevention interventions are working to stop the spread of HIV, particularly among key high risk population groups such as IDUs, FSWs and their clients. However, the rate of new infections has increased among MSM/TG in Nepal. In overall, the adult (15-49) HIV prevalence has started declining slowly (Figure 3), while the prevalence has been declining more rapidly among young populations (15-24) (Figure 4). This demands for a continued effective prevention efforts to be sustained among high risk populations, especially among young and new entrants into the risk behaviours.

Figure 3: Declining Adult (15-49) HIV prevalence in Nepal: 1985-2015 (NCASC, 2011)

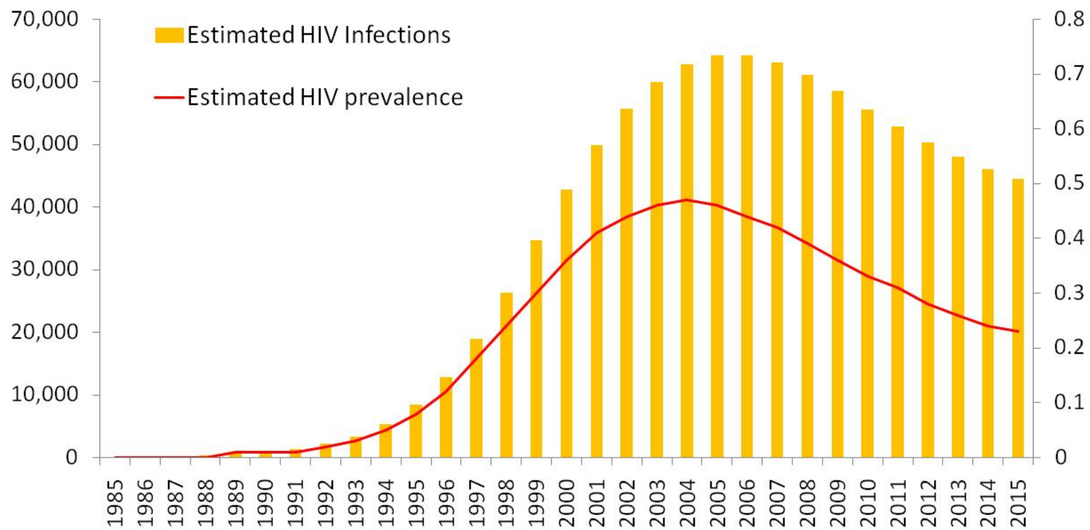
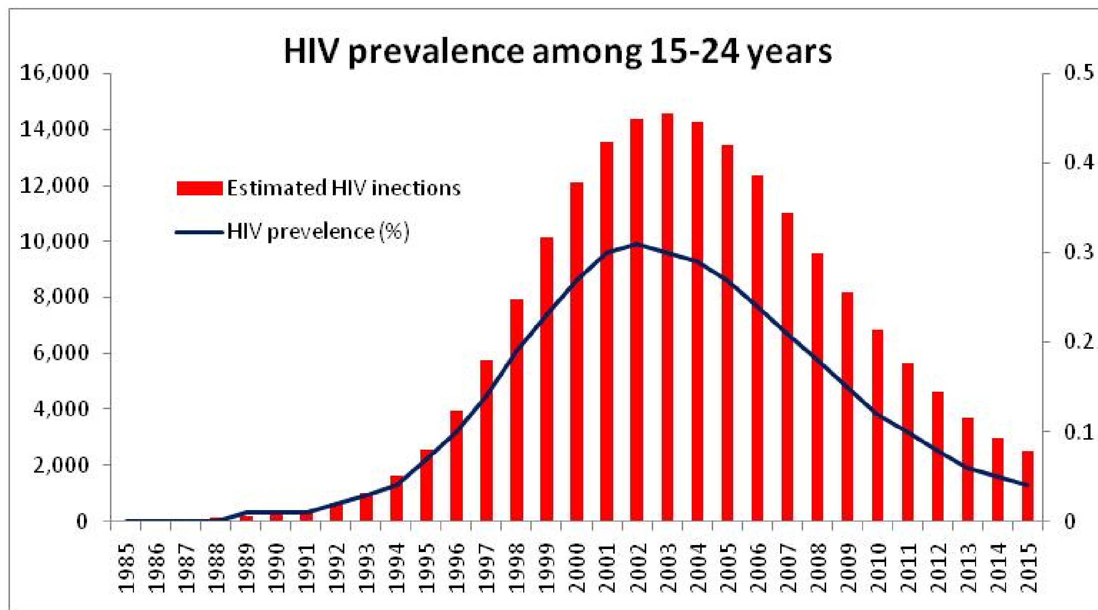


Figure 4: HIV Prevalence among Young (15-24) Population in Nepal: 1985-2015*



***NCASC, 2011**

CHAPTER II: STRATEGIC RESULT FRAMEWORK

VISION, GOAL and TARGETS

Vision

Nepal will become a place where new HIV infection are rare and when they do occur, every person will have access to high quality, life extending care without any form of discrimination.

Goal

To achieve universal access to HIV prevention, treatment, care and support.

Objectives

1. Reduce new HIV infections by 50% by 2016, compared to 2010;
2. Reduce HIV-related deaths by 25% by 2016 (compared with a 2010 baseline) through universal access on treatment and care services; and
3. Reduce new HIV infections in children by 90% by 2016 (compared with a 2010 baseline)

To achieve the broader health and development goals of Nepal, the National Strategic Plan, 2011-2016 is framed to achieve the following overarching impact-level results:

- The incidence of HIV is halved by 2016 compared to 2010;
- By 2016, the AIDS-related deaths are reduced by 25% compared to 2010; and
- Reduce new HIV infections in children by 90% (compared with a 2010 baseline)

This HIV/AIDS Strategy contributes to the overall health and national development plan as shown in the Figure:

Figure 5: Linkage of National HIV/AIDS Strategic Plan, 2011-2016 with overall National Development Plans

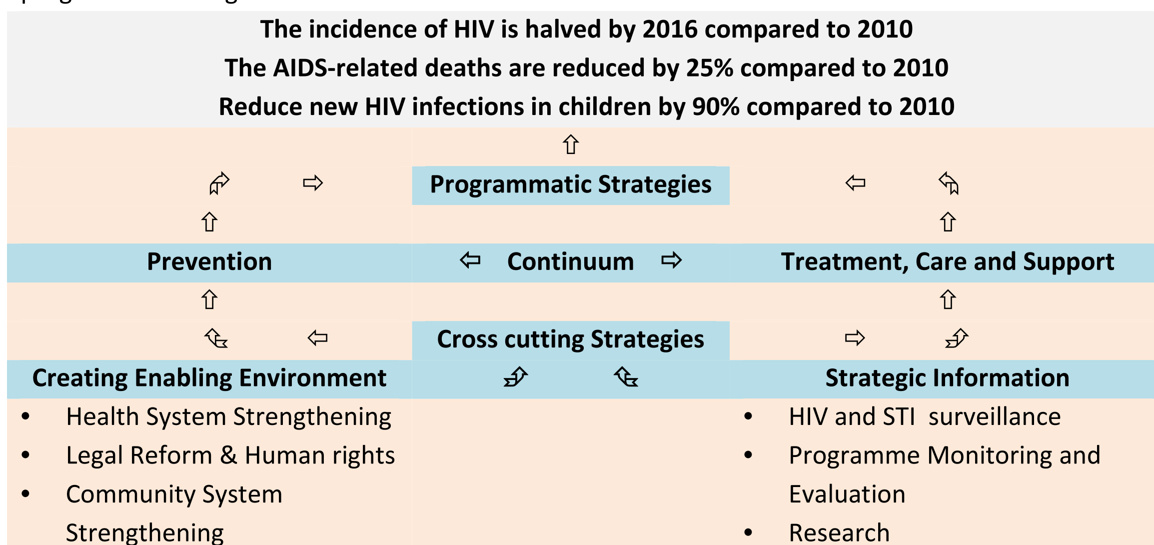
<table>
<tr><td colspan="4">Development Plan of Government of Nepal</td></tr>
<tr><td rowspan="3">• Reduce Poverty
• Achieve Millennium Development Goals</td><td colspan="3">Nepal Health Sector Programme Implementation Plan –II</td></tr>
<tr><td rowspan="2">• Achieve Millennium Development Goals
• Universal coverage to Essential Heath Care Services free against catastrophic health expenditure</td><td colspan="2">National HIV/AIDS Strategy 2011-2016</td></tr>
<tr><td>• Reduce new HIV infections</td><td>• Reduce AIDS related deaths</td></tr>
</table>

A joint effort of intermediated results (outcomes), immediate results (outputs) and actions (inputs) will contribute to achieve the desired final results of the Strategy, 2011-2016. The key impact-level indicators and targets are as shown below.

Results numbers	Indicators	Baseline, 2010	Targets by 2016
1	HIV prevalence in the population aged 15-24	0.12% (2010) (NCASC, 2011)	0.06%
2	Percentage of adults and children with HIV known to be on treatment 12, 24 and 36 months after initiation of antiretroviral therapy	89% - 12 months (2010) 84% - 24 months (2010) 70% - 36 months (2010)	At least 93% - 12 months At least 90% - 24 months At least 85% - 36 months

Strategies for Achieving Impact

The current national HIV/AIDS Strategy, therefore, builds two critical programme strategies (prevention and treatment care and support) and two cross-cutting strategies to underpin the programme strategies.



Target 1: The incidence of HIV is halved by 2015 compared to 2010

In the absence of easily doable methods of estimating incidence at population level, a proxy indicator for measuring the incidence "HIV prevalence in the population aged 15-24" will be monitored through HIV epidemic modelling and analysis.

The target for this indicator is 0.06% by 2015. This will be achieved through the following five Outcomes, related to each of the three modes of transmission of HIV:

Outcome 1.1: Reduction of sexual transmission of HIV
Outcome 1.2: Reduction of HIV through injecting drugs
Outcome 1.3: Reduction of vertical (mother-to-child) transmission of HIV

Outcome 1.4: Reduction in blood-borne transmission of HIV
Outcome 1.5: Creation of enabling environment in HIV Prevention

The components above mentioned outcomes are considered to prevent HIV (contribute to achieve impact) through one or combination of more than one preventive services among the risk population groups.
The targets to achieve the outcomes are set as below:

Outcome 1.1 Outcome 1.1 Reduce sexual transmission of HIV

Outcome indicators [(a, b)]		Baseline (2010)	Target by 2016
1.1.1	Percentage of most-at-risk populations (sex workers – female and male, and male labour migrants 15-49 years) who are HIV-infected	• FSWs = 1.7% (2011) • MSWs = 5.2% (2009) • MSM = 3.8% (2009) • Labour migrants (15-49) = 4.5% (2010)	• FSWs = 1.0% • MSWs = 2.5% • MSM = 2.0% • Labour migrants (15-49) = 0.5%
1.1.2	Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	• FSWs = 30% (2011) • MSM = 64% (2009) • Labour migrants (15-49) = 18.1% (2010)	• FSWs = 60% • MSM = 80% • Labour migrants (15-49) = 50%
1.1.3	% of men reporting the use of condom the last time they had anal sex with a male partner	75% (2009)	>80%
1.1.4	% of female and male sex workers reporting the use of a condom with their most recent client	FSWs: 83% (2011) MSWs: 87% (2009)	>85%
1.1.5	% of migrants aged 15-49 reporting the use of condom the last time they had sex with non-regular sexual partner	53% (2010)	>80%
1.1.6	Percentage of most-at-risk populations who received HIV test in the last 12 months and who know their results	• FSWs = 54.7% (2011) • MSWs = 65.2% (2009) • MSM = 42% (2009) • Labour migrants (15-49 years) = 13.8% (2010)	• FSWs = 80% • MSWs = 80% • MSM = 80% • Labour migrants (15-49 years) = 80%

Note: a: The baseline and targets referred to Kathmandu valley cluster of IBBS, used as proxy
b: The baseline and targets referred to mid-and far-western cluster of IBBS, used as proxy

Outcome 1.2: Reduction of HIV through injecting drugs

Outcome indicators *		Baseline (2010)	Target by 2016
1.2.1	Percentage of injecting drug users who are HIV-infected	6.3% (2011)	3%
1.2.2	Percentage of injecting drug users who both correctly identify ways of preventing the sexual	64% (2011)	80%

	transmission of HIV and who reject major misconceptions about HIV transmission		
1.2.3	Percentage of people who inject drugs reporting the use of sterile injecting equipment the last time they injected	95% (2011)	>95%
1.2.4	Percentage of injecting drug users who received an HIV test in the last 12 months and who know their results	21.4% (2011)	80%
1.2.5	Percentage of IDUs currently on OST who have been on OST continuously for the past 12 months	NA	80%

*Note: * The baseline and targets referred to Kathmandu valley cluster of IBBS, used as proxy.*

Outcome 1.3: Reduction of vertical (mother-to-child) transmission of HIV

Impact/Outcome indicators		Baseline (2010)	Target by 2016
1.3.1	Eliminate new HIV infections in children: reduce new HIV infections in children by 90% (compared with a 2010 baseline)	NA	90%
1.3.2	Percentage of infants born to HIV infected mothers who are infected	NA	12%
1.3.3	Percentage of HIV+ve pregnant women who received antiretroviral to reduce the risk of mother-to-child transmission of HIV	8.3% (2010)	80%
1.3.4	Percentage of infants born to HIV-infected women receiving a virological test for HIV within 2 months of birth	1.7% (2010)	100%

Outcome 1.4: Reduction of blood-borne transmission of HIV

Outcome indicators		Baseline (2010)	Target by 2016
1.4.1	Percentage of health facilities providing HIV services with post-exposure prophylaxis available	NA	100%
1.4.2	Percentage of donated blood units screened for HIV in a quality assured manner*	38% (2009)	100%

** Quality assured manner is defined as the blood units screened for HIV included in External Quality Assurance Scheme (EQAS).*

Outcome 1.5: Creation of enabling environment in HIV Prevention

Outcome indicators		Baseline (2010)	Target by 2016
1.5.1	Percentage of health workers both women and men aged 15-49 years expressing accepting attitude towards people living with HIV	NA	>90%

Target 2: By 2015, the AIDS-related deaths are reduced by 25% compared to 2010

This impact result targets to ensure the overall health status of people living with HIV, safeguarding their physical and mental well being. Thus, it encompasses not only access to treatment and care, but also adherence to this treatment and quality of care. Therefore, the overall care and treatment service package targets to reduce the AIDS-related deaths by 25% by 2015 as compared to 2010. The indicator selected to monitor the progress towards this result (adherence) is: percentage of people still alive (adults and children) and on treatment 12, 24 and 36 months after initiation of ART. This indicator is not perfect as it does not give any information about morbidity, and it is also not very sensitive about the quality of services that is included in the whole care and treatment package. However, it is still the best one we have monitored.

This result will be achieved through the following outcomes within the framework of comprehensive care and treatment for people living with HIV:
Outcome 2.1: People living with HIV received prophylaxis for opportunistic infection according to national guidelines
Outcome 2.2: Adults and children living with HIV who are eligible for antiretroviral received ART
Outcome 2.3: Adults and children with HIV associated co-infections received treatment of co-infection management
Outcome 2.4: PLHIV received care and support services according to their needs (palliative care for chronically ill PLHIV)
Outcome 2.5 PLHIV received impact mitigation support

The overall strategic framework for this result is shown as below:
Outcome 2.1: People living with HIV received prophylaxis for opportunistic infection, treatment and other common co-infections treatment according to national guidelines.

Outcome indicators		Baseline (2010)	Target by 2016
2.1.1	Percentage of people enrolled in HIV care and treatment who received cotrimoxazole prophylaxis in the last 12 months	NA	80%
2.1.2	Percentage of adults and children living with HIV enrolled in HIV care (currently) received opportunity infection prophylaxis (for common infections)	NA	80%

Outcome 2.2: Adults and children living with HIV eligible for antiretroviral received it.

Outcome indicators		Baseline (2010)	Target by 2016
2.2.1	Percentage of eligible adults and children currently receiving antiretroviral therapy	27% (2010)	80%
2.2.2	Percentage of people starting antiretroviral therapy who picked up all prescribed antiretroviral drugs on time	NA	80%
2.2.3	Percentage of health facilities dispensing antiretroviral therapy that have experienced a stock-out of at least one required antiretroviral drug in the last 12 months	0%	0%

Outcome 2.3: Adults and children with HIV associated co-infections received treatment of co-infection management.

Outcome indicators		Baseline (2010)	Target by 2016
2.3.1	Number (percentage) of adults and children enrolled in HIV care who had their TB status assessed and recorded during last visit (among all adults and children enrolled in HIV care in the reporting period)	0	22,500 (80%)
2.3.2	Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	NA	80%
2.3.3	Number (and percentage) of adults and children newly enrolled in HIV care who start treatment for latent TB infection (isoniazid preventive therapy) among the total number of adults and children newly enrolled in HIV care over a given time period	0	80%

Outcome 2.4: PLHIV received care and support services according to their needs.

Outcome indicators		Baseline (2010)	Target by 2016
2.4.1	Number (and percentage) of adults and children living with HIV who received care and support services outside facilities	NA	80%
2.4.2	Number (percentage) of (currently indentified) PLHIV who received at least one home visit and/or palliative care service in last 12 months	NA	80%
2.4.3	Number (percentage) of people living with HIV benefiting from nutritional support in the last 12 months	NA	80%
2.4.4	Number (and percentage) of children affected by AIDS (CABA) received minimum package of care and support services as defined in the national CABA guidelines	0	80%
2.4.5	Ratio of school attendance of orphans (AIDS orphans) to school attendance of non-orphans aged 10-14 years	NA	1

Outcome 2.5 PLHIV received impact mitigation support (social protection)

Outcome indicators		Baseline (2010)	Target by 2016
2.5.1	Number (and percentage) of adults and children living with HIV who need care and support services outside facilities (ART centres and sub-centres) received it	NA	80%
2.5.2	Percentage of PLHIV who have no formal education	NA	<10%
2.5.3	Percentage of health workers both women and men aged 15-49 years expressing accepting attitude towards people living with HIV	NA	>90%
2.5.4	System for officially documenting cases of stigma and discrimination exist (through DACC)	No	Yes

Guiding Principles

1) **Universal Access to Prevention, Treatment, Care and Support services for all people on equitable basis**
The primary focus of the strategy will be on universal access to prevention and treatment, care and support on an equitable basis with linkages to impact mitigation initiatives. The strategy is based on the premise of universal access targets to prevention and care services for members of key populations at higher risk and people living with HIV.

2) **Integration of HIV into general health programme:**
Integrated approach helps avoid the creation of vertical implementation of treatment and care of HIV, Sexual Reproductive Health, Maternal and Newborn Health and Control of Tuberculosis. It can be confusing, expensive and time-consuming for people to visit different facilities for HIV, sexually transmitted infections, TB and other SRH treatment and care. Integrated delivery can also reduce the unit cost of services. This strategy emphasises on integration of HIV into existing general health programme.

3) **Evidence-informed planning and programming**
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 of defined priorities based on vulnerability and risk factors associated with various groups and communities after thorough analysis of issues including gender analysis. Result based management and evidence on what works in prevention and care in Nepal will be used to develop effective and sustainable programmes.

4) **Decentralized, multi-sectoral and interdisciplinary engagement**
Since HIV and 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. This calls for a proactive response from all the related sectors with mutual accountability.

5) **Reducing Stigma and discrimination**
Zero tolerance to stigma and discrimination in all aspects of the HIV and AIDS related service provision and in employment relationship, including recruitment, terms and conditions of employment and termination on the basis of real or perceived HIV status.

6) **Centrality of PLHIV (GIPA/MIPA Principle)**
People living with HIV particularly WPLHIV are valuable partners in the response to HIV in the country. They have personal experience in the risks and vulnerabilities that lead to HIV acquisition and transmission and have a unique perspective as consumers of care, support, and treatment services.

Meaningful participation of people living with HIV particularly WPLHIV and affected communities in policy and programme development, implementation, monitoring and evaluation are the central concerns of this strategy. Their participation is necessary for the effectiveness of responses to ensure the policies and programs are informed by the experiences of PLHIV, are responsive to need, and take adequate account of the full range of personal and community effects of policy directions.

7) Gender mainstreaming

Gender sensitive (pro gender approaches recognising the different needs and constraints of individuals based on their gender differences) and gender transformative (structural determinants and social norms) interventions/approaches will be employed in addressing short and long term issues related to HIV and AIDS.

8) Equity and Human Rights

The response to HIV and AIDS will be gender and rights based with a specific focus on the rights of people infected and affected by HIV/AIDS as well as vulnerable people. As such, all aspects of human rights (such as confidentiality, right to health including sexual and reproductive rights of women and men, non discrimination etc) will be fully adhered to while providing HIV and AIDS related service to all Nepalese citizen. Mandatory HIV testing, screening and disclosure of HIV status will not be required for the purpose of employment, and in accessing health and other development services.

Equal and equitable access to prevention services is guaranteed for all members of key populations at higher risk of HIV as well as basic care and services is guaranteed for all persons infected by and affected by HIV. The key populations at higher risk are female sex workers, men who have sex with men, injecting drug users, and male labour migrants to India and their spouses.

9) Three ones principle

Three ones principle (one coordinating authority; one national programme, one national monitoring system) would guide the national response and its structures.

CHAPTER III: STRATEGIC DIRECTIONS

I: OPTIMIZING HIV PREVENTION

Reducing sexual transmission of HIV

Comprehensive Condom Programming (CCP)

Key Actions

1. Promote male and female condoms and lubricants so that they would be acceptable, effective and also as an essential product for dual protection, prevention of sexual transmission, HIV specially for the key populations – FSWs, MSMs, IDUs and labour migrants from STI clinics, family planning clinics and maternal and child health services.
2. Ensure quality, availability, accessibility and affordability of male and female condoms and lubricants provision with special emphasis to 'hot spots' of sexual activity and other places (such as, but not limited to bars and nightclubs, guesthouses and hotels, prisons and barracks) where people are confined for long periods of time and through non traditional outlets such as betel stalls *(paan shops*) and non traditional ventures. National and international quality control measures will be applied during condom procurement as applicable.
3. Promote social marketing of condoms and lubricants in partnership with private sectors for sustainable supply of commodities, complementing supply through public and NGOs services.
4. Mobilize national and international reproductive health, AIDS organisations and donor agencies for condom promotion.

Behaviour Change Communication

BCC will be implemented mainly by the inclusion of youth friendly IEC and BCC materials to deliver prevention message to reduce sexual transmission to HIV from targeted interventions, general health services (ANC, SRH Services) and education program for prevention of HIV transmission among MARPs, PLHIV and general population such as, outreach, one on one communication, and mass media through technical guidance by the National AIDS Program. The activity will focus to improved health seeking behaviour and adoption or maintenance of safe sexual practices including correct and consistent use of condom as well as utilization of preventive services such as STI with increased knowledge and social acceptance of HIV and AIDS issues among the general population. Current BCC strategy, guidelines and manuals will be update as appropriate with guidance from BCC technical working group.

Key Actions:

1. Update/develop BCC strategy and guidelines and training curriculum with clear gender perspectives to build the capacity of the peer educator and community mobilizers on regular uptake of counselling testing services, sexually transmitted infections services, Family planning, sexual and reproductive health including safe abortion and PMTCT and treatment, care and support for MARPs (female sex workers, MSM/TG, migrants).
2. Continue outreach activities in sites already covered and expand outreach activities to reach more female sex workers, MSM/TG and other MARPs through designing and developing specific targeted community based outreach and peer education activities in HIV prevention and sexual health. Develop IEC material tailored to specific risk and population (youth and adolescent friendly IEC, MARPs specific) with clear gender perspectives.
3. Strengthen the negotiation skills of FSW and MSM/TG on condom use, prevention of violence/torture, objectionable behaviours including operation of FSW friendly drop-in centres.

4. Design and target media programme to reach the MARPs and address their specific needs ensuring gender sensitive messages.

With the aim of maintaining or reducing the current low prevalence among the general population and reducing the stigma and discrimination, the strategic approach will be to provide minimum sets of messages about HIV (how it is transmitted and how it can be prevented) with three objectives; Make people aware about route of transmission of HIV and means of prevention; reduce stigma and discrimination; and provide minimum level of information about services available for prevention, treatment and care.

Specific actions for General Population

1. Develop and distribute BCC materials to suit local need (i.e. use of local language, and visuals/illustrations that represent locals), cultural sensitivity and geographical diversity.
2. Implement selected media activities including use of local FM radio stations, local print media(Mass media, interactive media events, brochures, IEC materials, radio and TV jingles, commemoration of special days/events, use of alternative media such as street theatre, use of local fair/festivals).
3. Disseminate message at reducing stigma and discrimination on a large scale, reinforced by interactive mass media events to stimulate dialogue among community members on pertinent HIV/AIDS related issues.

Detecting and Managing Sexually Transmitted Infections

Quality STI diagnosis and treatment will be standardised up to Health Post and Sub Health Post level as part of primary health care services. Syndromic approach will be standardised with referral for etiological treatment when needed and etiological diagnosis will be prioritized, where possible. Special focus will be made for the elimination of congenital syphilis for which priority will be given for making available elements of screening and diagnosing syphilis (RPR TPHA/TPPA, rapid diagnostics) among pregnant women. Resource allocation will be gradually increased focusing for this and integration of ANC with HIV and STI services will be strengthened. Presumptive treatment for sex workers will be made available from government and non- governmental organizational outlets. The STI services will be established as per the national standard guidelines and protocols.

Key Actions:

1. Develop STI diagnosis and treatment strategy.
2. Provide standardized and quality etiological diagnosis for some common STI (TV, GC and syphilis) at the service sites including sites that provide HTC where laboratory services are available including at FP and MCH clinics (for example: screening and treatment of pregnant mothers for syphilis). Such services will be the part of the comprehensive package to FSW, MSM, IDU and Migrant population either by integrated services or by linkages establishments between public and private services.
3. Strengthen documented linkages (referral of Follow up mechanisms) of community BCC services to quality HIV testing and counselling, including strengthening of linkage between HTC and STI services.
4. Build capacity to the health and other staff involved in detection and management of STIs (linked with HSS)

Comprehensive services for key populations

Specific package are designed for different MARPs groups keeping in view of their specific characteristic and specific needs.

Female Sex Workers (and their sexual partners)

A package of prevention services will be delivered to female sex workers who practice in a different settings from street based, institution based, and other settings. Focus will also be given to female sex workers with overlapping risks such as injecting drug use. As special HIV prevention intervention package for new entrants will be developed.

This strategy and subsequent plans will ensure that sex workers will have equitable access to reproductive health services including family planning (condom as dual protection and various contraceptive options) and safe abortion. Moreover, they should be proactively involved in design and delivery of program.

Key Actions

1. Provide comprehensive priority interventions (condom promotion, and communication through peer and community outreach, STI diagnosis and treatment, counselling and testing) for female sex workers and their partners; these services will be made available along with Sexual and Reproductive Health (SRH) including family planning (FP), and PMTCT, focused in every targeted geographical area either as an integrated or linked services.
2. Emphasize on reaching under aged and new entrants FSWs and those with overlapping risks (FSW who are also IDU) with prevention package and referral to other services.
3. Use innovative ways through use of technology to reach high-end FSWs not reached by traditional programme approaches.
4. Strengthen the FSW network by empowerment package to gradually take up advocacy role along with setting up community managed crisis response mechanism and Self Help Groups (SHGs) promoting community led approach.
5. Advocate sex workers' rights and needs with law enforcement authority at various levels, health service providers, and other stakeholders to encourage them to respect, protect, and fulfil the rights of female sex workers and build strong referral linkage to gender based violence service delivery sites, legal aid services and child protection/education programme and alternative options for income generation in their localities.
6. Develop/modify/adapt materials including training materials n HIV risk reduction and skills education (including negotiating skills, HIV risks and vulnerabilities in relation to their risky behaviours and use of Micro-planning for effective outreach, referral, linkages).

Providing services to MSM/MSW and Third Gender (TG)

A package of prevention services for MSM/MSW and Third Gender will be delivered.

Key Actions

1. Provide comprehensive priority interventions for MSM, MSW and Third Gender to prevent sexual transmission of HIV and other STIs including promoting condom use, water-based lubricants for them , detecting and managing STIs , information, education and communication through peer outreach; enabling people to know their HIV status and psychosocial and emotional counselling. These services will be made focused in every targeted geographical area either as integrated or linked services.
2. Advocate MSMs' right and needs with local law enforcement, health service providers, and other stakeholders to encourage them to respect, protect, and fulfil the rights of men who have sex with men/TG and meet the needs of men who have sex with men and TG and their female partners for services.

3. Sensitize MSM/MSW and TG on the importance of legal services and lawyers providing these services.

Labour migrants and their spouses

Two approaches will be undertaken for HIV prevention activities targeting labour migrants. For migrants those migrating to the high HIV burden states in India targeted approaches will be made to reach them in source, transit and destination. The labour migrants migrating officially to other countries, program approach for capturing them in the transit will be continued focusing on HIV prevention packages by Ministry of Labour and Transport Management in collaboration with Ministry of Health and population. Within the country, the existing programmes particularly the intervention for labour migrants and their sexual partners (prevention, treatment and care services) will be strengthened.

Key Actions

1. Ensure the prevention and awareness package to Migrant Population based on migration risk particularly focusing to those going to India in the source and transit points. Innovative yet informal approach will be explored to reach the migrants at the destination.
2. Build collaborative cross country activities between India and Nepal with continued bilateral dialogue with AIDS authority in India utilising various means and opportunities to establish access to and continuity of ART while moving across the border and ensure that the services are accessible and affordable to migrant workers and their spouses.
3. Conduct special seasonal programs with HIV prevention, testing and counselling and SRH services targeting returnee migrants and their spouse in targeted districts including pre-departure and home visit programmes (such as annual events/festivals, crop cultivation and harvesting) to increase knowledge of the risks of unprotected sex among male labour migrants to India.
4. Expand programme for young people and school adolescents in the prioritised potential migration districts with safe sexual behaviour and other prevention package before they become migrants.

HIV Testing and counselling

Strategically, HIV testing and counselling will be gradually taken up by public health system and will be expanded up to PHC and HP levels as an integral part of government health care service by 2015. As such, other divisions of MoHP will take increasing role in programming, implementation and monitoring. NGOs will be also engaged in testing and counselling where government service is not available or not reaching the targeted groups till the services are made available in the public health system. In all such operations, HIV-related information, including HIV testing results should be kept confidential. Special focus on PPP for establishing testing and counselling services will be adopted.
The testing and counselling services will be established as per the national standard guidelines and protocols.

Key Actions

1. Promote the uptake of counselling and testing among high risk population; injecting drug users, men who have sex with men, female sex workers, male labour migrants, and their spouses through targeted communications and linkages between community outreach (BCC peer outreach and demand creation programmes) and the counselling and testing service centres.
2. Promote PITC (Provider Initiated Testing and Counselling) especially in STI, ANC, child birth, post partum, FP and TB services including family and couple counselling but continue operating Client Initiated Counselling and Testing services.

3. Scale up rapid HIV testing services and mobile HTC services in a non duplicated manner in targeted locations in a cost effective way to ensure maximum utilization with strong referral linkage to higher level for treatment, care and support.
4. Institutionalize HIV testing and counselling services as a part of PPP in health institutions (teaching hospitals, private hospitals, nursing homes, poly clinics) following the national testing and counselling guidelines and protocols and ensure reporting the services to the government as per the national standards.
5. Expand couples counselling and sero-discordant couples counselling, drug-injecting partners through partner counselling, children and adolescents with HIV at HIV counselling and testing sites and by peer educators including providing active support for beneficial disclosure.
6. Increase access and utilization of Viral testing with DNA PCR Early Infant Diagnosis to all infants born to positive mothers for HIV diagnosis and counselling to the positive mothers and guardians in PMTCT and ART service sites (PMTCT services will be linked either onsite or through referral services).

Protecting HIV infection in People who Inject Drug

The activities will be strategized and implemented in close coordination and strengthened functional linkages between the Ministry of Health and Population and Ministry of Home Affairs.

Key Actions

Following key actions will be implemented for prevention as components of services.

1. Design the Harm Reduction program keeping in view of current national situation and evidence; international basic principles of harm reduction; and international best practices. A harm reduction approach advocates lessening the harms of drugs through education, prevention, and treatment, enabling people to know their HIV status, HIV treatment and care, promoting and supporting condom use, detection and management of sexually transmitted infections, prevention and treatment of viral hepatitis, tuberculosis prevention, diagnosis and treatment are linked in the specific headings.

Needle and syringe exchange programmes (NSEPs)

- Increase access and availability to sterile injecting equipment through outreach communities and peer groups, needle and syringe exchange and dispensing services, pharmacies, and drug dependence treatment services (OST) to the IDUs for reducing HIV risk transmission.
- Establish and strengthen referrals and linkages for drug dependence treatment (OST). in NSEPs
- Promote the safe disposal of used equipment to minimize re-use or accidental needle-stick injuries, educating IDUs and placement of sharps containers in drug-using locations.

Drug dependence treatment in particular opioid substitution therapy

- Continue and scale up Opioid substitution therapy (OST) treatment for Injecting drug users with opioid dependence in key locations and scaling up the service through public health facilities and also explore the opportunity of PPP. Doctors in health care setting will be trained on OST to facilitate the service expansion as well as establishing linkage to OST services to other health care services (e.g. HTC, ART, TB, hep B and C)
- Develop/ revise OST guidelines, protocol and curriculum for capacity building and standard delivery of OST services including psychosocial treatment for the treatment of drug dependence.
- Continue outreach activities in sites already covered and expand outreach activities to reach more injecting drug users through peer education approach on harm reduction

with targeted information, education and communication for IDUs linking them to Drop in centres. Special attention will be given to adolescent girls, boys and women in risk of injecting drug use.

2. Develop special HIV prevention intervention package and intervention modality for female IDUs. Depending on evidences, such intervention package can be adopted from existing harm reduction package to suit specific need of FIDU or a separate intervention package including harassment, stigma and discrimination.
3. Advocate IDUs rights and needs with local law enforcement, health service providers, and other stakeholders to encourage them to respect, protect and fulfil the rights of injecting drug users and meet the needs of injecting drug users.
4. Identify and change policies and laws that are restrictive and hinders effective harm reduction programme.
5. Standardize and monitor drug treatment package, including BCC, condom promotion, and safer behaviours and rehabilitation for its quality and consistency.
6. Strengthen aftercare service incorporating BCC and NSEP, exploring the possibility of NSEP social marketing. Family reintegration will be integral part of aftercare service.
7. Link Harm Reduction services with Drug detoxification services.

Preventing Mother to Child Transmission

Coverage of PMTCT is currently very low at 7% per cent. The programme will be integrated and delivered through reproductive health and child health services (Maternal Child Health, antenatal care services) and in health facilities linking with ART services. It will be delivered in district hospitals and service sites where established antiretroviral drug treatment is already available. To maximise the coverage, benefit and synergy, PMTCT will be integrated in RH programme under Family Health Division.

A comprehensive and integrated four prong approach for preventing HIV in infants and young children will be strengthened.

- Primary prevention of HIV transmission (linked to Heath System Strengthening)
- Prevention of unintended pregnancies among women living with HIV (linked with Health system strengthening)
- Prevention of HIV transmission from women living with HIV to their children, and
- Provision of treatment, care and support for women living with HIV and their children and families (linked to treatment and care)

Key Actions

1. Promote and ensure effective and accessible interventions to reduce sexual transmission of HIV, particularly preventing new HIV infections in women during pregnancy, childbirth (including assistance from a skilled birth attendant) and breastfeeding for all women with HIV.
2. Ensure that women with HIV have the skills, knowledge and commodities necessary to avoid unintended pregnancy, to plan a pregnancy including support services for them to make informed decisions, to make infant feeding safer with reduced HIV transmission and promotion of child survival.
3. Ensure that women with HIV have the skills, knowledge and commodities necessary to avoid unintended pregnancy, planning a pregnancy including support services for them to make informed decisions, making infant feeding safe to reduce HIV transmission and promote child survival.
4. Scale up PMTCT service by synchronising with the planned scale-up ART, HIV testing and counselling/STI, OI services for ensuring access to continuum of care, antiretroviral (ARV)

medicines to all pregnant women with HIV either ARV treatment for life, if eligible for therapy, or combined ARVs for prophylaxis to reduce HIV transmission. Special focus will be made for loss to follow up cases and the adherence to the care and treatment services.

5. Expand PMTCT programme by integrating - Community Based PMTCT into existing reproductive health, maternal , newborn, and child health services (Integration of different prongs of PMTCT in different level of public health facilities
6. Establish linkages between PMTCT and MARP TI intervention (especially FSW, Female IDUs and Spouse of Migrants), FP services psycho-social, nutrition, SRH, counselling including family support services.
7. Develop/update a national PMTCT strategy, integration framework(into maternal and child and sexual and reproductive health services), national PMTCT protocol, guidelines and training curriculum as necessary for standardize care, quality service delivery and capacity building of health care personnel at different levels.

1. Mobilize DACC for district commitment for virtual elimination of MTCT. Engage DACC in coordinating and monitoring the PMTCT activities and establish linkage with other development services to mobilise resources at local level i.e. accessing DDC and VDC fund for PMTCT activities.
2. Sustain capacity development and orientation on emerging issues and how to tackle them

Encouraging Positive Prevention

Key actions

Based on national experiences and international best practices following key actions will be adopted for positive prevention.

1. Encourage beneficial and voluntary disclosure of HIV-positive people's serostatus and ethical partner notification to other people and organizations, so that the person with HIV will feel comfortable accessing HIV services. This will be part of counselling process as well as integral component of PLHIV empowerment programme.
2. Promote access to treatment and care through engagement of positive people particularly acting as interface between treatment provider and treatment seeker.
3. Provide counselling for People living with HIV on safer sex interventions to prevent HIV transmission to others, avoiding contracting sexually transmitted infections and condom promotion including counselling on FP and reproductive health to couple and women living with HIV to enable them make an informed decision.
4. Promote ongoing behavioral counselling and psychosocial support to HIV-discordant couples through couples counselling and support groups that cover topics such as HIV transmission risk reduction, reproductive health issues, couples communication and condom provision.

Preventing HIV transmission in health care setting

Key actions

1. Promote and monitor universal precaution in health care settings.
2. Ensure safe waste disposal management.
3. Implement occupation health policy for health care workers.
4. Make availability of Post Exposure Prophylaxis (PEP) in all HIV related clinical sites, where HIV testing is available.
5. Ensure commodities for infection prevention in HIV health care settings.

Ensuring Blood Safety

Key Actions:

1. Ensure blood safety by mandatory screening to all collected blood for HIV, Hepatitis B, hep C and syphilis.

2. Ensure the participation of the blood bank in the national and international EQAS programs.
3. Ensure good laboratory practice in all aspects of the provision of safe blood, from donation to testing for transfusion-transmissible infections particularly to HIV.
4. Ensure the use of nationally recommended algorithm and test kits in accordance with National blood safety guidelines and National HIV guidelines.
5. Screen the blood donor in accordance to the national protocol in all blood collection centers.

Preventing HIV transmission in close settings

Uniformed Services

For the uniformed services, the priority is to protect the cadre from HIV transmission and provide full range of prevention, treatment and care services without any stigma, discrimination and prejudiced attached.

Capacity building of uniformed services especially for their policing practices can have major impact on the effectiveness of HIV prevention initiatives, and in perpetuating HIV/AIDS related stigma and discrimination.

Nepal Police is updating its current HIV and AIDS Strategy(year) to take into account of new challenges and opportunity, which will complement and supplement this strategy and build synergy in terms of expanding scope of both strategies. Other uniformed services will also be supported to develop sectoral plan to address the HIV related services to align and harmonize the need and realities of the organisation.

Prison Settings

Prisoners are entitled to the same standard of health care as others, thus wide range of services are required for them which should include condom distribution, harm reduction activity, Hep B, C, HIV testing counselling, provision of ART, treatment of STI and stigma and discrimination reduction activities.

1 Implement prevention programme (including means of preventions such as condom)in collaboration with Ministry of Home Affairs, taking into consideration of specific needs and dynamics of prison environment and linking with HTC and PMTCT services in jail health facility
2 Ensure access to ART to those in need to the inmates of prison.
3 Discuss rights and needs of prison inmates with authority, health service providers, and other stakeholders to encourage them to respect, protect and fulfil the rights of prison inmates and meet their needs including Stigma and discrimination. Continuity of HIV prevention, treatment and care services to prison inmates after release from prison will be ensured by linking with services available in his or her area.
4 Continue advocacy, capacity building and other effort to identify and change policies and practices that are restrictive and hinder effective HIV prevention and treatment programme in the prison setting.

Preventing Youth and Adolescents at Risk of HIV

Young people are significantly contributing to the HIV epidemic in Nepal. The focus will be made to the most at risk young people and the out of school youth. Youth friendly approaches will be designed in HIV prevention services and linkages will be strengthened into sexual and reproductive health services.

Key Actions:

1. Support generation of disaggregated data and evidence on vulnerability and risks of adolescents
2. Ensure accessible and affordable prevention HIV package for young people with emphasis to most at risk young and out of school young people into the existing prevention intervention approaches with linkages to SRH condom services as well as non-health services such as protection, HIV related information and skills and legal service.
3. Ensure adolescent friendly services in health (for example, HTC, ART, PMTCT) and other related facilities for most at risk adolescents to increase access and utilization of services. The establishment of these services will be done in consultation with adolescents and young people during the development and implementation of the programme
4. Build capacity of different level of service providers to ensure adolescent friendly health and non-health related services provisioning access to information and services.
5. Advocate and support functional collaboration among relevant ministries, departments and other stakeholders to bring comprehensive impact, to build support and to raise issues related to vulnerability of adolescents and young people.
6. Develop/modify/adapt effective advocacy materials focusing on situation analysis, needs, rights, gaps in services, policy and programme required for most-at risk adolescents and young people affected by HIV and AIDS.
7. Develop and implement age and gender sensitive sexual and reproductive health package
8. Provide psycho social support and counselling to adolescent key affected population

II: PROVISION OF HIV TREATMENT CARE AND SUPPORT

Optimizing HIV Treatment and Care for Children, Adolescents and Adults

ART will be delivered by the public and other health institutions like teaching hospitals following the national ART guidelines and protocols, ensuring report of services to the government as per the national standards.

Key Actions

1. Review and update national ART manual, guidelines and reporting formats for adults and children taking into account the new challenges, national and international evidences, WHO guidelines, and technology for quality service for children, adolescents and adults. Early infant diagnosis and virtual elimination of paediatric HIV will be actively pursued. The service will be integrated into decentralized public health systems. Management of comprehensive Paediatric HIV and AIDS Care will be piloted in feasible ART sites.
2. Establish linkages and integration between the HIV services and other health services for quality HIV prevention, treatment and monitoring of treatment adherence. Provision of and adherence support programme through community based organizations in order to increase the uptake of the ART, treatment preparedness, education treatment literacy, positive prevention and CHBC will also be established with ART centres with special focus to ensure the adherence and regular follow up of ART clients.
3. Strengthen national capacity for Adult and Paediatric HIV care and treatment services.
4. Endorse and implement a national training plan including ongoing basic, refresher and advanced training, CME, practical training, standardized national pre-service HIV training and clinical mentoring with mobile mentoring teams to ensure high quality HIV services.
5. Scale up of ART services up to targeted districts, selected PHC (as satellite sites) and in teaching hospitals following the national ART guidelines and protocols and ensuring report of services to the government as per the national standard. The services will be provided including HIV test, STI and OI.

6. Follow-up people migrating, particularly to India who is under ART and explore alternative approach with ART providers in India to ensure continuity of treatment. Bilateral dialogue at the government level will be initiated while at the same time NGO to NGO level advocacy and collaboration will also be initiated for continuity of ART for migrants. Dialogue will also be initiated with multilateral agencies and agencies that have presence in both countries for exploring opportunity of ART continuation in both countries for migrants.
7. Advocate to the government to ensure proportional fund contribution of ARV drug cost during the strategic period

Preventing HIV related illnesses

Interventions to prevent illness to HIV-infected individuals include chemoprophylaxis against common opportunistic infections; measures to reduce the incidence of pneumonia, diarrhea and other clinical conditions that are common or serious in children or adults with HIV infection. The services will be made available integrated from the service sites that provide the HIV testing and counselling, PMTCT services, HIV treatment care and community based institutions.

Key Actions:

1. Provide cotrimoxazole prophylaxis and prophylaxis for fungal infections at service delivery points up to primary health care centres.
2. Conduct nutritional assessment and provide nutritional support to children, pregnant and lactating women and adult living with HIV.
3. Raise awareness program for HBV and HCV co-infection, including message for dual protection through needle syringe exchange programs and oral substitution therapy for Hepatitis and HIV.
4. Provide screening and vaccination against the Hep B for PLHIV from ART sites.
5. Establish and strengthen linkage with TB centre and HTC, PMTCT and ART centres, treatment and screening for HBV and HCV for hepatitis, for better management of co infection
6. Ensure availability of higher level of palliative care in coordination with the Community and Home Base Care through building linkages between community care centres, social care units, CHBC and ART and OI sites.

Managing HIV associated Co-Infection

ART will be made available for all PLHIV with TB HIV co infection and Hepatitis and HIV co infection through standardized quality of care for OI management from ART sites. These services will be scaled up to the district and sub district level.

Key Actions:

1. Develop and roll-out TB/HIV collaborative programme as per the National TB/HIV Collaborative Strategy.
2. Revise and develop protocol guidelines including management protocol for managing common opportunistic infections for adults and children.
3. Provide care services for PLHIV with associated neurological conditions, mental health and other co-morbid conditions from HIV.
4. Build capacity of health professional at hospitals and other sites on prevention of HIV related illness and OI including creating platform for experience sharing through building strong linkages between all ART and OI sites.

5. Decrease burden of TB among PLHIV through capacity building of health care workers, prevention of co infection, TB screening and isoniazid therapy for people having HIV infection, intensive case finding and infection control.

Providing Community and Home Based Care for PLHIV (CHBC)

Community, PLHIV and their organizations will be actively designing the CHBC related interventions and engage in service provision. CHBC services will be standardized as per the National CHBC guidelines.

Given the socio economic diversity and geographical isolation, CHBC requires an innovative approach. For CHBC to be effective and acceptable, strong community outreach and support systems are necessary along with referral linkages with other services.

Key Actions

1. Support evaluation of CB-PPTCT to inform scaling up and capacity building of service providers.
2. Implement CHBC with strong link with ART, PMTCT, community care centre/social unit and other health services to establish continuity of care, ensure adherence, psychosocial and spiritual support from the health facility.
3. Ensure all CHBC services follow the National CHBC guidelines and protocol to provide standardized quality care.
4. Provide minimum standard palliative care with strong referral systems between Community care centers, Social care unit and especially to ART and OI sites
5. Provide spiritual, psychological supports to PLHIV and their families
6. Engage DACC in coordinating and monitoring the activities and establish linkage with other development services to mobilise resources at local level i.e. accessing DDC and VDC fund for CHBC activities.

Community Care Centre and Social Care Unit

Key Actions

1. Establish and strengthen Community Care Centre and Social Care unit to support PLHIV for treatment and care in close coordination with ART centre, following the national standard guidelines and protocols
2. Social care unit will be inside the hospitals providing ART services and strong linkages will be established between the ART, PMTCT and CHBC services and between social care unit and community care centres
3. Prioritize integrated approaches where possible between Community care centres and CHBC services

Supporting Children Affected by AIDS (CABA)

Linkage of Ministry of Health and Population with Ministry of Women and Social welfare and Ministry of Education will be key in effective implementation of CABA strategy

Key Actions

1. Develop a CABA national guideline which includes raising awareness at all levels through advocacy and social mobilization to create a supportive environment for children and families affected by HIV/AIDS.
2. Strengthen the capacity of families and community to protect and care for orphans and vulnerable children by prolonging the lives of parents (including care takers).
3. Support the development and implementation of comprehensive national social protection programs including cash and other social transfers, family support services, psychological

support, early childhood care, alternative care, rights to education and protect the most vulnerable children through improved policy and legislation particularly from sexual and other exploitation. The services will be promoted in collaboration with organisations promoting social development and security, particularly with the Ministry of Women, Children and Social Welfare, local elected bodies (DDC, VDC), media, religious leaders etc. on rights issues of vulnerable children and to support services, (health, education), protection and social services.

4. Mobilise and support community-based responses and care so that children are looked after within the social and community networks and any abuse is monitored and reported.
5. Ensure that BCC materials and programmes are accessible and affordable to most at risk vulnerable children

Establishing Social Protection

Social protection envisions the financial protection, access to affordable quality care, and law policy regulation in the context of HIV prevention, Treatment, Care and support for people living with and affected by HIV. It has been realized that social protection for PLHIV, Single women, and Children Affected by AIDS is very essential. This will be ensured in collaboration and linkages with the programs and activities of other line ministries like education ministries, Women and Social Welfare, food programs, business communities and poverty reduction programme.

Key Actions:

1. Financial support, income generation or micro credit to reduce risk of exposure to HIV for poor key population groups specially targeting to single women and CABA.
2. Empower PLHIV to prolong and improve life, protection of rights to health, treatment and work to improve life for people living with HIV through income-generating activities, livelihood strengthening, and microfinance.
3. Provide access to ART service through financial support and friendly services.
4. Involve district and community for developing social support needs including legal protection for affected (property rights of widows and orphans, birth registration, etc.).
5. Establish formal linkages between MoHP and other line ministries for social protection activities and legal reform, policy process and protection regulation to reduce risk of exposure to HIV.

III: CROSSCUTTING STRATEGIES

Health System Strengthening

Keeping in view of current ongoing health system strengthening initiatives from GAVI, IHP, and other sources, this Strategy will consider the critical system constraints that hinders or limit the effective delivery of health care to infected and affected population.

Besides, in line with NHSP – IP II where HIV related care and treatment is considered as an integral part of primary health care system, health system strengthening effort from the framework of this strategy will be directed towards linking and integrating the HIV related services into respective division and units of MoHP structure. All six building blocks of HSS will be considered within the prime intent of the strategy. Improving these six building blocks and managing their interactions in ways that achieve more equitable and sustained improvements across health services and health outcomes will be the mainstay.

Service delivery:

Integration and linkage of health services; infrastructure and logistics; demand for services; and management will be considered during implementing HIV-related service delivery.

Integration and linkages of health services:

Integration and linkages of services will be provided in a balanced way to meet the specific needs of target populations (that might be marginalized).

1. Deliver HIV-related services across a continuum of care.
2. Adopt integrated and linked service at all levels of the health system, from primary to secondary to tertiary (specialist) care including home-based and community-based outreach care.
3. Integrate and/or establish strong linkages HIV services with TB, sexual and reproductive health, family planning, antenatal care, childbirth, newborn and postpartum care.

Integration in antenatal, child and new born and post partum will include HIV testing and counselling, assessment of whether antiretroviral for treatment or prophylaxis are needed, initiation and monitoring of antiretroviral in women and exposed infants, follow-up HIV testing for infants, clinical review and cotrimoxazole prophylaxis when infants return for immunization.

Integration in sexual and reproductive health will include promoting condom use for preventing unintended pregnancy, sexually transmitted infections (STIs) and HIV; reproductive choice counselling and counselling for family planning and contraception; education on sexual health for people living with HIV; youth and adolescents friendly health services covering sexual and reproductive health.

1. Establish special linkages with mental health and HIV services for ongoing counselling
2. Provide support to limit the spread of nosocomial infections (resulting from treatment in health settings) and blood borne infections (such as HIV and hepatitis); comprehensive infection control, including specific consideration of the risk of the spread of TB and Post Exposure prophylaxis treatment.
3. Strengthen laboratories at the district and the sub district level for basic STI testing and HIV diagnosis facilities with emphasis on quality assurance and promoting participation in EQAS.
4. Establish and build capacity of National health laboratory for diagnosis of HIV infection including CD4, PCR (DNA and RNA) genotyping and phenotype. At the same time strengthen the already functional system in the quality assurance of the HIV testing, CD4 and viral load, HIV, HCV, HBV and the participation in the EQAS
5. Upgrade and expand diagnostic and essential laboratory services for antiretroviral treatment and capacity building of NPHL to function as national referral centre/centre of excellence in collaboration with ongoing health system strengthening initiatives (GAVI, GF, IHP) and National Public Health Laboratory.
6. Design programme according to the needs and concern of people living with HIV and those vulnerable or most at risk.
7. Establish effective communication between staff at local health centers and staff in health facilities and laboratories at higher levels of the health system.
8. Strengthen management capacity on having an adequate number of managers at all levels of the health system, ensuring managers have appropriate competencies
9. Advocate the line ministries at the policy for commitment and retention of the health workforce at the central and district level.

Ensuring the technical quality of services

1. Establish external and internal quality management systems to address clinical care, laboratory testing, and workplace improvement for ensuring and improving the quality of care.
2. Establish standardized procedures to accredit health facilities and to certify health care providers in the delivery of HIV prevention, treatment and care.
3. Establish regular supervision and clinical mentoring systems and a budget to deploy supervisors and mentors for post-training and on-the-job supervision
4. Establish well-functioning patient and programme monitoring systems to measure and improve the quality of care.
5. Update national guidelines, tools and training curriculum in regards to HIV and AIDS based on national and international practices and experiences and the latest recommendations. Continued provision of technical advisory committees and working groups will be ensured for this purpose.

Health workforce:

1. Build capacity of Public health workers in targeted intervention for sensitizing health workers to work with people living with HIV.
2. Build capacity of the health workforce through induction programs for uninterrupted HIV services at the service sites.
3. Build capacity of HIV commodities management into exiting LMIS commodity management packages.
4. Build capacity of the Laboratory Staff for HIV and STI screening.
5. Ensure health workers have access to prevention and other HIV- and TB-related services, immunization against vaccine-preventable diseases, especially hepatitis B immunization.
6. Consider task shifting as a way of increasing the pool of knowledgeable HIV-related service providers and more- to less-specialized health workers.
7. Ensure package of HIV prevention, treatment and care services to health workers and their families on a priority basis and should be tailored specifically to their needs.
8. Establish occupational health and safety procedures to reduce the risk of contracting HIV and other blood-borne diseases;
9. Address stress and burnout, prohibiting HIV-related and other forms of discrimination

Information:

HIV information system will be integrated into the HSIS strategy to align and harmonize with NHSPIP 2. In line with national HIV monitoring system and surveillance framework, will be aligned with HMIS from National to district level with emphasis will be led to strengthen district health databank ensuring all relevant HIV related information's are collected analyzed and used to inform the policies and programs. HIV information is to be incorporated in National household Surveys (methods and timings of data collections).

Medical products, vaccines and technologies:

Include HIV antiretroviral in national Pharmacovigilliance and at the same time strengthening the National Pharmacovigilliance system to determine future antiretroviral therapy needs and nature of intervention.

Strengthening capacity building of national health logistic management system will be done for procurement, supply chain and management of HIV commodities. National and regional medical ware house will be utilized as the critical component to establish such systems. A system of

integrated delivery of HIV related products will be initiated through national health logistic management system.

Health financing:

Government financing to HIV would be increased gradually of total contribute to AIDS spending in the country. Advocacy will be done to ensure proportional contribution of ARV drug cost from the government fund during the strategic period. Similarly, for HIV related catastrophic health care expenses for treatment reliance on out of pocket expenses will be minimised. Advocate for the inclusion of HIV infected people in existing insurance packages.

Different initiatives will be started to create a social responsibility towards health by creating a district health protection fund by mobilizing business houses, corporate groups, philanthropists and private sectors.

Leadership and Governance:

For effective decentralisation and effective service delivery of health care services and peripheral level, local capacity for e planning, monitoring and use of local data will be strengthened. Collaboration and coalition (with NGOs, private sectors, local stakeholders and community) will be strengthened to improve leadership accountability and governance.

1. Built in HIV in the district planning process such as “Jilla Parshad” and “Gau Parishad” to make them accountable for HIV response.
2. Strengthen district AIDS coordination committee with strong linkages with DACC in all above activities.
3. Advocate and strengthen the local governance
4. Develop a National Code of conduct to reflect the accountability of community stakeholders (NGOs, civil society, networks).

Community System Strengthening

Community systems strengthening (CSS) is an approach that promotes the development of informed, capable and coordinated communities and community based organizations, groups and structures. CSS involves a broad range of community actors, enabling them to contribute as equal partners alongside other actors to the long-term sustainability of health and other interventions at community level, including an enabling and responsive environment in which these contributions can be effective.

The goal of CSS is to achieve improved health outcomes by developing the role of key affected populations and communities and of community based organizations in the design, delivery, monitoring and evaluation of services and activities related to prevention, treatment, care and support of people affected by HIV.

Community organizations (PLHIV, most at risk community and community based organizations) and actors will be supported and strengthened. The primary focus of community system strengthening will be on capacity building, human and financial resources to enable community actors to play a full and effective role. All six core components of CSS will be considered as appropriate in keeping pace with need and expansion of HIV services[4].

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[4] Six components of CSS are: Enabling environment and advocacy; Community linkage, network, partnership and coordination; Resource and capacity building; Community activity and service delivery; Organisational and leadership strengthening; and Monitoring & evaluation and planning.

Key Actions:

Enabling environments and advocacy

The comparative advantage of CSO in advocacy, demand creation and community mobilisation for better policy development and service delivery will be fully capitalised by engaging the CSO leaders in all aspects of programme design and implementation.

Community networks, linkages, partnerships and coordination

While the public sector will remain fully responsible and accountable for ensuring equitable health and development services to its citizen, CSOs will be engaged in service delivery and demand creation in collaboration with health and other service of public sector.

Resources and capacity building

The technical & organizational capacities of CSO and its workforce will be carried to upgrade their skills and knowledge on HIV, social welfare, advocacy and other related programmes. Support to establishment of community organizations by mobilizing recourses.

Community activities and service delivery

Accessible to all who need them, evidence-informed and based on community assessments of resources and needs.

Organizational and leadership strengthening

Capacity building including management, accountability and leadership for organizations in community systems.

Monitoring & evaluation and planning

Community capacity building will be built to identify and documenting the local knowledge, lesson learnt, situation assessment, and building evidences for program planning and improving the quality of the services.

Strengthening the Strategic Information for Informed Planning, Program and Review of the National Response

Strategic information (HIV surveillance including HIV drug resistance surveillance, programme monitoring and evaluation and research) will be strengthen to inform HIV policies and programmes based on the approach of 'know the epidemic, know the response'. Following key areas of HIV strategic information will be strengthened to inform the overall response to the epidemic in Nepal.

1) HIV surveillance, including the surveillance of HIV drug resistance
2) Programme monitoring and evaluation
3) Research

National standards will be set and a functional mechanism of strategic information will be established and strengthen at national and sub-national level to understand the epidemics, monitor the interventions and review of the response. The overall strengthening of SI system will be lead to decentralized monitoring and evaluation of interventions as well as evidence will be generated and used in the local context.

HIV Surveillance, including the Surveillance of HIV Drug Resistance

Strengthening of the Second Generation Surveillance system will be key principle of strengthening surveillance of HIV and STI in Nepal. This includes (i) improving the case reporting of HIV, advanced HIV infection and STI, (ii) HIV surveillance, (iii) behavioural surveillance, (iv) STI surveillance, (v) population size estimation of high risk groups (vi) use of programme monitoring and evaluation data for surveillance, (vi) epidemic analysis and modelling for improved understanding of HIV epidemic for public health action. In the course of increased number of PLHIV accessing antiretroviral, surveillance of HIV drug resistance will be established and strengthened. Generation of quality surveillance data in regular intervals and analysis is critical for improved use of data for public health action.

Key Actions:

1. Develop and update national guidelines of surveillance of HIV and STI including surveillance monitoring tools, study protocols, surveillance designs and approaches of implementation for collecting data and analysis.
2. Improve case reporting of HIV, advanced HIV infections and STI from all HIV testing and counselling, STI services, ART, PMTCT and OI sites in the public and private facilities.
3. Continue integrated biological and behavioural surveillance (IBBS) surveys among high risk groups in risk areas in regular interval, and will be followed by updating national surveillance plan.
4. Re-vitalize Sentinel surveillance among ANC attendees, STI patients and TB patients.
5. Update Size estimation of High Risk Groups (HRGs) and CABA by districts in two to three years time.
6. Advanced analysis and modelling of HIV epidemic will be made using relevant models (EPP/SPECTRUM, Asian Epidemic Model, etc.) to understand the dynamics of HIV epidemic with increased emphasis to know the HIV incidence in Nepal and to set and update the targets.
7. Collect and analyse routine HIV infection data from TB control programme, screen of blood donations, HIV testing among Nepalese seeking foreign employment.
8. Annual HIV surveillance reports and epi-facts will be produced and shared.
9. Develop, implement and strengthen HIV drug resistance surveillance system including early warning drug resistance monitoring.

Programme Monitoring and Evaluation

A system of monitoring of interventions of HIV prevention, treatment, care and support will be established and updated to track the progress against the targets to express the accountability of the government and its partners as per the national strategic information framework. A national accountability framework (monitoring and evaluation) will be practiced to track the performance of the interventions. A decentralized functional system of M&E will be strengthened and harmonized to a broader system of health services to align with M&E framework of Nepal Health Sector Programme – Implementation plan II. Collecting quality data, its analysis and timely use of results will be especially emphasized at various levels of response planning, programming and review.

Key Actions:

1. Update national HIV monitoring and evaluation guidelines with defined set of core indicators, based on the global and national reporting commitments. A national M&E toolkit that includes standard recording and reporting templates, programme monitoring checklists, M&E training modules, data review and verification protocol will be developed and rolled–out across service sites in Nepal.

2. Establish and share national protocol for evaluation of HIV prevention, treatment, care and support interventions among the key stakeholders and implemented. Emphasis will be laid for outcome and impact evaluation of the interventions; and the results will be used to inform the programme update.
3. Review of routine programme (targeted prevention interventions including HTC, STI, PMTCT, ART and care and support) will be conducted using national evaluation protocol.
4. Strengthen clinical monitoring of people on ARVs and monitoring of Adverse Drug Reaction (ADR) as one of critical components of ART programme monitoring.
5. Establish and update a national HIV database for recording and reporting of routine programme monitoring data from both public and CSO services sites. This data base will be linked with the HMIS system with emphasis to be integrated into Heath Sector Information System (HSIS). Emphasis will be given to develop and strengthen district HIV information as one of the component of district health data bank at districts.
6. Ensure quality of data of the programme through development of contextualized data quality audit tools.
7. Develop and share annual national report and programme review factsheets among the stakeholders and share progress reports in the regional and national reviews.

Research

HIV research, specifically the operational research, will be strengthened as a critical component of HIV strategic information to document the knowledge gap in terms of effectiveness of interventions and implementation approaches so that the coverage of proven-interventions can be improved. Thus, a national HIV research agenda will be developed based on the principle of "getting research into policy and practice". This will be fostered with reference to what is already known, even if that is limited and further scientific knowledge will be updated to build effective coverage of interventions. Collaborative efforts will be strengthen to implement basic researches on HIV.

Key Actions:

- Develop and update a national HIV research agenda to inform research gaps to enhance quality, coverage and effectiveness of HIV prevention, treatment, care and support services in Nepal.
- Priority research areas are: modelling of scaling-up/down of effective interventions, timely exploring of emerging and re-emerging of HIV epidemic among key population groups, effectiveness, system and economic evaluation of key interventions.
- Research will be conducted with focus on three areas of interest: (i) prevention research (including mode of transmission); (ii) treatment care and support; and (iii) cross-cutting issues
- Publication of research findings in local and international peer-reviewed journals for wider dissemination

Stigma and Discrimination Reduction

Each MARP has distinct stigma attached to them resulting into discrimination of varied intensity and magnitude. Therefore all MARPs focused programme will have in build stigma and discrimination reduction activities.

Key Actions:

- Empower people living with HIV: this strategy will be closely linked with positive prevention and other empowerment activities aimed to PLHIV.
- Update education about HIV and stigma reduction message in IEC materials. Also ensure that media are sensitised and trained so that media reporting become sensitive and zero stigma.
- Conduct activities that foster direct or indirect interaction between people living with HIV and key audiences
- People living with HIV need to be actively involved in developing and implementing stigma and discrimination-reduction efforts.
- Promote sensitizing the stakeholders, health care provider, school teachers, members of the family and community on stigma reduction.

Legal support, legal reforms and human rights

Key Actions:

1. Address policy and structural limitations for accessing ART, PMTCT services for reducing stigma and discrimination.
2. Enable environment and effort to decriminalisation and access to legal aid services for the MARPs, PLHIV, CABA and single women due to HIV and AIDS.
3. Advocate and support the integration of HIV/AIDS and sexuality education in national education programmes.
4. Mobilize political will and policy change for creating enabling environment component in each of the MARPs intervention for improving access to services.
5. Build consensus to form alliances between government and civil society and other stakeholders for building their capacities to overcome resistance to change relevant religious (faith based) or cultural attitudes or barriers to the prevention of the epidemic.
6. Support community mobilization and empowerment to HIV/AIDS interventions, using a rights-based approach.

Addressing Sexual and Gender Based Violence

Key Actions:

1. Design special programs with prevention, treatment care and support for returnee and victims of human trafficking by establishing linkages with organizations working against human trafficking and gender based violence including legal aid services.
2. Work closely with other ministries particularly Ministry of Women, Children and Social Welfare who is leading the implementation of national action plan, CRC, CEDAW on reducing sexual and gender based violence, establish programmatic linkages so that HIV related activities and GBV related activities complements each other and synergy is achieved.
3. Engage stakeholders and social leaders advocating for women rights and elimination of GBV in designing and monitoring HIV and AIDS programme so that HIV programme remains relevant women and addresses the gender based violence by breaking gender stereotype.
4. Build national capacities in gender analysis and gender mainstreaming as the foundation for relevant and effective HIV-prevention programming.
5. Expand gender-specific and gender-responsive communication strategies and include HIV and gender issues in all training and orientation programmes, peer education manuals, IEC materials and other activities with the aim of changing attitude and behaviours of men and women; educating men and boys about a woman’s right to negotiate whether and how sex takes place; power relations and harmful traditional practices that increases the vulnerability and impact of HIV and AIDS.

6. Conduct periodic gender assessment and take stock of latest situation in order to make appropriate adjustment in programme implementation, service delivery and other HIV related activities.
7. Encourage and support HIV and AIDS stakeholder at all levels (central level, line ministries, DACC/DDC, NGOs, Private organisations) to design their programme gender transformative as well as gender-sensitive and user-friendly services that takes into consideration of gender stereotype, gender based violence, gender monitoring and reducing stigma and discrimination.

Workplace

Key Actions:

1. Enhance productivity by mitigating obstructions that may occur from HIV/AIDS in workplaces.
2. Ensure that all workers and employees infected or affected by HIV/AIDS in workplaces receive counselling, treatment care and support.
3. Build capacity of employers, association of employee (i.e. trade unions, associations) for effective workplace interventions and special attention will be given in making workplace safe.
4. Address stigma and discrimination at workplace setting.

Resource Mobilization

Government financing to HIV would be increased gradually of total contribute to AIDS spending in the country.

Key Actions:

1. Advocate ensuring proportional contribution of ARV drug cost from the government fund during the strategic period.
2. Explore alternative resource mobilisation potentials (i.e. creating HIV fund by contribution from government and other sources, putting some money aside for HIV from penalty and fees, and so on).
3. Advocate the corporate sector and other private institutions for mobilizing resources opportunities (for example, Corporate Social responsibility).
4. Mobilize resource at DDC level within the broader framework of Local Self Government Act (1998).
5. Mobilize adequate financing from domestic or foreign donors to continue scaling up HIV services, and to keep pace with increased demand.
6. Mobilize resources by developing different proposals to bid on potential funding agencies based on the national HIV/AIDS strategy.
7. Selected line ministries will secure/allocate budget for HIV related activity as mainstreamed in the sectoral guidelines and work plan.
8. Prepare realistic work plan and calendar of operation considering financial rules and regulation including regular assessment for effective and timely utilization of available resources.
9. Advocate for adapting transparent, flexible financial rules and mechanism that allows rapid flow of fund to service providers.

CHAPTER IV: CO-ORDINATION AND IMPLEMENTATION MANAGEMENT

CO-ORDINATION AND MANAGEMENT FRAMEWORK

Roles and Responsibilities

For the multisectoral engagement and effective implementation of this strategy, following roles and responsibilities are designed. It is however recognised that given the complex nature of HIV epidemic, strong collaboration and mutual ownership and accountability is required for effective response.

PUBLIC SECTOR

NATIONAL AIDS COUNCIL

National AIDS Council is highest policy body chaired by prime minister will provide highest political commitment and leadership to national response to HIV. It sets up broader policy directives for HIV response in the country as part of national development agenda and draws on the comparative advantage of each sectoral line ministries for mainstreaming HIV into their respective programmes.

MINISTRY OF HEALTH AND POPULATION

HIV AIDS AND STD CONTROL BOARD

Within the highest level of policy directives of National AIDS Council and taking into consideration of national and international commitments, as secretariat for the NAC, the Board will develop national strategy, coordinate multisectoral response, mobilise domestic and external resources and will be responsible for national level monitoring and evaluation of the response (Source: National AIDS Policy 2011).

NATIONAL CENTER FOR AIDS AND STD CONTROL

Under the Ministry of Health and Population, in order for providing HIV and AIDS services, National Centre for AIDS and STD Control will develop work plan, implement and monitor HIV and AIDS related services. The Centre will implement the activities through central, regional, zonal and district level health structures, district public health offices, health centres, health posts, sub health posts and female community health volunteers (Source: National AIDS Policy 2011).

DISTRICT AIDS COORDINATION COMITTEE

Under the remit of Local Self Governance Act (1998) and by laws (1999), District Development Committee (DDC) can and will play important role to mainstream HIV/AIDS in various sectoral plans. As such, DACC will have a crucial role in planning, programming and reviewing the local response to the epidemic at district level and below. More specifically, DACC will work with following objectives (DACC guidelines 2008).

1. Improve the effectiveness of the HIV intervention through coordination of all stakeholders engaged
2. Establish HIV as a multisectoral issue and mainstream it at local level
3. Implement HIV in participatory way
4. Strengthen legal assistance, advocacy, management and technical capacity for the benefit of infected or key affected population.

In order to help achieve the objectives of the DACC, technical and financial support will be made available. DACC will also seek technical support to strengthen its function and mobilise DDC/VDC grants/resources for district specific activities particularly in the area of social protection, impact mitigation and protecting human rights of vulnerable and infected.

Role of Sectoral Ministries in National Response to HIV

In the context of Nepal where epidemic is concentrated and its impact, though serious, is localised and not yet widespread, selective mainstreaming will be the strategic approach. The Strategy calls for systematic and coordinated action from line ministries beyond the Ministry of Health. Selected line ministries have a role to play in prevention by reducing vulnerability to and risk of HIV transmission among the population it serve, contribute to care and support for people living with HIV, to help reduce stigma and discrimination and to create enabling environment for coordinated and scaled up response by recognising and including HIV as a development agenda.

National AIDS Council at the highest policy level and National Planning Commission at the apex of planning hierarchy will ensure such mainstreaming is effectively executed through its regular meeting and review process.

Sectoral ministries towards the mainstreaming HIV in the respective sectors primarily focus on adapting sectoral functions and allocating resources as appropriate in order to take into account susceptibility to HIV transmission and vulnerability to the impacts of AIDS. And also adapt practice to help reduce the organisation's susceptibility to HIV infection and its vulnerability to the impacts of AIDS.

Relevant ministries incorporate HIV related functions in their core functions by preparing sectoral guidelines and monitoring its implementation in collaboration with MoHP/NCASC for technical support, and other stakeholders. The focal person in each ministry will continue to coordinate and facilitate the mainstreaming process in the respective ministries.

The work already initiated by following ministries will continue and additional sectors will gradually mainstream HIV as appropriate.

Table 4: Proposed Role of sectoral ministries

Ministry/Sector	Proposed Role and Mainstreaming approach
National Planning Commission	o Provide guidelines for sectoral line ministries in including HIV as a development agenda. o As with other P1 programme, agree a set of HIV related indicators for each ministry and monitor periodically with line ministries as a part of regular M& E function of NPC. o Advise, advocate and allocate appropriate resources as per the plan of line ministries for HIV related function. o Seek technical inputs from ministry of health (NCASC), HSCB as appropriate. o Provide policy inputs to National AIDS Council.
Ministry of Finance	o As with other P1 programme, advice, advocate and allocate appropriate resources as per the plan of line ministries for HIV related function.
Ministry of	o Prepare sectoral guideline to address issues around HIV within the broader

Ministry/Sector	Proposed Role and Mainstreaming approach
Education	framework of this strategy (with for example a special arrangement for education scholarship for CABA) and ensuring the rights of infected children is protected. o Incorporate HIV topics in curriculum at different level including in adult and continuing education curriculum. Emphasise on reducing stigma and discrimination in all related activities. o Research and capacity building and acquire technical and other support from HSCB and NCASC as appropriate. o Monitoring and evaluation by incorporating define indicator in routine monitoring forms
Ministry of Local Development	o Prepare sectoral guideline. o Incorporate suggestions/instruction for including HIV in VDC and DDC planning and resource allocation guidelines. Encourage investing in social protection at DDC and VDC level for women and children infected by HIV. o Incorporate HIV in its internal and external training programme. Emphasise on reducing stigma and discrimination in all related activities. o Research and capacity building and acquire technical and other support from HSCB and NCASC as appropriate. o Monitoring at central, district and VDC level with defined indicator included in routine progress reporting forms.
Ministry of Women, Children and Social Welfare	o Prepare sectoral guidelines. o Incorporate HIV in its internal and external training programme. o Prepare policy and implementation arrangement to safe guard rights of infected women, children, and HIV widows. Emphasise on reducing stigma and discrimination in all related activities. o Research and capacity building and acquire technical and other support from HSCB and NCASC as appropriate. o In the context where now women development sections at the districts are made responsible for child rights monitoring o CCWB and DCWB, and CCWB would regularly monitor and implement programme related to HIV. o Monitoring and evaluation by incorporating define indicator in routine progress reporting forms. **Central Child Welfare Board (CCWB)** o Promote HIV related activities through different networks, such as child clubs within the broader context of child rights as guided by CRC. o Develop nutritional guidelines in coordination with ministry of health and population and early childhood development and education guidelines in providing basic and life skills based education in coordination with Ministry of Education to the children who are infected and affected by HIV and AIDS and ensure the better implementation and universal access on it.
Ministry of Tourism	o Prepare sectoral guidelines in collaboration with tourism partners and associations (for example, encouraging free condom outlets/box in hotels, porters and trekking routs, implementation of National workplace policy in tourism sector).

Ministry/Sector	Proposed Role and Mainstreaming approach
	o Incorporate HIV in its internal and external training programme including tourism training institutions. Emphasise on reducing stigma and discrimination in all related activities. o Conduct awareness programmes to the adolescent girls who are in the hotels, restaurants and dance bar about the preventive ways from HIV and AIDS. o Organise research and capacity building activities and acquire technical and other support from HSCB and NCASC as appropriate. o Monitoring and evaluation by incorporating define indicator in routine progress reporting forms.
Ministry of Home Affairs	o Much of the HIV related functions to the extent it is linked with narcotic drugs has been recognised and mainstreamed in MOHA policy and related strategy (i.e. Drug Control Strategy 2010). o Prepare sectoral guidelines including HIV related functions at prisons and local law enforcing bodies and acquire technical and other support from NCASC, HSCB for collaborative implementation of Drug control strategy and HIV strategy. o Emphasise on reducing stigma and discrimination in all related activities. o Organise research and capacity building activities and acquire technical and other support from HSCB and NCASC as appropriate. o Monitoring and evaluation by incorporating defined indicator in routine progress reporting forms.
Nepal Police	o While revising the existing HIV and AIDS Strategy and Work plan (2005) incorporate strategic directions into sectoral strategy. o Monitoring and evaluation the activities of hotels, restaurants and dance bars and take appropriate action following the existing rules and regulations of the country for illegal activities. o Advocacy programme to all the persons who are in the jail, injecting drug users, female sex workers etc. develop harm reduction programme. o Emphasise on reducing stigma and discrimination in all related activities. o Organise research and capacity building activities and seek technical and other support from HSCB and NCASC as appropriate.
Ministry of Labour and Transport	o A national workplace policy (2007) is now in effect o Develop an implementation and monitoring mechanism for effective execution of the workplace policy in collaboration with private sectors and association (i.e. transport association, trade unions). o Issue of labour migration and associate HIV related risk is addressed. o Incorporate HIV in its internal and external training programme including labour training institutions. Emphasise on reducing stigma and discrimination in all related activities. o Research and capacity building o Monitoring and evaluation by incorporating define indicator in routine progress reporting forms.
Ministry of youth and Sports	o Youth policy and strategy is now in place o Include prevention message and stigma and discrimination activities in its

Ministry/Sector	Proposed Role and Mainstreaming approach
	regular programme for youth and adolescents o Incorporate HIV in its internal and external training programme including labour training institutions. o Research and capacity building in youth and adolescents related activities and organisations o Monitoring and evaluation by incorporating define indicator in routine progress reporting forms.

Private Sector

Private sectors will be engaged as social partners in HIV response through their umbrella associations (i.e. FNCCI, Bankers Associations, hotel association etc) and through other appropriate arrangements. Private sector will also be partner in accessing global resource and generating national resources for HIV response in the country. Following are some of the crucial role that private sector will play

1. Implementation of National workplace policy (2007) in respective workplaces
2. Private sectors has crucial role in national and international advocacy both for resource mobilisation and for effective implementation of national policy and programmes. As such Business Coalition against AIDS in Nepal (B CAAN) will be promoted and engaged in national response
3. PPP will be promoted. The approaches relevant to national response like cost sharing, matching fund, role sharing to HIV will be jointly explored and implemented. After assessing the strength and weakness of each partner, mutually benefiting approach will be followed
4. Government will provide options and opportunity through research, advocacy, and by engaging in capacity building activities for private sectors.
5. Government will ensure that procuring goods (drugs, chemicals and reagents, needle and syringes, and other) and services from national producers receive high priority.
6. Continue dialogue with private sector to expand their role and engagement in HIV prevention, treatment care and impact mitigation.

Media

1. Collaboration with national programme (NCASC, HSCB)
2. Capacity building of media – it must be continuing process
3. Encourage journalist to identify issue in HIV
4. Supporting CSR of media corporate houses
5. Media monitoring
6. HIV communication strategy (what are the communication issues, what are the role of media, how they can participate in such process, how to set up regular discussion and dissemination process)

Civil Society Organizations (CSOs), including networks, local NGOs, CBOs

Health system will increasingly take up and expand services (i.e. HTC, STI) and NGOs/CSOs will take more on demand creation, facilitative and supportive role to health care. In the regards, NGOs would provide service in collaboration and or in support of government health system. It is recognised that some MARPs group may not access government run services for various practical reasons (distance, opening hours, stigma and discrimination, confidentiality), therefore effort will be made to make government service user friendly adopting various approaches (for example,

attachment of a counsellor in government service site seconded from specific community, allowing such community to provide service under government supervision).

NGOs and community groups will actively engage in demand creation, advocacy, community mobilisation and work as 'watch dog'.

NGOs and community group will also engage in facilitating access of PLHIV to ART services and help in adherence monitoring. For this Community Care Centre or Social Unit will be promoted who also will closely work in CHBC programme (link with Networks of civil society (NGOs) are increasing and newer networks are also emerging. Their role and contribution in national response has been acknowledged and appreciated. Moreover, since the role of networks vis-a-vis its member organisations, is evolving in HIV response, this strategy will remain flexible in accommodating the changing role of networks and the member as it emerges. However, when it comes to direct health service delivery, it will be guided and shaped by the basic principle of continuity, sustainability of services and primarily the facilitative roles of NGO.

External Development Partners

The Strategy views the role of EDPs within the framework of Paris Declaration on Aid effectiveness, Accra Agenda for Action and IHP which all are rooted to the principle of harmonisation and alignment of international assistance. The following specific roles are envisioned from EDPs.

1. Promote locally owned programme in a coherent manner.
2. Promote and rely on country system.
3. Promote donor and country coordination to achieve program goals.
4. Advocate and support country initiative for resource mobilisation both at national and international level to sustain the programmes beyond external funding period.
5. Mode of financing can be parallel financing, pooled financing, general budget support, or a combination (based on principle of SWAP).
6. Strengthen national capacity and provide technical assistance for coordinated, harmonised and evidence informed HIV response.

Thematic Committees

Various thematic committees will be set up with representation from technical experts, technical partners, EDPs and CSOs as needed to provide strategic and technical guidance in respective thematic areas. The committees will avail their expertise on voluntary basis and members will be selected on the basis of their technical expertise and time availability. Such thematic committees will avail its service at all levels and agencies as appropriate.

R V: COSTING

OF National HIV/AIDS Strategy 2011-2016

	July 2011- July 2012	July 2012- July 2013	July 2013- July 2014	July 2014- July 2015	July 20 July 20
	14,831,873.0	**16,986,154.6**	**19,174,317.4**	**21,411,576.8**	**23,696,89**
ations					
dolescents focused interventions	183,156.5	219,232.8	233,592.3	224,183.9	189,43
workers and clients	1,823,970.7	2,015,140.1	2,210,873.7	2,411,254.1	2,616,36
rkers and clients	985,405.8	1,117,549.8	1,252,859.5	1,391,391.8	1,533,20
	108,451.7	100,689.0	84,123.6	66,646.1	46,15
ug users	3,083,625.0	3,436,644.0	3,817,255.9	4,227,337.3	4,668,88
ave sex with men	4,886,629.4	5,709,802.5	6,550,740.4	7,409,735.9	8,287,08
mobilization	-	-	-	-	
	1,565,070.0	1,844,988.4	2,130,583.9	2,421,944.8	2,719,16
	94,000.0	151,971.1	211,143.0	271,534.6	333,16
ry					
ovision	185,634.9	215,371.6	247,314.0	281,523.0	318,07
ment	40,625.9	51,808.1	63,168.2	74,708.3	86,43
	964,725.4	1,117,792.1	1,276,356.9	1,440,575.4	1,611,62
ncision	-	-	-	-	
	541,858.1	609,698.7	673,451.2	739,848.2	807,71
n	150,000.0	150,000.0	150,000.0	150,000.0	150,00
y	38,491.7	51,785.8	65,489.1	79,609.3	94,15
ure prophylaxis	4,370.6	9,105.4	13,840.2	18,575.0	23,30
on	-	-	-	-	
recautions	175,857.4	184,575.1	193,525.6	202,709.0	212,12

tment services	**6,202,588.8**	**7,336,288.5**	**9,238,451.2**	**11,806,972.6**	**15,352,77**
y	2,868,667.1	3,717,440.9	5,314,338.3	7,707,344.4	11,254,14
ophylaxis in the absence of ART	3,130,359.8	3,359,850.1	3,548,982.8	3,547,668.6	3,342,74
esting	1,961.9	3,637.6	5,530.1	7,639.6	9,96
are	-	-	-	-	
d care	-	-	-	-	
ART care	201,600.0	255,360.0	369,600.0	544,320.0	745,92
support	-	-	-	-	
s	-	-	-	-	
	294,450.4	**469,220.7**	**625,957.5**	**763,826.0**	**881,99**
	28,655.1	50,480.8	73,599.0	97,250.8	120,67
support	-	-	-	-	
ne support	238,509.4	375,431.5	494,686.2	596,273.6	680,19
support	517.7	652.0	767.0	862.9	93
n costs	26,768.2	42,656.4	56,905.2	69,438.7	80,18
	21,328,912.2	*24,791,663.7*	*29,038,726.1*	*33,982,375.4*	*39,931,65*
., research, M&E	**2,634,120.7**	**3,061,770.5**	**3,586,282.7**	**4,196,823.4**	**4,931,55**
NRs	**1,821,190,498.8**	**2,116,860,997.1**	**2,479,500,666.3**	**2,901,619,102.8**	**3,409,604,54**
USD	**23,963,032.9**	**27,853,434.2**	**32,625,008.8**	**38,179,198.7**	**44,863,21**

related to palliative care, CHBC, nutritional support, TB and OI are included in ARVs' cost.

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ANNEXE

Annex I

Chronology of events: Strategy development process

1. Strategic Planning 2011-2016 first preliminary consultation meeting conducted and inform all related stakeholders about Strategy development process, Agree roadmap including major milestone with time line and process

2. Joint Meeting of MoHP, HSCB and NCASC and formed Steering Committee (SC), Project Development Committee (PDC), Writing Team and Thematic Areas and agree on the TOR of different committees.

3. Joint meetings of PDC and Writing Team

4. Joint PDC and Writing Team Meeting principally agree on the road map for Strategy

5. Joint Meeting of SC, PDC and Writing Team agreed the strategic components

6. Writing Team drafted the HIV/AIDS Strategy 2011-16 Framework

7. Thematic consultations with MARPS community and major institution working with MARPS, private sector, Media, Youth, Gender, Treatment Care and Support partners, Regional Consultations (Dhangadhi and Chitwan)

8. First draft circulated for comments

9. Writing team meetings for discussion and incorporation of comments on the first draft

10. Brief Review of current Strategy with recommendations

11. Writing team meeting to refined the Strategy draft

12. Sharing of the Strategy to the Steering committee

13. National HIV/AIDS Strategy draft circulated for comments (second)