

Nepal's National HIV/AIDS Strategy

19TH JULY 2002

ABBREVIATIONS

AIDS	Acquired Immuno Deficiency Syndrome
ANC	Ante Natal Care
BSS	Behaviour Surveillance Survey
CBO	Community Based Organization
DDC	District Development Committee
FNCCI	Federation for Nepal Chamber of Commerce and Industries
GIPA	Greater Involvement of People Living with AIDS
HIV	Human Immunodeficiency Virus
HMG	His Majesty's Government
IDU	Injecting Drug User
IEC	Information Education and Communication
INGO	International Non-Governmental Organization
KAP	Knowledge, Attitude and Practice
MoH	Ministry of Health
MSM	Men who have Sex with Men
MTEP	Medium Term Expenditure Programme
NCASC	National Centre for AIDS and STD Control
NGO	Non-Governmental Organization
PLWHA	People Living with HIV/AIDS
PMTCT	Prevention of Mother To Child Transmission
STD	Sexually Transmitted Diseases
STI	Sexually Transmitted Infection
SW	Sex Worker
TB	Tuberculosis
UNGASS	United Nation General Assembly Special Session
USAID	United States Agency for International Development
WHO	World Health Organization

1	<u>BACKGROUND, RATIONALE AND STRATEGY DEVELOPMENT PROCESS</u>	1
1.1	<u>BACKGROUND</u>	1
1.1.1	<u>Geopolitical and Socio-economic Context</u>	1
1.1.2	<u>The HIV/AIDS Epidemiological Situation in Nepal</u>	2
1.1.3	<u>The Potential for a Rapid Increase in HIV Prevalence</u>	3
1.1.4	<u>Sexually Transmitted Diseases</u>	4
1.1.5	<u>Institutional Development and Policy Formulation</u>	5
1.2	<u>RATIONALE FOR UPDATING THE NATIONAL STRATEGY</u>	6
1.3	<u>THE STRATEGY DEVELOPMENT PROCESS</u>	6
1.3.1	<u>Situation Analysis</u>	6
1.3.2	<u>Response Analysis</u>	7
1.3.3	<u>The Development of the National Strategy</u>	8
2	<u>NEPAL'S HIV/AIDS STRATEGY</u>	9
2.1	<u>Overview</u>	9
2.2	<u>Guiding principles of the Nepal HIV/AIDS Strategy</u>	9
2.3	<u>Priority Areas</u>	12
3	<u>STRATEGIC COMPONENTS</u>	13
3.1	<u>VULNERABLE GROUPS</u>	13
3.1.1	<u>SEX WORKERS (SWs) AND THEIR CLIENTS</u>	13
3.1.1.1	<u>Creating an Enabling Environment</u>	14
3.1.1.2	<u>STI Management and Behaviour Change Communication</u>	14
3.1.1.3	<u>Capacity-building and Empowerment</u>	15
3.1.1.4	<u>Research</u>	16
3.1.2	<u>INJECTING DRUG USERS (IDUs)</u>	16
3.1.2.1	<u>Creating an Enabling Environment</u>	17
3.1.2.2	<u>Harm Reduction</u>	17
3.1.2.3	<u>Care and Support</u>	18
3.1.2.4	<u>Research</u>	18
3.1.2.5	<u>Demand Reduction</u>	19
3.1.3	<u>MOBILE POPULATION</u>	19
3.1.3.1	<u>Research</u>	20
3.1.3.2	<u>Addressing Vulnerability and Behaviour Change</u>	20
3.1.3.3	<u>Creating an Enabling Environment</u>	21
3.1.4	<u>MEN WHO HAVE SEX WITH MEN (MSM)</u>	21
3.1.4.1	<u>Creating an Enabling Environment</u>	22
3.1.4.2	<u>Addressing Vulnerability and Behaviour Change</u>	23
3.1.5	<u>PRISONERS</u>	23
3.1.5.1	<u>Creating an Enabling Environment</u>	23
3.1.5.2	<u>IEC and Support Services</u>	24
3.2	<u>YOUNG PEOPLE</u>	25
3.2.1	<u>CREATING A SUPPORTIVE POLICY AND COMMUNITY ENVIRONMENT</u>	26
3.2.2	<u>AWARENESS AND BEHAVIOUR CHANGE COMMUNICATION</u>	26
3.2.3	<u>YOUTH-FRIENDLY SERVICES</u>	27
3.2.4	<u>ENHANCE YOUNG PEOPLE'S KNOWLEDGE ABOUT HIV/AIDS/STI IN FORMAL AND NON-FORMAL EDUCATION SETTINGS</u>	28
3.3	<u>TREATMENT, CARE AND SUPPORT FOR PEOPLE INFECTED AND AFFECTED BY HIV</u>	29

3.3.1	<u>REDUCING THE STIGMA SURROUNDING PEOPLE LIVING WITH HIV/AIDS</u>	29
3.3.2	<u>VOLUNTARY CONFIDENTIAL COUNSELLING AND TESTING</u>	30
3.3.3	<u>COMMUNITY AND HOME BASED CARE AND SUPPORT</u>	31
3.3.4	<u>MEDICAL SERVICES</u>	32
3.3.4.1	Universal precautions	34
3.3.5	<u>PREVENTION OF MOTHER TO CHILD TRANSMISSION</u>	34
3.3.6	<u>BLOOD SAFETY</u>	35
3.4	<u>MEASURING CHANGES</u>	35
3.4.1	<u>2ND GENERATION SURVEILLANCE</u>	36
3.4.2	<u>BEHAVIOURAL AND CONTEXTUAL RESEARCH ON VULNERABILITY TO HIV/AIDS/STI</u>	36
4.	<u>MANAGEMENT AND IMPLEMENTATION OF AN EXPANDED RESPONSE TO HIV/AIDS IN NEPAL</u>	38
4.1	<u>CONTEXT AND CHALLENGES</u>	38
4.2	<u>THE VISION FOR THE FUTURE</u>	39
4.3	<u>STRATEGIES</u>	40
4.4	<u>THE NEXT STEPS</u>	44
5	<u>YEARLY TARGET</u>	46

EXECUTIVE SUMMARY

Behavioural and seroprevalence data indicate the high potential for a generalized epidemic in Nepal. In the absence of effective interventions, even a “low to moderate growth scenario” would make **AIDS the leading cause of death in the 15-49 year old population over the coming years**. For Nepal this would mean that around 100,000-200,000 young adults will become infected and that overall 10,000-15,000 annual AIDS cases and deaths may be expected.

For Nepal, a generalized epidemic with high mortality in the productive age group would start a “vicious circle”. The impact of HIV/AIDS would increase poverty and vulnerability. This increased vulnerability would lead to more HIV infections and a higher impact. Besides the negative impact on socio-economic development and the loss of productive life, the burden of disease would change dramatically over the next 10 years and would put further stress on the health sector and local communities.

There have been a number of important changes since the development of the “*Strategic Plan for HIV and AIDS in Nepal 1997-2001*” (1996: a) The epidemiological situation has dramatically changed between 1997 and 2001; b) Nepal has committed itself both to the Millennium Declaration and its Millennium Development Goals and to the time-bound targets spelled out in the Declaration of Commitment at the United Nations General Assembly Special Session on HIV/AIDS in July 2001; and c) Nepal’s Tenth Five-Year Development Plan has identified HIV/AIDS as a cross cutting issue affecting national development. This new National Strategy should guide the translation of these commitments into reality and to finally halt and reverse the spread of the epidemic in Nepal.

The overall objective of Nepal’s strategy for HIV/AIDS is to contain the HIV/AIDS epidemic in Nepal. The vision of the National Strategy is to expand the number of partners involved in the national response and to increase the effectiveness of the response. It will do this by focusing on activities within priority areas thereby optimising prevention and reducing the social impact of HIV/AIDS in the most cost-effective manner.

Nepal’s “National HIV/AIDS Strategy 2002-2006” has been designed to guide the expanded response to the HIV/AIDS epidemic in Nepal. An expanded response requires the commitment of all sectors, not just health, both within and outside government, and the coordinated support of external development partners. This strategy will promote and facilitate the coordination of their involvement.

HMG/N Ministries will use the National Strategy to develop and integrate relevant elements of this document into their respective sectoral plans and policies. Local authorities (for example DDCs and municipalities) will use the strategy as a basis for developing their own strategic and operational plans according to their own needs. This document also aims to guide private and social sector organisations (such as INGOs, NGOs, CBOs and businesses) and external development partners in defining their support and contribution to an expanded response. As this National Strategy describes the national priorities for the HIV/AIDS response, it will form the basis for future allocations of human, material and financial resources.

The priority areas identified in the *Situation and Response Analysis* that are addressed in the National HIV/AIDS Strategy are:

- **Prevention of STIs and HIV infection among vulnerable groups** (the groups identified as a possible nucleus for a generalized epidemic, because of their size, HIV seroprevalence and multiple interfaces to the general population are sex workers and their clients; injecting drug users; mobile populations – especially labour migrants to India; men who have sex with men; and prisoners because of their extreme conditions.
- **Prevention of new infections among young people.**
- **Ensuring care and support services are available and accessible for all people infected and affected by HIV/AIDS**
- **Expansion of a monitoring and evaluation frame through evidence based effective surveillance and research.**
- ***Establishment of an effective and efficient management and implementation mechanism for an expanded response***

Yearly targets were defined for the priority areas and key-strategies, and in a next step the strategy will be costed to allow resource mobilization and re-prioritization.

The development of the national strategy was a participatory process involving government, non-governmental organizations, private sector, civil society (including people living with HIV/AIDS), and external development partners. Regional and national consultations provided the opportunity for stake-holders to contribute and finally to shape this strategy.

The main challenge for Nepal is *now* to respond immediately to a rapidly evolving HIV/AIDS epidemic. This has to be undertaken in the context of a civil conflict in the country, weak implementation capacity both within the public and the private sector, structural weaknesses with respect to multi-sector involvement, coordination, policy, monitoring and evaluation, and scarce internal resources.

Recognizing all the above, Nepal has embarked to broaden and to deepen political commitment. For example, establishing the National AIDS Council under the chairmanship of the Rt. Honorable Prime Minister, defining HIV/AIDS as priority “1” in the MTEP of the MoH and integrating HIV/AIDS in the 10th Development Plan. HMG is also committed to reforming and strengthening the management mechanisms of an expanded, i.e. multi-sector and scaled-up, response to HIV/AIDS within the framework of the National Strategy.

The challenge will be to sustain and to broaden the political commitment in terms of policy, involvement of new partners and stake-holders, and finally also to translate political commitment and leadership into action. As a resource poor country with additional security expenses, it is difficult for Nepal to demonstrate commitment through budgetary allocations, but higher allocations to an expanded response are foreseen in the MTEP of the MoH. The recent active involvement of law-makers and municipalities both in the strategy development and in policy issues signals broadening commitment that goes beyond parties.

The strategy tries throughout to address the issue of commitment, enabling environment at all levels, and local ownership. It seeks to increase the understanding of decision-makers and communities, especially as regards the most vulnerable groups, and to actively involve them in the response. In doing so, a broader base of commitment will be established and ultimately facilitate the implementation of the strategy. The involvement of local communities and

authorities will also contribute to a public accountability as regards the implementation of the strategy.

Ideally, the National Strategy will be “programme” funded, i.e. pooled resources and/or earmarked contributions, to provide required resources. The future management and implementation structures will be designed to:

- Support and strengthen the leading role of government, and the MoH as the technical line ministry, as regards: policy and strategy; monitoring and evaluation, including quality assurance and quality control; epidemiology and surveillance; involvement of other government structures, e.g. other line ministries, and coordination;
- Provide the flexibility, accountability and results oriented management of a larger programme at the central and the decentralized level;
- Establish new public-private partnerships at all levels to fight the epidemic;
- “De-medicalize” the response to HIV/AIDS;
- Support decentralization and integration at the community level;
- Increase responsiveness; and,
- Provide the basis for sustainability through the involvement of the private sector and civil society.

The shift from individually funded “projects” to a “programme”, from outputs to results orientation, from donor interest to national priorities, from capacity building of central structures to strengthening of implementation capacity, and from a health sector response to a multi-sector approach will require time and resources. This is, however, the precondition for an effective and efficient national response.

Finally, in order to respond effectively, financial and human resources will be needed to translate the national strategy into action. As the epidemic advances day by day, the overall resource requirements to respond become bigger and bigger. Nepal will need the support by external development partners to fulfil the resource needs.

The strategy addresses sustainability in providing for innovative financing mechanisms (trust fund also to attract private sector contributions), and in strengthening the capacity and empowering vulnerable groups and communities. It is hoped that involvement of communities, decentralization, and integration in development programmes will also contribute to better sustainability.

1 BACKGROUND, RATIONALE AND STRATEGY DEVELOPMENT PROCESS

1.1 BACKGROUND

1.1.1 Geopolitical and Socio-economic Context

The Kingdom of Nepal is a highly heterogeneous country in terms of geography, ethnicity, language and culture. Nepal is landlocked sharing borders with India and China and is made up of 75 districts divided into five different development regions (Far-Western, Mid-Western, Western, Central and Eastern). The Himalayas cover the northern third of the country from east to west, bordering China. To their south lies a long east-west stretch of lower mountains (the hilly region) whose southern flanks flatten into the Terai, a fertile, sub-tropical plain spanning the border with India. These contours have played a major role in helping to determine the geographical and social diversity that characterizes Nepal.

In the Human Development Report 2001, Nepal features among the economically poorest countries in the world. Nepal's social indicators remain well below the average for the South Asia region: more than 40% of the Nepali population live below the national poverty line, nearly half of all children below 5 years are underweight and nearly 60% of all adults are unable to read or write. Additionally, women have traditionally a lower status than men and gender inequality is deeply rooted. Nepal is one of the few countries worldwide in which men live longer than women. More boys than girls receive any form of education, women generally work longer hours than men, and men have better access to services, including health.

The pressure of population growth on scarce and fragile land means that the benefits of better education or irrigation are often outweighed by more fragmented land and reduced availability of forest products upon which most of the rural population depends for all or part of its livelihood. In Nepal, the topography, environmental degradation, poverty and economic migration are all linked and they combine with other factors to increase vulnerability to HIV.

1.1.2 The HIV/AIDS Epidemiological Situation in Nepal

	Data	Date
Reported HIV cases	2392	June 2002
Reported AIDS cases	606	June 2002
Estimated number of adults & children living with HIV/AIDS	60,018	End 2002 ¹
Estimated adult and child mortality due to HIV/AIDS	2,958	End 2002
HIV prevalence		
IDUs	68%	2002
SWs	17.3%	2000
STI patients	0.7-6.6	2000
Blood donors	0.28-0.48	2000
ANC	0.2%	2000

Sources: reported cases: MoH data; Estimates: UNAIDS/WHO working group on global HIV/AIDS and STI Surveillance; Estimated HIV prevalence IDU: New Era Study 2002, MoH 1999; Estimated HIV prevalence SW: SACTS/FHI study, 2000; STI patients: MoH/University of Heidelberg 2000; Blood donors: Red Cross Nepal; ANC: MoH/University of Heidelberg.

Epidemiological factors

- Predominant mode of transmission is sexual contact, presumably mainly heterosexual
- Limited information available about homosexual/bisexual transmission.
- Highest rates of HIV have been identified in injecting drug users (IDUs)
- Data indicates that risk behaviours are widespread among sex Workers (SWs), their clients, injecting drug users, labour migrants and youth/young people.
- Current estimated HIV infection rate – 0.5 % of the adult population between the ages of 15 - 49.
- There is evidence of an explosive increase in the number of infections since 1996
- Increasing levels of Sexually Transmitted Diseases (STDs) reported

Male/female ratio

- Approximately 3:1 (NCASC, 2001)

•

Geographic distribution

- Highest prevalence rates found in the Central Region.
- Rural /urban ratio – to be determined
- HIV infection has been noted in all regions of the country, although HIV infection appears to be concentrated in urbanized areas and districts with high labour migration

The first cases of AIDS were reported in Nepal in 1988. Surveillance data is scarce in Nepal. However, limited data indicate that HIV prevalence is currently around 0.5 percent in the general population. As of June 2002, the Ministry of Health (MoH) has reported 606 cases of

¹ WHO/UNAIDS estimate

AIDS and 2,392 HIV infections. Given the existing medical and public health infrastructure in Nepal and the lack of continuity in national HIV/AIDS surveillance systems, it is very likely that the actual number of cases is many times higher. UNAIDS/WHO estimate for 2002 around 60,018 people living with HIV/AIDS, and 2958 AIDS related deaths in that year alone.

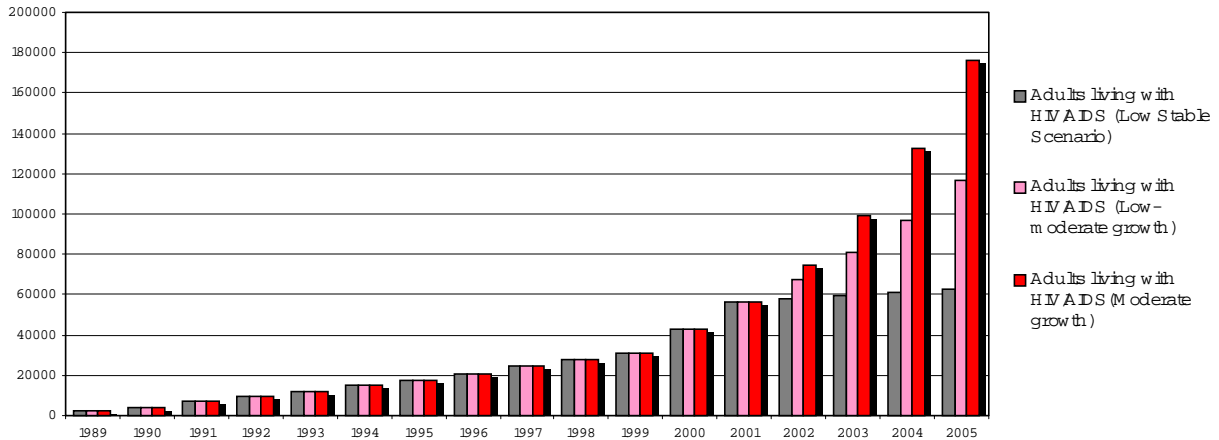
However, the currently low prevalence among the general population masks an increasing prevalence in several groups: SWs in Kathmandu 17.3% (SACTS/FHI, 2000), IDUs 40.4% nationwide, and 68% in the Kathmandu Valley (NCASC, 2000; FHI, 2002)). It is now evident that Nepal has entered a “**concentrated epidemic**”, i.e. the HIV/AIDS prevalence consistently exceeds 5% in one or more sub-groups.

- Among all IDUs in Nepal (estimated number 30,000), approximately 40% are HIV positive, and among IDUs in Kathmandu (estimated 10,000-15,000) the rate has increased to around 70%. In addition, a survey among 300 SWs in Kathmandu (FHI, 2000) revealed that 15 women had also injected drugs, representing 5% of the total sample. Of these 15 women, 11 were found to be HIV positive.
- A survey in Kathmandu in 2000 revealed that 17.3 percent of SWs were HIV-positive – up from 2.7 percent in 1996 (SACTS/FHI, 1996 & 2000). It is estimated that as many as 70 percent of SWs returning from India are HIV-positive. There are no national statistics for prevalence among SWs, but the proportion is high and no doubt growing.
- Estimates of the number of Nepali men working in India are around 1 million and above. Migration to India will undoubtedly continue to increase in coming years. Many of these men are contracting HIV/AIDS in India and bringing it back to their wives in Nepal. A recent survey of men returning from Mumbai to Nepal revealed an HIV infection rate of 10 percent (Poudel, 2001).
- Most of the 60,000 people living with HIV/AIDS (PLWHA) do not know they are infected and many of them may be engaging in unsafe sexual practices. Pervasive stigma and discrimination will prevent these people and others in the high-risk groups from practicing safe sex, undergoing testing, and if they know they are infected from seeking treatment and care.

1.1.3 The Potential for a Rapid Increase in HIV Prevalence

Behavioural and seroprevalence data indicate the high potential for a generalized epidemic in Nepal. In the absence of effective interventions, even a “low to moderate growth scenario” would make **AIDS the leading cause of death in the 15-49 year old population over the coming years**. For Nepal this would mean that around 100,000-200,000 young adults will become infected and that overall 10,000-15,000 annual AIDS cases and deaths may be expected.

The following table shows three scenarios: a “low-stable” scenario, with the seroprevalence leveling off at 0.5% in 2005; a “low-moderate growth” estimate with a prevalence rate of 1% in three years time; and finally a “moderate growth” model, reaching 1.6% in 2005. The difference between the three scenarios is the actual gain in lives, provided that the response to the epidemic in Nepal is effective enough to impact on the development of the epidemic.



For Nepal, a generalized epidemic with high mortality in the productive age group would start a “vicious circle”. The impact of HIV/AIDS would increase poverty and vulnerability. This increased vulnerability would lead to more HIV infections and a higher impact. Besides the negative impact on socio-economic development and the loss of productive life, the burden of disease would change dramatically over the next 10 years and would put further stress on the health sector and local communities.

1.1.4 Sexually Transmitted Diseases

STDs also form a significant part of the epidemic. It is estimated that 200,000 episodes of STDs occur annually in Nepal. The STD prevalence rate in women is approximately 4.7% ranging from 2.7% - 5.4%. Access to STD services is still very poor, especially for women. In addition, the use of condoms for effective infection prevention is not yet commonly known or accepted. Condoms contributed to only 1.1% of the total contraceptive prevalence rate. At present other methods of contraception are emphasized, which leave women vulnerable to infection and force them to negotiate condom use for infection prevention.

1.1.5 Institutional Development and Policy Formulation

In 1988, HMG/Nepal launched the first National AIDS Prevention and Control Programme. This programme, known as the Short-Term Plan for AIDS Prevention and Control, formed the basis for the First Medium Term Plan 1990-92. This programme was externally reviewed in December 1992 and on the basis of the recommendations made during the review, the Second Medium Term Plan for AIDS Prevention and Control in Nepal was formulated covering the years 1993-97.

In 1993, HMG/Nepal accepted the need for multi-sectoral involvement in AIDS and STD control and different focal points were appointed in various sectoral ministries. However, due to frequent political changes neither the National AIDS Coordination Committee nor the multi-sectoral coordination and cooperation has been fully functional.

In 1995, HMG/Nepal adopted a national policy for AIDS prevention, with 12 key policy statements which includes: priority to HIV/AIDS and STD prevention programmes; the need for a multi-sectoral and decentralized response; the acknowledgment of NGO implemented programmes, coordination; evaluation, services for people living with HIV/AIDS; a non-discriminatory approach, confidentiality for test results; and blood safety. The National Centre for AIDS and STD Control (NCASC) was formed within the department of Health for the implementation of the AIDS prevention programme. Policy guidance for the NCASC comes from the National AIDS Coordination committee, a multi-sectoral body with participation from public and private sectors.

Based on the National Policy, a “Strategic Plan for HIV and AIDS in Nepal”, covering 1997 to 2001 was developed and adopted. It tried to operationalize the national policy and to define key activities for each policy objective. Although the strategic plan contained a number of activities aimed at prevention of a fast spread of the epidemic, only few of them were actually implemented. The strategic plan sought to broaden the response to other sectors beyond the health ministry and to integrate HIV/AIDS concerns within these sectors. Factors relating to mobility of populations, urbanization, heavy labour migration to areas where huge infrastructure programmes are being undertaken, the open border between Nepal and India and poverty have been recognized as casual factors for the spread of the infection in the country.

Recently Nepal established a “National AIDS Council” chaired by the Prime Minister. The Council with representation from government, non-governmental organisations, private sector and civil society will take the lead in policy making and will advocate for multi-sectoral participation in the fight against HIV/AIDS in Nepal.

1.2 RATIONALE FOR UPDATING THE NATIONAL STRATEGY

There have been a number of important changes since the development of the “*Strategic Plan for HIV and AIDS in Nepal 1997-2001*” (1996):

- A. The epidemiological situation has dramatically changed between 1997 and 2001;
- B. Nepal has committed itself both to the Millennium Declaration and its Millennium Development Goals and to the time-bound targets spelled out in the Declaration of Commitment at the United Nations General Assembly Special Session on HIV/AIDS in July 2001; and
- C. Nepal’s Tenth Five-Year Development Plan has identified HIV/AIDS as a cross cutting issue affecting national development.

This new National Strategy should guide the translation of these commitments into reality and to finally halt and reverse the spread of the epidemic in Nepal.

1.3 THE STRATEGY DEVELOPMENT PROCESS

The strategy development process was designed to be highly participatory and was undertaken in the following three stages:

1.3.1 Situation Analysis

To provide a better understanding of the HIV situation in Nepal, the NCASC commissioned a Situation Analysis as a first step in the strategic planning process. Fieldwork for the Situation Analysis started in late 2000 with a report being published in December 2000.² The Situation Analysis team performed a literature review, group discussions, and field visits. Those involved included government, external development partners, INGO/NGOs and members of vulnerable groups such as SWs, IDUs and PLWHA.

The three main conclusions were:

- Groups already highly affected by HIV/AIDS (namely SWs and IDUs) must be considered as a priority for immediate targeted interventions;
- Other groups such as mobile populations and young people are also clearly vulnerable to HIV/AIDS/STI and interventions for these groups should be designed and implemented; and
- The capacity of the institutions involved in Nepal’s HIV/AIDS response is weak and therefore interventions have been limited in scope

² NCASC. *Situation Analysis of HIV/AIDS in Nepal*. NCASC, Ministry of Health, Kathmandu, December 2000.

1.3.2 Response Analysis

The Response Analysis conducted in 2000³ followed up issues identified by the Situational Analysis.

The Response Analysis highlighted the weak nature of the institutional response. For example, a number of ministries of HMG/N had some involvement in HIV/AIDS, but only a minority had integrated HIV/AIDS into their plans and budgets. The major burden for dealing with a multi-sectoral response to the epidemic has been left to the Ministry of Health which itself lacked the capacity to mount a response on the scale required.

A number of non-governmental organisations were identified who were actively engaged in responding to HIV. While some of their work appears to be highly effective, its coverage is insufficient to control the epidemic. Much of it is related to awareness raising which by itself is not enough to change behaviour, especially in the most vulnerable groups such as SWs, their clients and IDUs. In addition, current resources and institutional arrangements are inadequate to provide appropriate care and support to those infected and affected by HIV/AIDS.

IDUs, SWs, their clients, and mobile populations were identified as vulnerable to HIV/AIDS not only because of their behaviour, but also because of lack of social and legal protection. The report points to the main challenges of providing a supportive environment for these groups, providing protection and empowerment and access to legal, social, and health services.

The main recommendations of the report include:

- the need to develop a clear national strategy;
- the need to improve the political commitment to fight HIV/AIDS;
- the need to increase the capacity and the budget of the NCASC to fulfil a central role of providing leadership/expertise in the management of an expanded response to HIV/AIDS in the country;
- the need for a rapid increase in coverage of interventions for key target groups (SWs, IDUs and bridging populations) and for an improved response to mobile/migrant populations; and
- the importance of providing care and support for PLWHA.

³ NCASC. **Report on Response Analysis of HIV/AIDS in Nepal**. NCASC, Ministry of Health, Kathmandu, December 2000.

1.3.3 The Development of the National Strategy

A five member-working group, chaired by the director of the NCASC was formed in December 2001 to facilitate the strategic planning process.

In order to include all major stakeholders in the process, four “theme groups” were established covering the following priority areas identified by the Situation and Response Analysis:

- Vulnerable Groups
- Young People
- Care and support
- Epidemiology and research

A fifth group (composed of government officials and external development partners) looked at the management issues of an expanded response.

These groups met between three and five times during February and April 2002 to develop, review and revise draft strategies. Participation in these groups was from all sectors, including people living with HIV/AIDS (detailed in the appendix).

Updated drafts of the strategy components were also posted on the Internet and a special email account was established for comments and suggestions from people who could not participate in the thematic meetings.

Regional Consultation

Regional meetings were held in Biratnagar, Nepalgunj and Pokhara in March 2002 to incorporate a regional and district perspective. The organisations represented at these meetings are also detailed in the appendix.

1st National Workshop

A first National Workshop was held in February 2002 involving all stakeholders within and outside government.

2nd National Workshop

A second National Workshop was held on 4th June 2002. The purpose of this workshop was to enable all stakeholders to review the final draft of the strategy.

2 NEPAL'S HIV/AIDS STRATEGY

2.1 Overview

The overall objective of Nepal's strategy for HIV/AIDS is to contain the HIV/AIDS epidemic in Nepal. The vision of the National Strategy is to expand the number of partners involved in the national response and to increase the effectiveness of the response. It will do this by focusing on activities within priority areas thereby optimising prevention and reducing the social impact of HIV/AIDS in the most cost-effective manner.

The strategy emphasises prevention as the mainstay for an effective response. It also highlights the need for care and support for people infected and affected by HIV/AIDS. This is not only important in its own right, but it is also an important contribution to effective prevention. Considering the dynamic nature of the HIV/AIDS epidemic, the strategy acknowledges the importance of accurately tracking the epidemic and monitoring the effectiveness of interventions.

Nepal's "National HIV/AIDS Strategy 2002-2006" has been designed to guide the expanded response to the HIV/AIDS epidemic in Nepal. An expanded response requires the commitment of all sectors, not just health, both within and outside government, and the coordinated support of external development partners. This strategy will promote and facilitate the coordination of their involvement.

HMG/N Ministries should use the National Strategy to develop and integrate relevant elements of this document into their respective sectoral plans and policies. Local authorities (for example DDCs and municipalities) should use the strategy as a basis for developing their own strategic and operational plans according to their own needs. This document also aims to guide private and social sector organisations (such as INGOs, NGOs, CBOs and businesses) and external development partners in defining their support and contribution to an expanded response. As this National Strategy describes the national priorities for the HIV/AIDS response, it should form the basis for future allocations of human, material and financial resources.

The National Strategy is not meant to be a document purely for the government but needs to be equally owned by all stakeholders involved in the fight against HIV/AIDS in Nepal. Although this strategy will remain in place for five years it will be reviewed regularly and, if needed, adapted accordingly.

2.2 Guiding principles of the Nepal HIV/AIDS Strategy

The HIV/AIDS epidemic has brought about challenges that are too diverse and complex to be tackled by government or by NGOs alone. It raises socio-economic, legal, ethical and human rights issues that all need to be adequately addressed if the fight against the epidemic is to be successful. Partnership and involvement of all relevant sectors and a

wide range of agencies and individuals including those directly affected by the epidemic are essential to any attempt to stop the spread of HIV/AIDS.

Nepal has been a signatory to a number of international declarations – the most recent being the UNGASS Declaration on HIV/AIDS agreed to in June 2001. In addition, Nepal has been a party to other key international agreements such as the “Melbourne Manifesto” emanating from the Sixth International Congress on AIDS in Asia and the Pacific in October 2001. Further, Nepal has implicitly adopted the “Greater Involvement of People Living with AIDS Principle (GIPA)” through its participation and approval of the UNGASS and Melbourne documents and other international agreements. Thus, at the international level, Nepal has adopted a sound fundamental set of general guidelines and principles, which should underpin the national strategy. These guidelines and principles include:

- Multi-sectoral engagement. As the epidemic is complex, affects all parts of society, involves individual, institutional and social behaviour, and far transcends the health sector, effective national responses must be multi-sectoral in spirit and structure.
- Broad political commitment. As the UNGASS Declaration states, “Leadership by governments in combating HIV/AIDS is essential and their efforts should be complemented by the full and active participation of civil society, the business community, and the private sector. Leadership involves personal commitment and concrete actions.”
- Civil society involvement. As sub-components of a multi-sectoral approach and political commitment, the involvement of civil society is nevertheless worthy of highlighting as a central principle in the response. Without meaningful involvement of those groups representing all segments of society, the response will be inadequate. In particular, groups representing PLWHA need to be involved not only as meaningful participants in policy and program discussions, but also actively involved in the organizations and agencies that implement programs. The GIPA principle is a critical element.
- Stigma reduction. The adverse impacts of stigma and discrimination are being increasingly recognized as key barriers to combating the epidemic. Commitment to reducing stigma is therefore a central guideline and principle in all-international agreements.
- Prevention to care continuum. A keystone to the international response is recognition and adoption of programmes that address the epidemic at all stages from prevention to care, support and treatment. To wit: “acknowledging that prevention of HIV infection must be the mainstay of the national, regional and international response to the epidemic; and that prevention, care, support and treatment for those infected and affected by HIV/AIDS are mutually reinforcing elements of an effective response and must be integrated in a comprehensive approach to combat the epidemic” (UNGASS). Specifically, UNGASS emphasizes “...that care, support, and treatment can contribute to effective prevention through increased acceptance of voluntary and confidential

counselling and testing and by keeping PLWHA and vulnerable groups in close contact with health-care systems and facilitating their access to information, counselling, and preventive supplies.”

- Human rights based approaches. All international declarations reference the absolute need to take strong human rights approaches for combating the HIV/AIDS epidemic. The reasons for this are well documented and related to fundamental rights such as access to health care, information, and gender equity. In addition, human rights approaches have powerful programmatic effects as they reduce vulnerability to HIV/AIDS and also help prevent stigma and discrimination against people living with or at risk of HIV/AIDS.

Based on international commitments and principles, and on the findings of the situation and response analysis in Nepal, the following are the guiding principles for the design of HIV prevention and care strategies and interventions in Nepal over the next five years:

1. HIV/AIDS is more than a public health priority. It is a complex, multifaceted problem affecting all aspects of society.
2. Multi-sectoral and interdisciplinary involvement is essential for building an adequate response to the HIV epidemic.
3. The primary focus of the strategy will be on prevention.
4. The response to HIV/AIDS will be rights based with a specific focus on the rights of people infected and affected by HIV/AIDS, in particular the right to confidentiality.
5. Resources allocated must take into consideration defined priorities based on the vulnerability of various affected groups and communities.
6. People and communities must be empowered to protect themselves against HIV infection within a supportive environment.
7. Equal access to basic care and services must be guaranteed for all persons infected and affected by HIV/AIDS.
8. Gender considerations will be central to the development of programmes and interventions.
9. Universal precautions must be well known and applied to prevent the possibility of HIV transmission through medical interventions and to prevent discrimination.
10. HIV testing must be voluntary with guaranteed confidentiality and adequate pre- and post-test counselling both in the public and private sectors.

11. The participation of “target groups” in the design and implementation of programmes and projects is essential.

12. Emphasis must be on involvement of people living with HIV/AIDS in the design and implementation of policies, strategies, programmes and projects.

2.3 Priority Areas

The priority areas identified in the *Situation and Response Analysis* that are addressed in the National HIV/AIDS Strategy are:

1. Prevention of STIs and HIV infection among vulnerable groups.
2. Prevention of new infections among young people.
3. Ensuring care and support services are available and accessible for all people infected and affected by HIV/AIDS
4. Expansion of a monitoring and evaluation frame through evidence based effective surveillance and research.
5. Establishment of an effective and efficient management system for an expanded response

3 STRATEGIC COMPONENTS

3.1 VULNERABLE GROUPS

This strategy defines vulnerable groups as those whose lifestyles, social or professional context and behaviour make them most vulnerable to HIV/AIDS. Although a number of groups and communities in Nepal have to be considered as “vulnerable”, the groups identified as a possible nucleus for a generalized epidemic (because of their size, HIV sero-prevalence and multiple interfaces to the general population) are SWs and their clients; injecting drug users; mobile populations – especially labour migrants to India; men who have sex with men; and prisoners because of their extreme conditions.

The dynamics of the epidemic follow a predictable pattern - a rapid increase in the most vulnerable groups (e.g. SWs and IDUs); then a spread via “bridge populations” (e.g. clients of SW) into the general population (e.g. partner/wives of clients). Therefore the top priority to prevent a generalization of the epidemic in Nepal is to address the needs of the most vulnerable groups.

In the past interventions have been limited in terms of coverage, they also had to deal with an unsupportive environment and they did not sufficiently include members of vulnerable groups in the programming cycle. Members of most vulnerable groups are also marginalized within society and often do not enjoy their basic human rights. This strategy recognises the need to empower these groups so that they are able to protect themselves from HIV infection.

Overall Objective

To prevent STIs and HIV infections among SWs and their clients, injecting drug users, mobile populations – especially labour migrants to India, men who have sex with men and prisoners.

Priorities

- 1 Sex Workers and their Clients
- 2 Injecting Drug Users
- 3 Mobile Populations, especially labour migrants to India
- 4 Men who have Sex with Men
- 5 Prisoners

3.1.1 SEX WORKERS (SWs) AND THEIR CLIENTS

Due to their highly marginalized status in society, SWs have little access to accurate information about reproductive health and STIs. Cultural, economic and social constraints limit their access to legal protection and to medical services.

A survey by Family Health International in 1999 among SWs⁴ and truckers along the high way routes in the Terai showed that 75% of the truckers had had sex with a sex worker and that only 70% of the truckers had used a condom in the last sexual encounter. The survey showed that the STD prevalence among the truckers was 10.2% and the HIV prevalence was 1.5%. As regards SWs, 69% of clients were truckers and 51% migrant workers. Only 40% of clients had used a condom in the last sexual encounter. Overall, HIV prevalence among SWs was 4%. Of those SWs who had recently worked in Mumbai (India) it was up to 50%.

A survey in Kathmandu in 2000 revealed that 17 percent of SWs were HIV-positive – up from 2.7 percent in 1997 (USAID 2001). It is estimated that 70 percent of SWs returning from India are HIV-positive. There are no overall national statistics for prevalence among SWs but it is likely to be high and growing.

Most SWs experience increased vulnerability to HIV/AIDS due to a low level of education, which restricts access to information and health care services. They have little control over the risk in sexual encounters because the client often determines whether or not to use a condom. Moreover violence against SW is common.

3.1.1.1 Creating an Enabling Environment

Objective

To create a supportive environment for behaviour change among SWs and their clients.

Strategies

- Increase awareness among decision-makers of the risks confronting SWs and clients and the factors impacting on efforts to reduce these risks.
- Advocacy focusing on policy makers and communities with regards to the needs of harm reduction through behaviour change for SWs and their clients.
- Enhance collaborative relations with the police, local authorities/communities to support prevention interventions among SWs and their clients.

3.1.1.2 STI Management and Behaviour Change Communication

Objective

To ensure that SWs and their clients know how to avoid HIV and STIs and have the power and means to act on their knowledge.

⁴ FHI (1999): “STD and HIV prevalence survey among sex workers and truckers on highway routes in the Terai, Nepal, FHI, Kathmandu

Strategies

- Design and implement appropriate STI services for SWs and their clients with active participation of the target group, including:
 - 1) syndromic management of vaginal discharge and genital ulcers;
 - 2) counselling and condom promotion.
- Scaling up of behaviour change communication, including IEC materials for SWs and clients on safe practices and occupational safety.
- Promotion of “100%” condom use.
- Condom (including female condom) social marketing programmes linked with high-risk areas.
- Development and gradual implementation of VCT capacity in prioritised locations.

3.1.1.3 Capacity-building and Empowerment

Objective

Increased capacity of NGOs and sex worker organizations to address the needs of SW and empower them to protect their health and personal safety.

Strategies

- Strengthen the self-organizational capacity of SWs through capacity building, leadership training, legal support and networking.
- Capacity building of NGOs and SW-organizations to develop and implement interventions, which address environment, risk behaviours and service needs of SW and clients.
- Peer education programmes for sex workers including negotiating skills and self-protection.
- Educate pimps and madams about the importance of the using condoms in commercial sex and support an informal “no condom, no service, no refund” policy.

3.1.1.4 Research

Objective

Improved knowledge about behaviour, practice and networks of sex workers and their clients in order to monitor effectiveness of existing interventions and to guide development/modification of potential interventions.

Strategies

- Sustain and expand behavioural surveillance systems (including clients of SWs).
- Develop and maintain a database of interventions with SWs and clients including relevant activities and research reports.
- Conduct qualitative research about SWs and their clients' behaviour determinants.

3.1.2 INJECTING DRUG USERS (IDUs)

Nepal was the first developing country in which an NGO established a “harm reduction” programme with needle exchange for IDUs and was until recently considered as an example of how early interventions could prevent the spread of HIV/AIDS in this community. Unfortunately, this perception proved to be misplaced. Due to the limited coverage of interventions, HIV spread undetected among IDUs and a rapid assessment in 1999⁵ showed an HIV prevalence among injecting drug users nationwide of 40% and 68% in the Kathmandu Valley (Response Analysis, 2000, FHI, 2002). Behavioural research among IDUs in Nepal clearly indicates that needle sharing, the major risk factor for HIV, is common.

Although IDUs constitute the population sub-group in which HIV threatened to rise most rapidly neither governmental nor non-governmental capacity and policy were positioned to mount an effective response.

IDUs in Nepal are threatened not only by their behavioural risks but also by a societal response, which ostracizes drug use and uses a predominantly punitive model coupled with limited drug treatment facilities. HIV and STI prevention services for IDU are often of questionable quality mainly because they are not designed with the needs of the end-user in mind. These limitations signal an ominous trend of increasing HIV prevalence among this highly marginalized group.

The main thrust of the strategy is therefore to establish an environment conducive to a rapid scaling-up of harm reduction interventions and to build the capacity needed to do

⁵ NCASC

so. The harm reduction approach gives drug users options to reduce their risk at various levels and focuses on supportive rather than punitive strategies. The strategy recognizes that while stopping drug use is often the ideal goal, several intermediate goals such as safer injection techniques and drug treatment (including drug substitution therapy) have to be implemented in order to stop HIV transmission among IDUs.

3.1.2.1 Creating an Enabling Environment

Objective

To create a supportive environment for the implementation of effective harm reduction programmes for IDUs.

Strategies

- Improve the understanding of authorities and communities about the behaviour of IDUs, their vulnerability to STIs and HIV infection and the importance of harm reduction interventions.
- Create an understanding about the principles and philosophy of harm reduction among relevant authorities including parliament and law enforcement.
- Increase collaboration between NGOs active in harm reduction and respective authorities both at local and at national level.
- Ensure that the legal and policy framework is conducive for implementation and scaling up of harm reduction activities including needle and syringe exchange.

3.1.2.2 Harm Reduction

Objective

All IDUs have the knowledge, power and means to protect themselves from the harmful consequences of injecting drug use.

Strategies

- Build capacity for the establishment and rapid expansion of harm reduction programmes including those for needle and syringe exchange and drug substitution therapy.
- Expand peer-education training and programming using IDUs as the primary facilitators/peer-educators.
- Develop and gradually implement appropriate support services for IDUs (counselling, primary health care, harm reduction based education, legal support).

- Develop guidelines, policies, and capacity for the rehabilitation of injecting drug users.

3.1.2.3 Care and Support

Due to the high sero-prevalence levels among IDUs (and by association their partners), a focused care and support system has to be gradually implemented.

Objective

An appropriate care and support system for HIV infected IDUs and their respective families (partners).

Strategies

- Develop and gradually implement counseling and VCT capacity and services in prioritized locations.
- Establishment of an informal referral system for HIV infected pregnant female partners of IDUs to access PMTCT in prioritized locations.

3.1.2.4 Research

Objective

Enhance knowledge of behaviour, practices and networks of IDUs in order to monitor the effectiveness of existing interventions and to guide development and modification of potential interventions.

Strategies

- Sustain and expand behavioural surveillance systems of IDUs.
- Conduct qualitative research about the behaviour determinants of IDUs.
- Develop and maintain a database of interventions with IDUs including relevant activities and research reports.

3.1.2.5 Demand Reduction

Objective

To reduce the number of IDUs.

Strategies

- Promote school-based awareness raising activities
- Include information about drugs in life skills curricula.
- Develop appropriate IEC materials

3.1.3 MOBILE POPULATION

“Mobility” has complex causes, ranging from economic and/or political reasons to “forced” displacement (e.g. conflict, trafficking). Each of these mobile groups and their respective families are vulnerable to HIV/AIDS/STI in different ways. The aim of this strategy is to address the more behaviour related factors of HIV/AIDS/STI vulnerability, but at the same time to advocate for a holistic approach to address the broader determinants of HIV/AIDS/STI vulnerability among mobile populations.

Economic migration, both internal and external is not a new phenomenon in Nepal. Estimates range from 1.5 to 2 million Nepali nationals who work outside the country, 1 million are estimated to be in different parts of India alone. Although information is limited about the behaviour of labour migrants in their respective host countries, the assumption is that during their long absence from their families a considerable number of them become clients of SWs. Recent studies among labour migrants revealed HIV seroprevalence rates of between 2-10% for migrants returning from Mumbai/India.

Estimates of women trafficked to India range from between 150,000 - 200,000.

Conflict triggered migration from rural areas in Nepal to urban centers is not exactly known but is thought to be considerable.

Nepal’s response cannot address the needs of mobile populations whilst they are outside the country. Research and targeted interventions on HIV/AIDS/STI aimed at this population whilst they are in Nepal (including their families) is a priority considering the large numbers and the high potential for a spread of HIV/AIDS/STI to the general population through their partners.

3.1.3.1 Research

Objective

To increase the understanding of contextual factors and consequential risk behaviour which contributes to the vulnerability of mobile populations and their families as regards STIs and HIV/AIDS.

Strategies

- Develop a coordinated approach to research on factors leading to economic migration and trafficking of women, mobility patterns and vulnerability both at the sites of departure and in respective host locations.
- Use of BSS, and sero-prevalence studies to prioritise intervention sites both as regards departure location and destination.
- Increase the knowledge about socio-economic coping mechanisms of remaining families and related vulnerability to HIV/AIDS/STI.

3.1.3.2 Addressing Vulnerability and Behaviour Change

Objective

To reduce the vulnerability of mobile populations and their families to STIs and HIV/AIDS.

Strategies

- Position HIV/AIDS/STI among mobile populations and their families as a development issue.
- Establish pre-departure and post-arrival information and counselling services as regards HIV/AIDS/STI and mobility at prioritised locations.
- Use peer-education to address knowledge and group norms as regards behavioural risk factors of labour migration and trafficking.
- Increase communication between labour migrants and their families.
- Build capacity of local authorities, NGOs and communities to identify and to address needs of mobile populations and their families.
- Integrate interventions targeting the specific needs of mobile populations and their families as regards HIV/AIDS/STI into district development plans.

- Advocate for programmes addressing the economic needs of women especially female-headed households.
- Conduct seminars and workshops with employers and trade unions in Nepal on HIV/AIDS/STIs at the workplace and related vulnerability.
- Advocate for programmes to increase the legal protection, capacity and skills of labour migrants.
- Develop and disseminate IEC materials regarding mobility and HIV/AIDS/STI vulnerability.

3.1.3.3 Creating an Enabling Environment

Objective

Increased responsiveness to the needs of migrants in their respective host locations.

Strategies

- Increased bilateral cooperation (especially with India) as regards programmes focusing on Nepali migrants, including trafficked women.
- Regular bilateral meetings between Nepal and India as regards HIV/AIDS and mobility.
- Regional consultations with govt., external development partners and INGOs/NGOs about the needs of Nepali migrants and an appropriate response.

3.1.4 MEN WHO HAVE SEX WITH MEN (MSM)

Only recently have small surveys reported that sex between men seems to be relatively common in Nepal, particularly within Kathmandu⁶. In this marginalized community many of the men engaged in casual sex with other men neither have the knowledge nor practice safe sexual behaviour when having sex with their male partners. Furthermore, it has been found that many MSM are also married and therefore put their spouses at high risk of being infected with HIV.

⁶ Pant, S. (2001): "Report on the first outreach training workshop for men who have sex with men in Nepal", Blue Diamond Society, Kathmandu

3.1.4.1 Creating an Enabling Environment

Objective

To create a supportive environment for MSM to address their own needs.

Strategies

- Research (qualitative and quantitative) cum intervention with full participation of the target group.
- Increase the awareness among decision-makers of the existence of MSM and the risks that they face.
- Reduce public discrimination against MSM through awareness-raising activities.
- Review and amend, if necessary, the legal and policy framework.

3.1.4.2 Addressing Vulnerability and Behaviour Change

Objective

To strengthen community based organizations to identify and address the specific needs of MSM and to prevent the spread of HIV/AIDS/STI among this group.

Strategies

- Capacity building for and an increase in the number of activities aimed at preventing HIV/AIDS/STI among MSM by:
 - Establishing pilot projects in key locations
 - Supporting peer education activities
 - Supporting the establishment of networks among MSM
- Increase the availability and accessibility of IEC materials on safer sex practices and sexual health among MSM.
- Build capacity to design and implement counselling services for MSM at prioritised locations.

3.1.5 PRISONERS

There is only limited information available in Nepal as regards prisoners and their vulnerability to HIV/STI. But worldwide (injecting) drug use, and sex (either between men or sexual harassment in female prisons) are common. As there is no access to condoms and/or sterile injection equipment, HIV, once introduced into the prison community, may spread quite rapidly. Moreover, most prisons are overcrowded and poor hygiene is a risk factor for all communicable diseases (including TB and Hepatitis).

3.1.5.1 Creating an Enabling Environment

Objective

To increase awareness and understanding among decision makers as regards HIV/AIDS/STI in prisons.

Strategies

- Advocacy about vulnerability of prisoners to HIV/AIDS/STIs focusing on decision makers and prison staff.
- Ensure an appropriate policy framework as regards HIV/AIDS/STIs in prisons including care and support mechanisms for people living with HIV/AIDS.

3.1.5.2 IEC and Support Services

Objective

To ensure that every prisoner is aware of the risks of HIV/AIDS/STI and has the power and means to act on that knowledge.

Strategies

- Educate prison staff about HIV/AIDS and STI.
- Ensure that prisoners living with HIV/AIDS have access to quality care and support.
- Establish counselling services to prisoners through NGOs as part of the correctional system.
- Develop and distribute appropriate education materials in prisons.
- Implement peer education activities on HIV/AIDS/STI among prisoners.
- Allow possession and distribution of condoms in prisons.

3.2 YOUNG PEOPLE

Young people (10-24 years) constitute 32% of the total population of Nepal but Nepal's national HIV/AIDS/STI response has not sufficiently prioritised them as a primary target audience. Recent behavioural data indicate the increasing vulnerability of young people to HIV/AIDS in terms of a widening generational and cultural gap between emerging new values, (group) norms, knowledge and independence on the side of adolescents, and the values, reference points and norms on the side of the older generation. Girls, with their traditionally lower social status sometimes have knowledge about STDs and HIV/AIDS, but no access to any means of protection.

A KAPS survey among 1400 young people in seven different districts of Nepal⁷ shows that Nepalese teenagers are highly aware of the HIV risk but that this awareness does not necessarily translate into safe sexual behaviour. Although an overwhelming majority (92%) of teenagers have heard of HIV/AIDS, only 74% of teenagers knew that they should use condoms when having sex and only two-thirds (69%) said that they should not have sex with commercial sex workers.

The study also shows that almost 20% of teenagers considered premarital sex as proper. One in five boys and nearly one in 10 girls interviewed had had a sexual experience. 65% of boys said that they had used condoms; while 74% of girls said that their partners used a condom during sexual intercourse. Unprotected sex led to a 14% pregnancy rate and a 22% sexually transmitted diseases (STD) infection rate in boys and 13% rate in girls. Pregnancy rates were high in districts where girls were pressured into having sex. The number of boys who had had sex was far higher than the number of girls. Furthermore, the survey showed that 13% had taken drugs, although only 5.4% injected the drugs.

The national strategy therefore contains elements that move beyond providing youth with basic knowledge. It also strives to strengthen the skills of young people in decision-making, communication with their partners, negotiation of safe health behaviour, and anticipation of high-risk situations. It further recognizes the need to help young people to develop their self-esteem and their ability to contribute through their active involvement in programming activities. Interventions can only be effective if they move beyond individual knowledge and encourage group norms for safe healthy behaviour. While it is important to continue activities that offer a basic knowledge about HIV/AIDS, as young people approach the age where they might become sexually active, it is equally important that messages be refined to address common misconceptions and gaps in knowledge identified by research.

In order to achieve empowerment of young people to voice their concerns and needs and to be included in decision making, key areas of intervention have been identified: ensuring an appropriate policy framework; the use of traditional and non-traditional mass media; and youth friendly services.

⁷ UNICEF (2001): "A survey of teenagers in Nepal – for life skills development & HIV/AIDS prevention"

Overall Objective

To prevent HIV infection among young people.

Priorities

1. Creating a supportive policy and community environment.
2. Awareness and behaviour change communication.
3. Youth-friendly services.
4. Enhance young people's knowledge about HIV/AIDS/STI in formal and non-formal education settings

3.2.1 CREATING A SUPPORTIVE POLICY AND COMMUNITY ENVIRONMENT

In order to translate knowledge into practice, a supportive environment is needed for young people to protect themselves from HIV/AIDS/STI. The first priority therefore is to give young people a “voice” and to establish mechanisms through which this voice can be heard. Policy makers and communities should have accurate and relevant information about young people's issues and needs and include them in decision making around developing a youth-friendly environment and policy.

Objective

To create a supportive environment for behaviour change among young people by increasing the understanding among decision makers at all levels and communities about young people's needs and behavioural patterns.

Strategies

- Establishment of a mechanism for joint consultation between ministries, local authorities, NGOs, trade unions, educational and sport institutions, private sectors, CBOs and young people, on policy making and programming affecting young people.
- Advocacy for the needs and rights of young people with a focus on policy makers, decision-makers, parents and communities.
- To conduct qualitative research about the determinants of young people's behaviour.

3.2.2 AWARENESS AND BEHAVIOUR CHANGE COMMUNICATION

Creating awareness among young people about HIV/AIDS/STI and reproductive health is a crucial first step for behaviour change. But awareness alone is not sufficient for behaviour change to occur. Therefore interventions need to be designed and targeted at empowering young people to have the knowledge, skills and the will to change their behaviour, and providing access to means of protection.

Objective

To empower young people with the knowledge and life skills to avoid HIV/AIDS and sexually transmitted infections.

Strategies

- Increase the use of mass and non-traditional media to promote safe sexual norms and healthy behaviour among young people including the options of consistent condom use, abstinence and delayed sexual activity.
- Empowerment of young people, particularly girls, in decisions regarding their sexual and reproductive lives through a life skills approach.
- Develop and implement programmes with full participation of young people to support young people's development and a healthy lifestyle.
- Expand quality peer education programmes for young people by building capacity of implementing organizations.
- Increasing information and education activities (IEC) for recruits of uniformed services.
- Support and expand social marketing of behaviour change, including safer sex practices, through NGOs and private sector by:
 - focussing on young people, especially those most at risk and uniformed services
 - increasing the availability and accessibility of condoms
- Promote condoms within family planning networks as the only method with a dual benefit of being able to prevent both HIV/ STDs and unwanted pregnancies.

3.2.3 YOUTH-FRIENDLY SERVICES

Youth friendly services in Nepal are virtually non-existent. Information for young people comes mainly from peers and family members. In order to reduce the vulnerability of young people services including information must be tailored to their needs. The implementation of youth friendly services will have to start at selected locations with a view to future expansion.

Objective

To increase the accessibility and availability of youth-friendly and gender-sensitive services with an emphasis on information about reproductive health and sexuality.

Strategies

- Strengthen the capacity of young people to become equal partners in the design and implementation of services for young people.
- Strengthen the capacity of government and non-government organisations to provide services for young people in ways sensitive to their needs, particularly in the areas of counselling, reproductive health and STI treatment.
- Establish information centres including internet resources where young people can confidentially access additional information on HIV/AIDS (including referral services), sexually transmitted diseases, sexuality and related issues.

3.2.4 ENHANCE YOUNG PEOPLE’S KNOWLEDGE ABOUT HIV/AIDS/STI IN FORMAL AND NON-FORMAL EDUCATION SETTINGS

Information provided through the formal and non-formal education settings plays an important role in supporting the other priorities defined in this chapter. Moreover, addressing HIV/AIDS/STI in educational settings can bring about positive changes in the immediate environment of young people (e.g. school, family and community).

Objective

To enhance young people’s knowledge about HIV/AIDS and methods of prevention.

Strategies

- Development of an age-appropriate 'healthy life styles' curriculum, including basic information about HIV/AIDS and sex education.
- Include basic information on HIV/AIDS and reproductive health in the teacher’s training and strengthen the capacity of teachers to deliver this information in an effective way.
- Involve NGOs in teacher training particularly in relation to young people’s health, development and protection.
- Strengthen coordination and cooperation between key stakeholders in educational settings under the leadership of the Ministry of Education.
- Incorporate HIV/AIDS/STI into the curriculum of Non-Formal Education and educational/training activities of employers and trade-unions.

3.3 TREATMENT, CARE AND SUPPORT FOR PEOPLE INFECTED AND AFFECTED BY HIV

Care and support for people living with HIV/AIDS has not been a prioritised part of the national response to the epidemic. However, given the increasing number of people infected and affected by HIV, this strategy will place more emphasis on care, support and basic treatment options. Stigma against and misconceptions about people living with HIV/AIDS currently inhibits access to what limited services are available. The specific needs of groups vulnerable to HIV/STI have not been addressed sufficiently by health and support services, in part because the users of these services have not been involved in their design.

Services and resources for confidential HIV testing, counselling, laboratory investigations, treatment, care and support have been inadequate in terms of coverage and quality. Training and guidelines for health workers regarding counselling, care and treatment of those infected and affected by HIV/AIDS have been lacking. Similarly little support is available to help those caring for people living with HIV/AIDS within families and communities.

Overall objective

Care and support services of a defined quality are available and accessible for all people infected and affected by HIV/AIDS.

Priorities

1. Reducing the stigma surrounding people living with HIV/AIDS
2. Voluntary confidential counselling and testing for selected groups
3. Prevention of mother to child transmission for known cases
4. Community and home based care and support
5. Standard treatment guidelines
6. Expansion of VCT
7. Medical services

3.3.1 REDUCING THE STIGMA SURROUNDING PEOPLE LIVING WITH HIV/AIDS

Reducing stigma surrounding people living with HIV/AIDS is a crucial first step towards not only improving the uptake of support services such as voluntary counselling and HIV testing but also increasing acceptance within society.

Objective

To ensure that all people infected and affected by HIV/AIDS are fully accepted and integrated into normal social and work activities.

Strategies

- Use of mass media featuring political and religious leaders as well as celebrities to break down the barriers surrounding HIV/AIDS like exclusion, misconceptions and denial.
- Ensure that Nepal's legal and policy environment does not represent a barrier to the acceptance and integration of people infected and affected by HIV/AIDS into society.
- Ensure that legal and policy environment allows people living with HIV/AIDS to attain their full human rights and that there is no barrier to increased acceptance of these people.
- Strengthen the ability of people living with HIV/AIDS to organize themselves, and to effectively voice issues that are of concern to them through:
 - support groups;
 - leadership training;
 - legal support.
- Ensure the full involvement of people living with HIV/AIDS in the decision-making process at all levels of policy and programme development, implementation and monitoring.
- Ensure that policies are in place and implemented focusing on HIV/AIDS and the workplace.
- Ensure all HIV/AIDS/STI prevention programmes include activities aimed at reducing stigma.

3.3.2 VOLUNTARY CONFIDENTIAL COUNSELLING AND TESTING

Voluntary confidential counseling and HIV testing is a key entry point for care and support services as well as helping individual decision-making.

Nepal will adopt a phased approach, as defined by the following key strategies, in order to reach the objective. In a first phase, VCT services will be implemented focusing on selected groups (sex workers, clients, injecting drug users, labour migrants, uniformed services and their respective partners). At a later stage it will be expanded to focus on young people and the general population.

Objective

To establish a non-discriminatory, accessible, voluntary, confidential HIV testing system with pre- and post-test counselling.

Strategies

- Develop a policy and quality framework for government and private institutions, including NGOs, in relation to HIV testing and counselling procedures by:
 - developing a national protocol on HIV testing and counselling including a reference (confirmation) system according to the current WHO-recommended criteria;
 - developing counselling criteria including training, supervision and monitoring; and
 - establishing quality assurance and control mechanisms for HIV testing and counselling.
- Ensure that no HIV testing contravenes with either the constitution or the law.
- Design and gradually implement VCT services based on prioritised needs focusing on sex workers, clients, injecting drug users, labour migrants, uniformed services and their respective partners.
- Expand VCT services based on the prioritised needs of other groups starting with young people
- Provide public information about the importance of voluntary counselling and testing and the right to confidentiality.

3.3.3 COMMUNITY AND HOME BASED CARE AND SUPPORT

Community home-based care acknowledges that care and support is much more than medical treatment. It is seen as the basis for any support system for people infected and affected by HIV/AIDS. The pre-requisite for community and home-based care is that those infected and affected are fully accepted by and integrated into their respective environment.

Objective

To provide the most cost-effective and accessible combination of care and support for people infected and affected by HIV/AIDS, namely community and home-based care.

Strategies

- Develop information material about community and home-based care describing possible roles of the family, community and service providers to provide support to people infected and affected including palliative care.

- Support the establishment of support networks at different levels for people infected and affected by HIV/AIDS.
- Build capacity among government and non-government programmes who have an existing relationship with communities in order to inform and motivate communities for home based care and support
- Ensure that health care providers (including traditional healers, spiritual healers and local government services) have the capacity to provide basic care and counselling services. Priority will be given to the most affected areas.
- Develop a policy framework regarding mechanism for government institutions to involve NGOs or other organisations in providing services to people infected and affected by HIV/AIDS.
- Develop a policy framework for orphans and children in families made vulnerable by HIV/AIDS.

3.3.4 MEDICAL SERVICES

In a resource poor setting like Nepal, immediate universal access to anti-retroviral therapy and certain other AIDS-related medical interventions is not possible. However, every effort must be put into building up a system of effective medical care, providing a basis for future treatment options.

Objective

To ensure that all people living with HIV/AIDS have access to adequate medical services and treatment.

Strategies

- Develop a standard treatment protocol that:
 - includes treatment, mental health care, terminal care
 - ensures that treatment is initiated based on the recommendation of trained health personnel;
 - describes a referral system
- Ensure that drugs to treat opportunistic infections are included in the essential drug list and are available.
- Design and implement a quality control/assurance system to monitor medical services both in public and private sectors as regards to HIV/AIDS

- Establish regional centres at locations that provide equitable access for all people in Nepal. Each of those centres should be able to provide diagnosis, treatment and care for HIV/AIDS, related illnesses and STDs. It should therefore have adequate staffing, laboratory and X-ray facilities.
- Ensure confidential services at all levels, through training of staff and regular follow-up.
- Establish a reporting and information system preferably using existing structures (e.g. HMIS, district coordination mechanisms)

3.3.4.1 Universal precautions

Objective

All health staff are fully aware of universal precautions and have the skills and means for protection.

Strategies

- Review, update and distribute the guidelines for universal precautions including recommendations for post exposure prophylaxis.
- Development and dissemination of information-education-communication materials on universal precautions for health service providers and for the general public on the importance of limiting the number of injections and surgical interventions, and on receiving them only from qualified health care staff with sterile equipment
- Establish a mechanism for training all health service providers on universal precautions and giving safe injections.
- Develop HIV/AIDS related medical waste disposal guidelines and ensure its integration into national medical waste disposal policy.

3.3.5 PREVENTION OF MOTHER TO CHILD TRANSMISSION

Based on the current epidemiological situation, a nationwide system for PMTCT is not feasible in the medium term. Nevertheless as sero-prevalence among certain subgroups is dramatically increasing, in a first phase, PMTCT should be available for pregnant women known to be HIV positive at a few selected facilities in the country. At a later stage PMTCT will be gradually expanded.

Objective

To minimize mother to child transmission of HIV.

Strategies

- Develop a standard protocol for anti-retroviral treatment for pregnant women known to be HIV positive and ensure that there are sufficient resources to implement PMTCT free of cost in selected facilities.
- Increase awareness raising about HIV/AIDS through FCHVs and health workers.
- Develop IEC materials appropriate for use during ANC.
- Ensure that women accessing antenatal care receive adequate information about HIV/AIDS and have access to other HIV prevention services.

- Integrate into the Safe Motherhood Strategy that known HIV positive status is a possible indication for a caesarean section.

3.3.6 BLOOD SAFETY

Screening of all blood donations for HIV was initiated in 1992 and according to the National Policy on AIDS control (1995) all donated blood must be screened before transfusion. However, several issues have to be addressed in the future to secure a safe supply of blood and blood products in Nepal: a) develop a clear policy and/or legal framework on blood and blood products; b) establish a quality control/quality assurance system exists for testing of blood for HIV and other blood borne diseases; and c) increase the cooperation and coordination between the Nepal Red Cross Society (which is mandated by HMG/N for blood transfusion services) and the MoH.

Objective

To minimize the risk of HIV and other blood borne infections through safe blood transfusions/blood products and organ transplantation

Strategies

- Develop a national legal and policy framework for safe blood transfusion and organ transplantation.
- Develop operational guidelines on safety of blood and blood products.
- Establish a quality control and assurance system under the MoH.
- Promote the rational use of blood and blood products.

3.4 MEASURING CHANGES

Nepal's surveillance system for HIV has improved but remains inadequate in tracking the epidemic in all risk groups. An emphasis on male patients symptomatic for sexually transmitted infections as a marker for risk groups meant that the sentinel surveillance missed the recent dramatic increase in HIV prevalence amongst sex workers and injecting drug users. Moreover the results of many HIV tests conducted in hospitals and private clinics are not reported to the NCASC and research on HIV (prevalence and behavioural studies) has not been well coordinated and/or prioritized and ethical questions have been raised about some of the research protocols.

Overall Objective

An expanded monitoring and evaluation frame based on serological, behavioural and contextual factors contributing to the spread of HIV/AIDS/STI.

Priorities

1. An effective and efficient 2nd generation surveillance system.
2. Behavioural and contextual research on vulnerability to HIV/AIDS/STI.

3.4.1 2ND GENERATION SURVEILLANCE

Objective

Establishment of an effective and efficient 2nd generation surveillance system to track the prevalence and the trend of HIV epidemic in the country.

Strategies

- Design a 2nd generation surveillance and epidemiological reporting system defining the groups, locations, frequency and method for surveillance in Nepal including:
 - coordination and cooperation between NCASC and other agencies implementing surveillance activities;
 - an assessment of capacity needed to implement a 2nd generation surveillance system;
 - feedback mechanisms for analysed data to national and local authorities, health care staff and other key stake-holders of the national response;
 - a quality control, monitoring and feedback system for reporting compliance, delay, and completeness.
 - mechanisms that protect confidentiality and/or anonymity.
- Strengthen the capacity of the NCASC to manage and monitor an effective 2nd generation surveillance system.
- Ensure the capacity necessary to implement and sustain a 2nd generation surveillance system nationwide.

3.4.2 BEHAVIOURAL AND CONTEXTUAL RESEARCH ON VULNERABILITY TO HIV/AIDS/STI.

In the past research on HIV/AIDS/STI in Nepal was focused mainly on individual behaviour and sero-prevalence. While these are important factors in the epidemic, vulnerability and contextual factors influencing individual behaviour have not received enough attention. In order to address the root causes of the epidemic, more research on vulnerability and related contextual factors is needed.

Objective

An expanded knowledge base on behavioural and contextual factors contributing to vulnerability towards HIV/AIDS/STI.

Strategies

- Establish a web-based 'reference centre' ("clearing house") on HIV/AIDS/STI related research, including contextual research on vulnerability and the spread of the epidemic in Nepal.
- Ensure a timely information flow between authorities approving HIV/AIDS related research and the NCASC.
- Ensure that research funded through the national strategy is reviewed by a technical advisory group under the NCASC as regards relevance (priorities, duplications) and methodology.

4. MANAGEMENT AND IMPLEMENTATION OF AN EXPANDED RESPONSE TO HIV/AIDS IN NEPAL

4.1 CONTEXT AND CHALLENGES

The main challenge for Nepal is to respond immediately to a rapidly evolving HIV/AIDS epidemic. This has to be undertaken in the context of a civil conflict in the country⁸, weak implementation capacity both within the public and the private sector, structural weaknesses with respect to multi-sector involvement, coordination, policy, monitoring and evaluation, and scarce internal resources.

Recognizing all the above, Nepal has embarked to broaden and to deepen political commitment. For example, establishing the National AIDS Council under the chairmanship of the Rt. Honorable Prime Minister, defining HIV/AIDS as priority “1” in the MTEP of the MoH and integrating HIV/AIDS in the 10th Development Plan. HMG is also committed to reforming and strengthening the management mechanisms of an expanded, i.e. multi-sector and scaled-up, response to HIV/AIDS within the framework of the National Strategy.

The challenge will be to sustain and to broaden the political commitment in terms of policy, involvement of new partners and stake-holders, and finally also to translate political commitment and leadership into action. As a resource poor country with additional security expenses, it is difficult for Nepal to demonstrate commitment through budgetary allocations, but higher allocations to an expanded response are foreseen in the MTEP of the MoH. The recent active involvement of law-makers and municipalities both in the strategy development and in policy issues signals broadening commitment that goes beyond parties.

The strategy tries throughout to address the issue of commitment, enabling environment at all levels, and local ownership. It seeks to increase the understanding of decision-makers and communities, especially as regards the most vulnerable groups, and to actively involve them in the response. In doing so, a broader base of commitment will be established and ultimately facilitate the implementation of the strategy. The involvement of local communities and authorities will also contribute to a public accountability as regards the implementation of the strategy.

Ideally, the National Strategy will be “programme” funded, i.e. pooled resources and/or earmarked contributions, to provide required resources. The future management and implementation structures will be designed to:

⁸ At present many parts of the country are difficult to access, internal migration has peaked in the recent months, and the security operations strain both the national budget and the immediate environment of communities and people. Even a post-conflict situation will trigger dynamics which may impact on the programme (competing priorities of communities, damage to infrastructure and service delivery, back-migration, etc.).

- Support and strengthen the leading role of government, and the MoH as the technical line ministry, as regards: policy and strategy; monitoring and evaluation, including quality assurance and quality control; epidemiology and surveillance; involvement of other government structures, e.g. other line ministries, and coordination;
- Provide the flexibility, accountability and results oriented management of a larger programme at the central and the decentralized level;
- Establish new public-private partnerships at all levels to fight the epidemic;
- “De-medicalize” the response to HIV/AIDS;
- Support decentralization and integration at the community level;
- Increase responsiveness; and,
- Provide the basis for sustainability through the involvement of the private sector and civil society.

The shift from individually funded “projects” to a “programme”, from outputs to results orientation, from donor interest to national priorities, from capacity building of central structures to strengthening of implementation capacity, and from a health sector response to a multi-sector approach will require time and resources. This is, however, the precondition for an effective and efficient national response.

Finally, in order to respond effectively, financial and human resources will be needed to translate the national strategy into action. As the epidemic advances day by day, the overall resource requirements to respond become bigger and bigger. Nepal will need the support by external development partners to fulfil the resource needs.

The strategy addresses sustainability in providing for innovative financing mechanisms (trust fund also to attract private sector contributions), and in strengthening the capacity and empowering vulnerable groups and communities. It is hoped that involvement of communities, decentralization, and integration in development programmes will also contribute to better sustainability.

The following is an outline of a “vision”, which in the process of operationalizing and reviewing may change. Based on “lessons learned” in Nepal and other countries, it reflects the will and commitment of Nepal to respond to the epidemic.

4.2 THE VISION FOR THE FUTURE

A dynamic public-private partnership charged with managing and implementing an expanded response to HIV/AIDS in Nepal.

Weak management at all levels may seriously affect the implementation of the national strategy. The experience of the past was frequently changing key-staff in line ministries, slow government procedures, and sometimes lack of transparency and accountability.

The change to result oriented management (and this means primarily implementation), outsourcing of defined parts of the strategy to a private entity with appropriate capacity,

ensuring transparency and accountability through a trust fund mechanism, and restructuring of the NCASC to the technical wing of an expanded response will secure the competence and flexibility needed to respond quickly and effectively.

The modification of the NACC to an executive public-private body overseeing the implementation of the national strategy will in itself ensure broader involvement of key-stake holders and will put the focus on implementation (result oriented workplans).

4.3 STRATEGIES

1. Leadership at the highest possible level
2. Establishment of a public-private partnership at the central level for policy development, programme decisions, monitoring and evaluation, coordination and financial allocation for the operationalization of the National Strategy.
3. Establishment of a Nepal Trust Fund to fight HIV/AIDS
4. Restructuring and strengthening of the NCASC as the “technical authority” in Nepal as regards to evidence based policy/strategy, research, monitoring and evaluation, epidemiology and surveillance, STD, and technical assistance to government, e.g. line ministries, DDCs.
5. Establishment of a private entity to execute the programme within the framework of the National Strategy, and the objectives of the 10th Five Year Plan and MTEP respectively.
6. Development of district strategies through public-private partnerships to respond to HIV/AIDS at the decentralized level, and the establishment of appropriate management bodies at the district level.
7. Strengthening of implementation capacity.

4.3.1 Leadership at the highest possible level

National AIDS Council

With the establishment of the National AIDS Council under the chair of the Prime Minister, Nepal has set the stage for the highest possible leadership. The multi-sector composition of the council will allow for greater involvement of different ministries, the private sector and civil society, and will serve as an important advocacy body.

The National AIDS Council will review and approve national policies and strategies and will be involved in advocacy and monitoring the implementation of the strategy.

4.3.2 *Establishment of a public-private partnership at central level for policy, programme decisions, monitoring and evaluation, coordination, and financial allocation for the operationalization of the National Strategy.*

The National AIDS Coordination Committee

The NACC originally included representatives of all line ministries, NGOs, the private sector and donors. In order to improve its efficiency and to make it the executive body to oversee the implementation of the National Strategy, the composition was reviewed and the new NACC will have 12 members: 4 government representatives, 2 representatives from the private sector, 4 NGO representatives (including PLWHA), 1 bilateral donor and 1 multilateral organization.

The NACC will act as a “board of directors” to the Nepal Trust Fund, and will be responsible for reviewing and approving workplans and budgets, reviewing reports, and guiding implementation of the national strategy. The NCASC will have the technical review authority and will advise the board of directors on policy and funding issues. The NACC will report to the NAC.

The Minister of Health will chair the NACC. The NCASC will act as the secretariat to the NACC.

The NACC will be the governing body of the Nepal Trust Fund and will:

- Set policies and strategies for the Fund consistent with the agreed Purpose, Principles and Scope;
- Set operational guidelines, and budgets for the NCASC and the private entity executing the programme;
- Approve workplans and budgets;
- Appoint and, if necessary, replace the Executive Head of the private entity (other appointments will be made by the Head and approved by the Board);
- Set criteria for membership of advisory groups as appropriate;
- Establish a framework for monitoring and periodic independent evaluation of performance and financial accountability of activities supported by the Fund;
- Consider, approve, and monitor cooperative arrangements or agreements with other organizations and institutions;
- Represent the views of the various constituencies;
- Act as the main coordination mechanism for an expanded response;
- Advocate for the Fund, and mobilize resources.

4.3.3 *Establishment of a Nepal Trust Fund to fight HIV/AIDS*

A future programme approach requires the establishment of adequate fund flow mechanisms both to government and to private (non-government) institutions. This will be done through the establishment of a Trust Fund. The purpose of the Fund is to attract, manage and disburse resources for an expanded response to HIV/AIDS in Nepal through

a new public-private partnership. This partnership will strengthen services and participation of all strata of society and make a sustainable and significant contribution to the reduction of infections, illness and death, and thereby mitigate the impact caused by HIV/AIDS and STIs.

The trust fund will provide resources for the implementation of the National Strategy for government and non-government partners. It will be governed by the NACC (as board of directors).

- 4.3.4 *Restructuring and strengthening of the NCASC as the “technical authority” in Nepal as regards to evidence based policy/strategy, research, monitoring and evaluation, epidemiology and surveillance, STD, and technical assistance to government, e.g. line ministries, DDCs.*

The National Center for AIDS and STD Control

The NCASC will be restructured and strengthened to act as the technical authority for the national programme with the following key functions:

- Policy and Strategy
- Research, Epidemiology and Surveillance
- Sexually transmitted diseases
- Monitoring and evaluation, including quality control and assurance
- Technical assistance to government, e.g. line ministries, DDCs
- Technical advisor to the NACC
- Technical review of workplans submitted by the private entity to the NACC
- Ensure integration of HIV/AIDS into other national programmes, strategies and development plans.

The NCASC reports to the NACC, and will advise the NACC on technical aspects of policy, strategy, and programme execution/implementation.

The NCASC will prepare annual workplans and budgets to be approved by the NACC. Resources for the core functions of the NCASC will come from the national budget and, if needed, from the trust fund.

- 4.3.5 *Establishment of a private entity to execute the programme within the framework of the National Strategy, and the objectives of the 10th Five Year Plan and MTEP respectively.*

Acknowledging that the private sector (including NGOs) and civil society play a crucial role in an expanded response, the execution of the National Strategy, especially in areas where government has either no specific interfaces or capacity will be outsourced to a newly established private entity and monitored by the NCASC and the NACC respectively.

This private entity will, under the leadership of the NCASC, develop annual workplans and budgets. It will be guided by the board, and by yearly targets set by the NCASC and other national authorities. Based on these results oriented workplans, which will address priorities defined in the National Strategy, the private entity will call for proposals from implementing partners. Proposals and capacity of implementing partners will be reviewed and will be integrated in the workplan, thus forming an annual programme. The programme will also identify necessary areas for capacity building among implementing partners, and will facilitate and support new partnerships at all levels. Technical assistance to implementing partners will be provided, if needed, both for the development of proposals, and for actual implementation. In this regard, the private entity will only facilitate, broker and resource the needed technical assistance.

The board and the NCASC will review the programme, and funds (in defined installments) will be released to the entity after approval by the board.

The board of directors will set the operational guidelines, approve workplans and budget and will appoint the CEO. The entity will be staffed with 5-7 professionals and adequate support staff.

The main functions of this private entity are to:

- Prepare annual workplans, budgets and quarterly reports to be approved by the board (NACC);
- Manage all aspects of sub-contracts to implementing partners (call for proposals, review, contractual arrangements, supervision and monitoring, reporting);
- Establish a technical review panel and ensure the independence of the review process;
- Coordinate with all relevant agencies, especially with the director NCASC;
- Facilitate and support technical assistance to implementing partners;
- Communicate the board's decisions to stakeholders;
- Support the board in advocacy and fund raising.

4.3.6 Development of district strategies to respond to HIV/AIDS at the decentralized level and the establishment of appropriate management bodies at the District level.

The National Strategy provides the overall guiding framework for an expanded response at the decentralized level. In order to support districts and communities to identify issues of their concern and to develop adequate responses within the framework of the national strategy, the facilitation and support to the development of District strategies is seen as a priority area of the National Strategy.

Strategies:

- Ensure that at District level DDCs are held responsible for developing and monitoring District HIV/AIDS strategies as an integral part of their respective overall district development strategies.

- Technically support and facilitate the development of district HIV/AIDS strategies through a public-private participatory process, starting with prioritized districts according to their vulnerability profile (e.g. sero-prevalence, labour migration to Mumbai, communication infrastructure with high density on female sex workers and IDUs) including future management structures for an expanded response at the decentralized level.
- Ensure direct resource flow for approved district strategies conditional to a public-private partnership at district level and existence of adequate management mechanisms.

4.3.7 *Strengthening of implementation capacity.*

Ultimately the national strategy has to be translated into a programme with concrete actions. The biggest risk for not achieving the goals of the strategy (and thus failing to stop the epidemic) lies in the weak implementation and management capacity at all levels. Although the strengthening of implementation and management capacities are priority areas of the national strategy, the challenge is to balance implementation and “central” capacity needs in order to start activities in a quality and quantity necessary to produce impact on the epidemic.

This will be achieved through a programme approach, which will focus on the priority areas of the national strategy and combines implementation with strengthening of needed capacities. The expanded response is therefore not a combination of individual projects, but a carefully designed and managed partnership approach. Using synergies and comparative advantages of different actors, actively promoting partnerships, providing technical assistance to implementing partners, and improved coordination are defined key-strategies and will enable a rapid scaling up of activities.

4.4 **THE NEXT STEPS**

The National Strategy is the starting point for an expanded response. The following issues will be addressed immediately:

- Costing of the strategy. This will be done based on the year-wise targets (see annex) and average unit costs for specific interventions from Nepal and the region respectively;
- Resource mobilization based on the costed strategy;
- Detailed operationalization of the management part, including the restructuring and strengthening of the NCASC;
- Development of an interim management plan to bridge the time necessary to establish the defined management and financial mechanisms;
- Development of the first result oriented annual workplan.

Strategic Component Key-Partners	Objective Key-Activities	Targets
OVERALL	To prevent the spread of HIV/AIDS in Nepal	HIV sero-prevalence is less than 1% in the general population
VULNERABLE GROUPS	<i>To prevent STIs and HIV infections among SWs and their clients, injecting drug users, mobile populations – especially labour migrants to India, men who have sex with men and prisoners.</i>	90% of targeted vulnerable groups are reached and 70% show constant safe behaviour.
SEX WORKERS (SWs) AND THEIR CLIENTS		
CREATING AN ENABLING ENVIRONMENT	<i>To create a supportive environment for behaviour change among SWs and their clients</i>	
Parliamentarians Sex Workers Ministry of Home Ministry of Health Ministry of Women’s affairs Police Royal Nepalese Army PR Companies Municipalities DDCs	<ul style="list-style-type: none"> • Interaction programmes with SWs, decision-makers and communities • Develop advocacy material relating to the risks of SW and their clients • Develop national and local government support for 100% condom programme with a human rights focus • Sensitize and train local police, (incl. other uniformed services) on intervention sites and motivate for direct collaboration with respective programmes 	<p><u>By the end of 2002</u></p> <p>Advocacy material on HIV/AIDS developed.</p> <p><u>By the end of 2003</u></p> <p>SWs identified and empowered to interact with decision-makers and communities</p> <p>Increased understanding among relevant authorities of the risks faced by SWs and their clients</p> <p>Increased collaboration of police and other uniformed services with respective programmes</p> <p>National government support a 100% condom use programme</p> <p>By the end of 2004</p>

Strategic Component Key-Partners	Objective Key-Activities	Targets
		Selected local governments support a 100% condom use programme
STI MANAGEMENT AND BEHAVIOUR CHANGE COMMUNICATION	<i>To ensure that SWs and their clients know how to avoid HIV and STIs and have the power and means to act on their knowledge</i>	
Sex Workers I/NGOs PSI CSR VCT providers Police HMG/N Municipalities DDCs	<ul style="list-style-type: none"> • STI service delivery for SWs designed according to needs of SWs • Develop criteria for prioritizing locations for SW interventions • Design VCT services and social marketing programmes in prioritized locations • Develop BCC and IEC material for SWs and their clients on safe practices and occupational safety • Build capacity among NGOs to develop behaviour change interventions for SWs with a focus on peer-education • Ensure adequate drug supplies in sites where SWs seek STI treatment 	<p><u>By the end of 2002</u> Key NGOs in Kathmandu and Pokhara are capable of developing behaviour change interventions with SWs</p> <p><u>By the end of 2003</u> SWs in urban settings have access to appropriate STI services</p> <p>50% of SWs seek STD services</p> <p>Drug supplies are adequately provided to SW interventions</p> <p>Condom social marketing strategy developed and implemented in at least 5 prioritized locations.</p> <p>50% of SWs are reached by outreach sessions and condom programmes</p> <p>At least 50% of SWs report condom use in the last sex act</p>

Strategic Component Key-Partners	Objective Key-Activities	Targets
		<p>At least 80% of SW are reached by BCC and have utilized STI services in Kathmandu and Pokhara.</p> <p>At least 5 VCT providers are trained and equipped in Kathmandu and Pokhara.</p> <p>90% of STD facilities have adequate and maintained supply of drugs</p> <p><u>By the end of 2004</u></p> <p>Behaviour change coverage of SW in Pokhara and Kathmandu at least 65%, nationwide 50%.</p> <p>NGOs in other locations are capable of developing behaviour change interventions with SWs</p> <p><u>By the end of 2005</u></p> <p>VCT for SW is provided in all municipalities.</p> <p>90% of SWs are reached by outreach sessions and condom programmes</p> <p>90% of SWs seek STD services</p> <p>50% decline in STD rates among SWs</p> <p>90% of SWs report condom use in the last sex act</p>

Strategic Component Key-Partners	Objective Key-Activities	Targets
CAPACITY BUILDING AND EMPOWERMENT	<i>Increased capacity of NGOs and sex worker organizations to address the needs of SW and empower them to protect their health and personal safety.</i>	
Sex Workers I/NGOs Pimps and madams HMG/N Municipalities	<ul style="list-style-type: none"> • Build the capacity of organized peer-groups among SWs for self-organization • Establish organized peer networks among SWs • Build the capacity of NGOs and SWs-organizations to design interventions regarding environment, risk behaviour and service needs of SWs • Develop IEC material for pimps and madams about HIV/AIDS and condom use 	<p><u>By the end of 2003</u></p> <p>All SW interventions are designed, planned and implemented jointly with NGOs and SW peer-groups.</p> <p>80% of pimps and madams in Kathmandu and Pokhara have been trained in HIV/AIDS issues, including condom use.</p> <p>SWs based organizations created to address their needs with regard to HIV/AIDS</p> <p><u>By the end of 2004</u></p> <p>Nationwide capacity available to plan, implement and monitor SW interventions.</p>
RESEARCH AND SURVEILLANCE	<i>Improved knowledge about behaviour, practice and networks of sex workers and their clients in order to monitor effectiveness of existing interventions and to guide development/modification of potential interventions</i>	

Strategic Component Key-Partners	Objective Key-Activities	Targets
Sex Workers and their clients I/NGOs Health Research Council Research institutions	<ul style="list-style-type: none"> • Identify gaps in knowledge regarding SWs and their clients' behavioral determinants and networks. • Qualitative research addressing the knowledge gaps identified regarding SWs and their clients. • Expand behavioural surveillance systems for SWs and their clients to selected sites 	<p><u>By the end of 2002</u></p> Database on SW related research developed and web-based. <p><u>By the end of 2003</u></p> Research gaps identified and study protocols developed. Behavioural surveillance systems expanded
INJECTING DRUG USERS (IDUs)		
CREATING AN ENABLING ENVIRONMENT	<i>To create a supportive environment for the implementation of effective harm reduction programmes for IDUs.</i>	
Parliamentarians Law enforcement Ministry of Health Ministry of Home I/NGOs Municipalities Universities	<ul style="list-style-type: none"> • Interaction programmes with IDUs, authorities and communities • Training workshops for relevant authorities regarding harm reduction • Exposure visits for relevant authorities to countries where harm reduction programmes have been successfully implemented • Establish a network among NGOs working on harm reduction and local as well as national authorities • Review the legislative and policy framework in terms of harm reduction interventions for IDUs and identify amendments that need to be changed 	<p><u>By the end of 2002</u></p> Legislative and policy framework reviewed Advocacy material as regards harm reduction and IDUs developed. <p><u>By the end of 2003</u></p> Increased understanding among relevant authorities of HMG/N and the legislative about the philosophy of harm reduction among IDUs Necessary policy/legal amendments done

Strategic Component Key-Partners	Objective Key-Activities	Targets
		<p>to provide an enabling environment for harm reduction</p> <p>Network among NGOs, communities and local law enforcement established</p>
HARM REDUCTION	<i>All IDUs have the knowledge, power and means to protect themselves from the harmful consequences of injecting drug use</i>	
<p>NGOs Ministry of Home Ministry of Health Municipalities DDCs Universities</p>	<ul style="list-style-type: none"> • IDUs map their needs and design the needed support services • Build the capacity of organized peer-groups among IDUs for training and programming • Build capacity of NGOs in outreach and peer strategies • Develop national guidelines and policies for oral substitution 	<p><u>By the end of 2002</u></p> <p>Guidelines for oral substitution developed and approved</p> <p><u>By the end of 2003</u></p> <p>Clean needles and syringes easily available and accessible for IDUs in prioritized locations</p> <p>Sterile injection techniques regularly used by at least 50% of IDUs nationwide</p> <p>Oral substitution available and used by at least 25% of eligible IDUs</p> <p>Wide support among governmental authorities for a harm reduction approach</p>

Strategic Component Key-Partners	Objective Key-Activities	Targets
		<p>Sharing of needles/X decreased by 50%</p> <p><u>By the end of 2004</u></p> <p>Sterile injection techniques regularly used by at least 70% of IDUs nationwide</p> <p>Oral substitution available and used by at least 50% of eligible IDUs</p> <p>60% report use of condom during last sex act with a non-regular partner or commercial sex worker</p> <p>By the end of 2005</p> <p>Sterile injection techniques regularly used by at least 90% of IDUs nationwide.</p>
CARE AND SUPPORT	<i>An appropriate care and support system for HIV infected IDUs and their respective families (partners)</i>	

Strategic Component Key-Partners	Objective Key-Activities	Targets
NGOs Ministry of Health Municipalities DDCs Universities	<ul style="list-style-type: none"> • Develop criteria for prioritizing locations for VCT and PMTCT • IDUs map their needs and design as regards VCT services • Develop IEC material regarding PMTCT • Disseminate IEC material regarding PMTCT among IDUs and antenatal clinics 	<p>By the end of 2002</p> <p>Criteria developed to prioritize VCT and PMTCT for IDUs and families.</p> <p>By the end of 2003</p> <p>VCT available in at least 5 locations</p> <p>PMTCT available in Kathmandu</p> <p><u>By the end of 2004</u></p> <p>VCT available in at least 15 locations</p> <p>PMTCT available in Pokhara</p>
RESEARCH	<i>Enhance knowledge of behaviour, practices and networks of IDUs in order to monitor the effectiveness of existing interventions and to guide development and modification of potential interventions</i>	

Strategic Component Key-Partners	Objective Key-Activities	Targets
<p>Injecting drug users I/NGOs Health Research Council Research Institutions</p>	<ul style="list-style-type: none"> • Identify gaps in knowledge regarding IDUs and their behavioral determinants and networks • Qualitative research addressing the knowledge gaps identified regarding IDUs • Expand behavioural surveillance systems for IDUs to selected sites 	<p><u>By the end of 2002</u></p> <p>Database on IDU related research developed and web-based.</p> <p><u>By the end of 2003</u></p> <p>Research gaps identified and study protocols developed.</p> <p>Behavioural surveillance systems expanded</p>
<p>DEMAND REDUCTION</p>	<p><i>To reduce the number of IDUs</i></p>	
<p>Ministry of Education Ministry of Health Ministry of Home NGOs</p>	<ul style="list-style-type: none"> • HIV/AIDS training workshops with Ministry of Education and other relevant ministries • Develop a demand reduction strategy 	<p><u>By the end of 2003</u></p> <p>A demand reduction strategy is developed</p> <p><u>By the end of 2004</u></p> <p>Implementation of demand reduction activities start in urban centers.</p>

Strategic Component Key-Partners	Objective Key-Activities	Targets
MOBILE POPULATIONS		
RESEARCH	<i>To increase the understanding of contextual factors and consequential risk behaviour which contributes to the vulnerability of mobile populations and their families as regards STIs and HIV/AIDS</i>	
Mobile populations Research institutions I/NGOs Ministry of Health ILO MoLD DDCs Municipalities	<ul style="list-style-type: none"> • Establish a network among researchers on socio-economic determinants of migration and respective vulnerability factors of migration • Conduct research on migration patterns, particularly to higher prevalence areas in India • Identify criteria to prioritize interventions sites at sites of departure and in host locations • Conduct qualitative research regarding coping mechanisms of remaining families of mobile populations 	<p><u>By the end of 2002</u></p> <p>Criteria developed to prioritize intervention sites focusing on mobile populations</p> <p><u>By the end of 2003</u></p> <p>Research gaps identified and respective protocols developed</p> <p>Database available on research and data related to mobility</p>
ADDRESSING VULNARABILITY AND BEHAVIOUR CHANGE	To reduce the vulnerability of mobile populations and their families to STIs and HIV/AIDS	
DDC VDC I/NGO FNCCI Trade Unions Ministry of Labour Ministry of Health	<ul style="list-style-type: none"> • Advocate for the integration of HIV/AIDS related issues into non-health activities/ programmes related to mobile populations • Needs assessment as well as design of information and counseling services for mobile populations at the prioritized locations • Build capacity among labour migrants and trafficked women to do peer-education • Build capacity of local authorities, NGOs and communities to identify and address the needs of 	<p><u>By the end of 2003</u></p> <p>IEC material developed</p> <p>District development planners sensitized to integrate HIV/AIDS/STI issues into the district development plans</p> <p>Employers and trade unions are sensitized to HIV/AIDS issues and have</p>

Strategic Component Key-Partners	Objective Key-Activities	Targets
	<p>mobile populations and their families</p> <ul style="list-style-type: none"> • Establish interventions in source and destination areas • Sensitize the district development planners to the needs of mobile populations and their families with regard to HIV/AIDS/STI • Conduct HIV/AIDS training seminars and workshops with employers and trade unions • Identify the needs of labour migrants for legal protection as well as capacity and skill building • Develop and disseminate IEC materials regarding mobility and HIV/AIDS/STI vulnerability 	<p>integrated these issues into their work</p> <p><u>By the end of 2004</u></p> <p>Interventions to address vulnerability of mobile populations started in at least 10 locations</p> <p>Legal/policy environment assessed and modified to address needs of mobile populations and their remaining families</p> <p>50% decline in STD rates among migrant populations</p> <p>By the end of 2005</p> <p>Local authorities, NGOs and communities in particularly vulnerable areas are able to identify and address the needs of mobile populations</p> <p>90% use condoms with sex workers</p>
CREATING AN ENABLING ENVIRONMENT	Increased responsiveness to the needs of migrants in their respective host locations	

Strategic Component Key-Partners	Objective Key-Activities	Targets
<p>Various govt. from the region HMG/N Bi- and multilateral donors I/NGOs</p>	<ul style="list-style-type: none"> • Identify the issues regarding migrant labourers and trafficked women which need to be addressed at bi-lateral and regional level • Bilateral meetings between the Indian Government and HMG/Nepal to discuss the cross-border issues related to HIV/AIDS • <i>Regional consultations with govt., external development partners and I/NGOs about the needs of Nepali migrants</i> 	<p><u>By the end of 2003</u></p> <p>The first bilateral meeting has been held between the Indian and Nepali government</p> <p>The first regional consultation meeting has been held</p>
<p><i>MEN WHO HAVE SEX WITH MEN (MSM)</i></p>		
<p>CREATING AN ENABLING ENVIRONMENT</p>	<p>To create a supportive environment for MSM to address</p>	

Strategic Component Key-Partners	Objective Key-Activities	Targets
	their own needs	
MSM Ministry of Home Ministry of Health Parliamentarians Lawmakers I/NGOs Municipalities Journalists	<ul style="list-style-type: none"> • Qualitative vulnerability research with active participation of MSM • Interaction programmes between the MSM community and relevant decision-makers • Publish articles about the issues surrounding the MSM community in the Nepali and English daily newspapers <ul style="list-style-type: none"> • <i>Review and amend the legal and policy framework</i> 	<p><u>By the end of 2003</u></p> <p>Decision-makers are aware of the issues related to MSM and HIV/AIDS</p> <p>Pilot programmes are in place to address safe sexual behaviour of MSM</p> <p><u>By the end of 2004</u></p> <p>The legal and policy framework has been reviewed and amendments are proposed</p>
ADDRESSING VULNERABILITY AND BEHAVIOUR CHANGE	To strengthen community based organizations to identify and address the specific needs of MSM and to prevent the spread of HIV/AIDS/STI among this group	
MSM I/NGOs	<ul style="list-style-type: none"> • MSM map their needs and design the service delivery as regards counseling services in prioritized locations • Build capacity among MSM to do HIV/AIDS/STI peer outreach work as well as to establish organized peer networks in the MSM community • Build capacity of NGOs to work with HIV/AIDS interventions in the MSM community • Develop IEC material regarding safer sex practices and sexual health • Develop criteria to identify the prioritized locations for MSM interventions 	<p><u>By the end of 2003</u></p> <p>At least 3 NGOs are strengthened to work closely with MSM to address their specific needs.</p> <p>IEC material developed, pre-tested and used.</p> <p>Mapping and size estimation done in Kathmandu Valley</p> <p>30% of MSM use condom consistently during commercial sex</p>

Strategic Component Key-Partners	Objective Key-Activities	Targets
		<p>By the end of 2004</p> <p>Geo locations and sexual networks mapped and intervention sites identified across the country</p> <p>By the end of 2005</p> <p>60% of MSM use condom consistently during commercial sex</p>
PRISONERS		
CREATING AN ENABLING ENVIRONMENT	To increase awareness and understanding among decision makers as regards HIV/AIDS/STI in prisons	
<p>Prison staff Ministry of Home Ministry of Health I/NGOs</p>	<ul style="list-style-type: none"> • Develop advocacy material targeted at decision-makers and prison staff as regards the vulnerability to HIV/AIDS of prisoners • HIV/AIDS awareness raising workshop for key decision-makers and prison staff about the vulnerability of prisoners to HIV/AIDS/STI • <i>Develop a policy framework as regards HIV/AIDS/STI in prisons</i> 	<p><u>By the end of 2003</u></p> <p>Policy framework as regards HIV/AIDS/STI in prisons developed</p> <p>Increased understanding among key decision-makers and prison staff about the vulnerability of prisoners to HIV/AIDS</p> <p><u>By the end of 2004</u></p> <p>STD treatment available in prisons</p>
IEC AND SUPPORT SERVICES	To ensure that every prisoner is aware of the risks of HIV/AIDS/STI and has the power and means to act on that knowledge	
<p>Prisoners Prisons NGOs</p>	<ul style="list-style-type: none"> • HIV/AIDS/STI training for prison staff • Needs assessment and design of HIV/AIDS related services, including VCT and care and support services, 	<p><u>By the end of 2002</u></p> <p>IEC material developed and disseminated</p>

Strategic Component Key-Partners	Objective Key-Activities	Targets
Ministry of Home Ministry of Health	with active involvement of prisoners <ul style="list-style-type: none"> • Develop and disseminate IEC material in prisons • Build capacity among prisoners to implement peer education activities in prisons 	in prisons <u>By the end of 2003</u> Prison staff have developed an understanding about HIV/AIDS/STI and related issues <u>By the end of 2004</u> HIV/AIDS related services available for prisoners

Strategic Component Key-Partners	Objective Key-Activities	Targets
YOUNG PEOPLE	To prevent HIV infection among young people	HIV sero-prevalence among young people is less than 0.2%.
CREATING A SUPPORTIVE POLICY AND COMMUNITY ENVIRONMENT	To create a supportive environment for behaviour change among young people by increasing the understanding among decision makers at all levels and communities about young people's needs and behavioural patterns	

Strategic Component Key-Partners	Objective Key-Activities	Targets
<p>Young people I/NGOs Trade Unions Sports Institutions Private sector CBOs PR companies UNICEF HMG/N DDCs VDCs Municipalities</p>	<ul style="list-style-type: none"> • Key-partners facilitate and support young people's participation in programming and local (decision making) processes. • Motivate for and select pilot locations to establish "youth advisory committees" • Develop a communication brief together with young people targeting policy makers, decision-makers, parents and communities regarding the needs and rights of young people 	<p>By the end of 2003</p> <p>Advocacy campaign on young people started.</p> <p>Pilot locations for young people's participation selected</p> <p>Network among young people and CBOs started</p> <p>Qualitative research results used both in advocacy campaign and negotiations with local authorities and communities</p> <p><u>By the end of 2004</u></p> <p>Nationwide coverage of advocacy campaign on young people</p> <p>In at least 3 municipalities/ DDCs/ VDCs young people are accepted as part of the local decision making process</p> <p><u>By the end of 2005</u></p> <p>In at least 20% of municipalities/ DDCs/ VDCs young people are accepted as part of the local decision making process</p>
<p>AWARENESS AND BEHAVIOUR CHANGE COMMUNICATION</p>	<p><i>To empower young people with the knowledge and life skills to avoid HIV/AIDS and sexually transmitted infections</i></p>	

Strategic Component Key-Partners	Objective Key-Activities	Targets
<p>Young people I/NGOs Uniformed Services Private Sector Media Family planning networks</p> <p>DDCs VDCs Municipalities UN HMG/N</p>	<ul style="list-style-type: none"> • Televised discussion fora in which, issues related to HIV are discussed by politicians, government leaders, medical professionals, social scientists, PLWAs, prevention activists and the general public. • Production and airing of a series of HIV/AIDS prevention television, cinema, and radio infomercials • “Celebrities talk about AIDS” campaign in which popular Nepali personalities from sports, music, fashion and entertainment deliver public service announcements promoting AIDS awareness and prevention. • Use of non-traditional media such as street and stage drama to increase awareness and motivate participation in prevention campaigns especially in rural areas • Action Teams to motivate existing formal and informal athletic, cultural, educational and social networks to participate in development and implementation of outreach activities: • Identification and recruitment of action team members from geographic and sectoral contexts • Contests for youth and young adults to use written, performance and graphic arts to communicate about HIV/AIDS, with winners to be involved in the further development of messages and campaigns targeting youth • Development, pre-testing and distribution of communication material including adequate material for illiterate youth and communities. • Establish organized peer-groups among young people to give young people a voice in decisions regarding their sexual and reproductive lives • Build capacity among organizations working with programmes for young people with a focus on a life skills approach • Motivate the leadership of the uniformed services to fully integrate HIV/AIDS in their training curricula 	<p><u>By the end of 2002</u></p> <p>Communication brief developed, actors identified</p> <p>Social marketing programme operationalized and new condom brand launched</p> <p>“First wave” of public announcements and mass media campaign implemented</p> <p><u>By the end of 2003</u></p> <p>Condom sales increased by 50%</p> <p>Young people actively involved in design and implementation of awareness and BCC.</p> <p>Capacity for peer-education programmes increased by at least 50% nationwide</p> <p>Uniformed services have integrated HIV/AIDS into their training curricula</p> <p><u>By the end of 2004</u></p> <p>At least 90% of young people have a correct knowledge about HIV/AIDS/STI</p> <p>Reported condom use among boys at least 80%, girls 85%.</p> <p>Peer-education programmes are running covering at least 50% of young people in</p>

Strategic Component Key-Partners	Objective Key-Activities	Targets
		<p>prioritized locations.</p> <p>90% of members of uniformed services have a correct knowledge about HIV/AIDS/STI</p> <p><u>By the end of 2005</u></p> <p>Condom sales increased by 50% compared to 2003</p>
YOUTH-FRIENDLY SERVICES	<p><i>To increase the accessibility and availability of youth-friendly and gender-sensitive services with an emphasis on information about reproductive health and sexuality</i></p>	
<p>Young people I/NGOs Ministry of Health Service providers UNFPA UNICEF WHO Municipalities DDCs</p>	<ul style="list-style-type: none"> • Build capacity among young people to identify their needs as regards services • With active participation of young people, design services for young people, including youth friendly VCT, STI treatment and information/counselling • Interaction programmes between young people, government and NGOs to discuss the needs of young people • Build capacity of government and NGOs/private sector to provide young people with services, particularly as regards counseling and reproductive health • Establish information centres where young people can confidentially access information on HIV/AIDS 	<p><u>By the end of 2003</u></p> <p>At least 1 “youth friendly” pilot established</p> <p>Web-based information designed and running focusing on young people’s needs</p> <p><u>By the end of 2004</u></p> <p>Pilot evaluated and expansion of youth friendly services designed</p> <p>At least 2 youth friendly service centers operational offering VCT, STI treatment and information/counselling.</p> <p><u>By end 2005</u></p> <p>At least 5 youth friendly service centers</p>

Strategic Component Key-Partners	Objective Key-Activities	Targets
		established
ENHANCE YOUNG PEOPLE'S KNOWLEDGE ABOUT HIV/AIDS/STI IN FORMAL AND NON-FORMAL EDUCATION SETTINGS	<i>To enhance young people's knowledge about HIV/AIDS and methods of prevention.</i>	
<p style="text-align: center;">Young people Ministry of Education I/NGOs Teachers UN</p>	<ul style="list-style-type: none"> • With active participation of young people develop an age-appropriate 'healthy life styles' curriculum • Integrate basic information on HIV/AIDS and reproductive health in the teacher's training • Strengthen the capacity of teachers in communication skills to deliver HIV/AIDS and reproductive health issues in an effective way 	<p><u>By the end of 2003</u></p> <p>Curricula modified and teachers in pilot locations adequately trained to deliver HIV/AIDS/STI information in formal and non-formal settings.</p>

Strategic Component Key-Partners	Objective Key-Activities	Targets
	<ul style="list-style-type: none"> • Identify key stakeholders in the educational settings • Identify effective coordination mechanisms to strengthen the coordination and cooperation between key stakeholders • Integrate HIV/AIDS/STI into the curriculum of Non-Formal Education 	<p><u>By the end of 2004</u></p> <p>In at least 5 formal and non-formal settings HIV/AIDS/STI information and education provided</p> <p>Networking mechanisms established and active for peer-education in schools</p> <p><u>By end 2005</u></p> <p>School based life skills education implemented in at least 20 districts nationwide.</p>
TREATMENT, CARE AND SUPPORT FOR PEOPLE INFECTED AND AFFECTED BY HIV	Care and support services of a defined quality are available and accessible for all people infected and affected by HIV/AIDS.	Access to services for at least 80% of people infected and affected by HIV/AIDS
REDUCING THE STIGMA SURROUNDING PEOPLE LIVING WITH HIV/AIDS	To ensure that all people infected and affected by HIV/AIDS are fully accepted and integrated into normal social and work activities	
PLHA Media organizations HMG/N Parliamentarians Nepal Law Society Press	<ul style="list-style-type: none"> • Identify political and religious leaders as well as celebrities for a mass media campaign against destigmatization of HIV/AIDS • Review policy and legal framework for violations of human rights of PLWA • Build the capacity of organized peer-groups among 	<p>By the end of 2002</p> <p>Communication brief for campaign finalized</p> <p>A seat on every HIV/AIDS committee is available for PLWHA</p>

Strategic Component Key-Partners	Objective Key-Activities	Targets
PR Companies Multi/Bilaterals	PLWA <ul style="list-style-type: none"> • Leadership training for key PLWA representatives • Develop standard guidelines for HIV/AIDS at the workplace 	<p>By the end of 2003</p> <p>Policy/legal review findings available</p> <p>Mass media campaign implemented</p> <p><u>By the end of 2004</u></p> <p>Policy/legal amendments done</p> <p>PLWHA actively participate in HIV/AIDS programmes and committees</p>
VOLUNTARY CONFIDENTIAL COUNSELLING AND TESTING	<i>To establish a non-discriminatory, accessible, voluntary, confidential HIV testing system with pre- and post-test counselling.</i>	
NCASC MoH NMA NPHL NGOs Law Association Service users NHIECC	<ul style="list-style-type: none"> • Develop national guidelines on HIV testing as well as counseling criteria and quality and assurance and control mechanisms • Ensure that VCT programs are linked with treatment, care, and support programmes • Review the legal framework • Develop criteria to prioritize the needs for VCT services among vulnerable groups • Design VCT services for and together with the priority groups • Design VCT services for other prioritized groups starting with young people • Develop IEC material for the general population regarding VCT and confidentiality 	<p><u>By the end of 2002</u></p> <p>National guidelines available</p> <p>Legal framework reviewed</p> <p><u>By the end of 2003</u></p> <p>Prioritization criteria available</p> <p>VCT services for priority groups commenced at five sites</p> <p>Linkages of VCT to treatment and care and support programmes established</p> <p><u>By the end of 2005</u></p>

Strategic Component Key-Partners	Objective Key-Activities	Targets
		Design available for expanded VCT service
COMMUNITY AND HOME BASED CARE AND SUPPORT	<i>To provide the most cost-effective and accessible combination of care and support for people infected and affected by HIV/AIDS, namely community and home-based care.</i>	
MoH NGOs PLWA UN MoLD DDCs VDCs DACCs	<ul style="list-style-type: none"> • Identify key information needs of care providers • Produce needs-based information pack for communities • Needs assessment of support networks for people living with and affected by HIV/AIDS • Capacity building of NGOs and GOs to inform and motivate communities for home based care and support • Develop training package on basic care and counseling for health care workers, including treatment for opportunistic infections • Gradually train health care workers starting in most affected areas • Develop policy frameworks on orphans and children 	<p><u>By the end of 2003</u></p> <p>Needs of care givers for information and support identified</p> <p>Information material developed and distributed</p> <p><u>By the end of 2004</u></p> <p>Most affected communities implement home based care and support, support structures available.</p> <p>Training package developed for health care workers</p> <p><u>By end 2005</u></p> <p>Training commenced</p>
MEDICAL SERVICES	<i>To ensure that all people living with HIV/AIDS have access to adequate medical services and treatment</i>	
MoH I/NGOs HMIS DDCs	<ul style="list-style-type: none"> • Develop standard treatment guidelines • Identify drugs needed to treat opportunistic infections and add them to the essential drug list • Map the needs for a quality control/assurance 	<p><u>By the end of 2003</u></p> <p>Essential drug list updated and drugs available</p>

Strategic Component Key-Partners	Objective Key-Activities	Targets
VDCs Universities/Teaching Hospitals	system for private as well as public medical services <ul style="list-style-type: none"> • Identify locations in which to establish regional centers for HIV/AIDS treatment and care services • Train staff of medical services in the concept of confidentiality and how to maintain confidentiality when providing care and support services • Train staff on appropriate treatment strategies • Develop a reporting and information system 	<p><u>By the end of 2004</u></p> <p>Guidelines published and distributed</p> <p>IEC materials published and distributed</p>
UNIVERSAL PRECAUTIONS	<p><i>All health staff is fully aware of universal precautions and have the skills and means for protection.</i></p>	
MoH NMA NGOs NNA Nepal Dentists Association Universities/Teaching Hospitals	<ul style="list-style-type: none"> • Review and update guidelines on universal precautions • Develop IEC materials for health providers as well as the general population • Identify different mechanisms for training of health service providers • Develop HIV/AIDS related medical waste disposal guidelines • Integrate medical waste disposal guideline into the relevant policy 	<p><u>By the end of 2003</u></p> <p>Guidelines published and distributed</p> <p>IEC materials published and distributed</p>

Strategic Component Key-Partners	Objective Key-Activities	Targets
PREVENTION OF MOTHER TO CHILD TRANSMISSION	<i>To minimize mother to child transmission of HIV.</i>	
MoH NMA I/NGOs NNA UNICEF WHO NHIECC NSMP Teaching Hospitals Private service providers	<ul style="list-style-type: none"> • Review international best practice for PMTCT • Review existing Nepali safe motherhood guidelines • Develop National PMTCT guidelines • Train health workers in PMTCT and HIV/AIDS in selected priority areas • Develop IEC materials for the antenatal population regarding PMTCT • Train antenatal care providers in counseling regarding PMTCT in particular breastfeeding 	<p><u>By the end of 2002</u></p> <p>International best practice and Nepali SM guidelines reviewed</p> <p><u>By the end of 2003</u></p> <p>National PMTCT guideline developed and published</p> <p><u>By the end of 2004</u></p> <p>IEC materials produced</p> <p>PMTCT at prioritized locations implemented</p> <p><u>By the end of 2005</u></p> <p>Phased expansion of PMTCT started</p>

Strategic Component Key-Partners	Objective Key-Activities	Targets
BLOOD SAFETY	<i>To minimize the risk of HIV and other blood borne infections through safe blood transfusions/blood products and organ transplantation</i>	
Red Cross Public/Private health service providers WHO MoH Teaching Hospitals	<ul style="list-style-type: none"> • Develop quality assurance/quality control system • Develop testing guidelines for blood donations/blood products • Regular coordination meetings between Red Cross and NCASC • Improve reporting systems • Review screening system for blood donors • Develop IEC material for potential blood donors • Review blood donor policies 	<p>By the end of 2002</p> <p>Guidelines reviewed and modified</p> <p>Regular coordination meetings started</p> <p>By the end of 2003</p> <p>Quality control/quality assurance system in place and functioning</p> <p>Regular reports from service providers received</p> <p>By the end of 2004</p> <p>Staff training nationwide implemented</p>

Strategic Component Key-Partners	Objective Key-Activities	Targets
MEASURING CHANGES	<i>An expanded monitoring and evaluation frame based on serological, behavioural and contextual factors contributing to the spread of HIV/AIDS/STI.</i>	An efficient monitoring and evaluation system as regards the epidemic and the response.
2 ND GENERATION SURVEILLANCE	<i>Establishment of an effective and efficient 2nd generation surveillance system to track the prevalence and the trend of HIV epidemic in the country.</i>	
Research organizations MoH I/NGOs Municipalities Public/private health care providers	<ul style="list-style-type: none"> • Design 2nd generation surveillance system • Needs assessment of necessary capacity building to manage system and work with collaborating organizations • Establish reporting and feedback mechanisms 	<p>By the end of 2002</p> <p>Surveillance system designed</p> <p>Capacity assessed and capacity building operationalized</p> <p>By the end of 2004</p> <p>Surveillance system implemented nationally</p>
BEHAVIOURAL AND CONTEXTUAL RESEARCH ON VULNERABILITY TO HIV/AIDS/STI	<i>An expanded knowledge base on behavioural and contextual factors contributing to vulnerability towards HIV/AIDS/STI.</i>	
Research organizations IT companies MoH NCASC I/NGOs UN	<ul style="list-style-type: none"> • Existing research databases identified • Set up web site for research data • Establish and promote the clearing house as a one-stop shop for registering research results • Enhance capacity of NCASC to technically review 	<p>By the end of 2003</p> <p>Existing research databases compiled and web-based</p> <p>New web site developed</p>

Strategic Component Key-Partners	Objective Key-Activities	Targets
	research	<p>NCASC has the capacity to coordinate and review research</p> <p><u>By the end of 2004</u></p> <p>Database regularly maintained</p>
MANAGEMENT AND IMPLEMENTATION OF AN EXPANDED RESPONSE	<i>Programme and resources for an expanded response are managed and monitored.</i>	A resourced, coordinated, effective and well monitored expanded response to the epidemic in Nepal.
NEPAL TRUST FUND TO FIGHT HIV/AIDS AND STIs	<i>Financial systems in place to resource an expanded response to HIV/AIDS/STIs</i>	
<p>HMG/N MoF MoH Multi/Bilateral donors I/NGOs Private sector</p>	<ul style="list-style-type: none"> • Review the legal situation as regards establishment of a trust fund and respective governance mechanisms • Develop ToR and operational details for board, trust fund, and financial flow mechanisms 	<p>By the end of 2002</p> <p>Trust fund established</p>
RESTRUCTURING AND STRENGTHNING OF THE NCASC	<i>The NCASC fulfils its role as technical authority as regards HIV/AIDS/STI in Nepal</i>	

Strategic Component Key-Partners	Objective Key-Activities	Targets
<p>MoH MoF UN Bilateral donors Private sector I/NGOs</p>	<ul style="list-style-type: none"> • Identify TA needed for restructuring exercise • Develop management plan including ToR, profiles and staff structure • Identify capacity needs • Develop TA and resource plan for restructuring • Establish core units • Recruitment 	<p>By the end of 2002</p> <p>Management plan developed and approved by HMG/Board</p> <p>“Bridge plan” for the next years developed and approved</p> <p>Capacity building started</p> <p>By the end of 2003</p> <p>NCASC is 70% operational</p> <p>By the end of 2004</p> <p>NCASC is fully restructured and operational</p>

Strategic Component Key-Partners	Objective Key-Activities	Targets
ESTABLISHMENT OF A PRIVATE ENTITY TO MANAGE AN EXPANDED RESPONSE	<i>A functioning public-private partnership for the management of an expanded response</i>	
MoH MoF UN Bilateral donors Private sector I/NGOs	<ul style="list-style-type: none"> • Legal assessment • Development of management plan including ToR, profiles, staff structure and resource needs • Finalization of governance structures • Identification of capacity and TA needs • Recruitment • Development of interim arrangements (bridge plan) and TA 	<p><u>By the end of 2002</u></p> <p>Entity established</p> <p>Bridge mechanisms finalized and approved</p> <p><u>By the end of 2003</u></p> <p>Entity staffed, equipped and 30% operational</p> <p><u>By the end of 2004</u></p> <p>Agency fully operational</p>
COSTING OF NATIONAL STRATEGY	<i>The national strategy is costed</i>	
MoH MoF HMG Multi/Bilateral donors I/NGOs	<ul style="list-style-type: none"> • TA for costing identified 	<p><u>By the end of 2002</u></p> <p>Resources in place for an expanded response reaching 90% of the defined target groups at a sero-prevalence level among the general population of < 1%.</p>

Strategic Component Key-Partners	Objective Key-Activities	Targets
OPERATIONALIZATION OF NATIONAL STRATEGY	<i>An effective expanded response implemented</i>	
NACC NCASC Agency I/NGOs Private sector Line ministries DDCs MoF MoH	<ul style="list-style-type: none"> • TA for operationalization identified • Draft of workplans • TA to line ministries • TA to districts • Indicator and M&E frame development 	<p>By the end of 2002</p> <p>Priority areas are operationalized on an annual workplan base, including year targets, monitoring and evaluation indicators and programme resource requirements</p>
DISTRICT STRATEGIES	<i>District HIV/AIDS/STI strategies form integral part of the overall district development plan</i>	Programme resourced district strategies
TECHNICAL ASSISTANCE TO DISTRICTS	<i>Timely and professional technical assistance to districts for the development of district strategies</i>	
MoH NCASC DDCs I/NGOs Multi/Bilateral donors	<ul style="list-style-type: none"> • Establish the necessary capacity and competence in the NCASC • Develop criteria to prioritize districts • Provide TA to districts 	<p>By the end of 2002</p> <p>Prioritization criteria developed and applied</p>

Strategic Component Key-Partners	Objective Key-Activities	Targets
UN MoLD MoF		<p>Capacity assessment for NCASC done and ToR/profiles developed</p> <p>By the end of 2003</p> <p>Technical capacity in NCASC established</p> <p>Development of district strategies started in 15 districts</p> <p>By the end of 2005</p> <p>75 District Strategies developed and integrated in district development plan</p> <p>5 District strategies programme resourced</p>