



Family Planning

Association Of Nepal

International Planned
Parenthood Federation

HIV/AIDS STRATEGY 2002-2006

SECTION A

STI/HIV/AIDS EPIDEMIC AND INTERVENTION PROGRAMS IN NEPAL

1. Global Overview of HIV/AIDS

HIV is a global health problem affecting all regions and countries around the world. There were about 40 million adult and 2.7 million children worldwide living with HIV at the end of 2001 (UNAIDS and WHO, <http://www.aveart.org.html>, 2002). During 2001 some 5 million people become infected with HIV and 3 million deaths from HIV/AIDS were recorded. Out of the total 42.7 million of HIV/AIDS infected people, 6.1 million estimated were living in Asia, where infections are increasing faster than anywhere else in the world (UNAIDS and WHO, <http://www.aveart.org.html>, 2002). Asia's vulnerability to AIDS owes evidently to high risk sexual behavior and sharing of needles among IDUs, high incidence of STI, gender inequities which heighten vulnerability of women and girls at many levels, poverty and low level of education and cultural taboos that surround sexual behavior. Information dissemination and negotiation for safer sex are yet a challenge. Highly mobile populations are more likely to engage in risk behaviors and act as breeding stocks transmitting HIV from one population to another. Cross boarder trafficking of girls and women and rapidly growing urbanization and high unemployment rates of youth might reinforce the transmission.

2. STI/HIV/AIDS Epidemiological Situation in Nepal

The HIV/AIDS epidemic is relatively recent in Nepal. The first case was identified in Nepal in 1988 (NCASC, 2002). As of 31 May 2002 a total of 2,307 HIV infection cases were reported in government facilities. Of this number 601 were infected by AIDS of which 153 had already died. Actual HIV/AIDS infection in Nepal is feared to be many times higher than the recorded cases. Lack of access to testing facilities, counseling, fear of being exposed, ignorance, non-availability and little use of condoms are the major factors responsible for the low reporting of HIV/AIDS. Independent estimates reveal that the actual number of HIV/AIDS infected cases is much higher than those reported by the government. The number of the adults and children living with HIV/AIDS until December 2001 was 38,000 (estimated) and AIDS related deaths were 3000 (UNAIDS, 2002). The HIV/AIDS infection in the total sample test was 1.16 percent (NCASC, 2002). Current estimated HIV infection rate of 0.3 percent pervades on the adult population between the age cohorts of 15-49 (UNAIDS, 2002).

Of the total reported HIV/AIDS infections, males comprise 72 percent and females only 28 percent (NCASC, 2002). The age-wise data of HIV/AIDS infection is: 54 percent in the age cohort of 20-29, 29 percent in 30-39, 9 percent in 14-19 and the rest in the other groups. Young people make the highest suffering group from HIV/AIDS. The HIV scenario of Nepal reveals 67 percent of HIV including AIDS is found in the age group of 14 to 29 years and it could be assumed that a high portion of adolescent and youth population falls in this group (NCASC, 2002).

Since sexually transmitted infections are proven co-factors increasing the risk of HIV transmission, their appropriate diagnosis and treatment are critical. It is estimated that there come about 200,000 new STI episodes in Nepal in every year (MoH, 2002). Therefore, this component cannot be left out while addressing HIV/AIDS. Seroprevalence and behavioral data indicate a high potential for HIV/AIDS epidemic in Nepal. It is estimated that about 100,000-200,000 young adults will become infected and 10,000-15,000 AIDS related deaths might occur annually if the present situation of intervention is not improved progressively (MoH, 2002).

3 STI/HIV/AIDS Vulnerable and High Risk Groups in Nepal

The geographical distribution of HIV sentinel sites for different population groups in Nepal demonstrate that HIV/AIDS incidence is prevalent in major urban areas and transportation routes where high-risk sexual behavior prevails. Those most at risk include migratory populations, commercial sex workers and their clients, and intravenous drug users. Adolescents and youths who constitute the largest segment (32 percent) of the total population in Nepal are predominant among those at risk. Similarly, street children, migrant children, scavengers, hotel and restaurant workers, transport workers, refugees, industrial labors, construction workers, police, military, prisoners and people living urban slums are vulnerable to HIV infection due to their low earning for subsistence living.

3.1 Migrant Populations

The migrant populations are one of the most vulnerable to STI/HIV infection. There are different types of migrant people in Nepal, which are as follows:

3.1.1 Periodic and Seasonal Job Migrants (National and International)

Pervasive poverty has multiplier effect on the overall socio-economic development in a debt-ridden poor country like Nepal. About 42 percent of the total population live below the absolute poverty line with a daily earning of less than 1 US\$ (UNDP, 2001). Poverty forces the economically active people to move from their residence within and outside the country to earn subsistence living for their families. The total number of periodic migrants mobile in search of job was as registered in official statistics 400,000 in 1981 (CBS, 1982), which rose to 660,000 in 1991 (CBS, 1992) and 762,181 in 2001 (CBS, 2002) constituting about 6 percent of the active labor force aged 15-59 in 2001. Independent estimates reveal that the number of periodic migrants is even higher than it is recorded in official statistics. About 800,000 people cross the southern boarder as seasonal migrant labors to India every year and approximately 350,000 labors migrate from one part of the country to another for wage earning (MEH and REGHED, 2000). Overwhelmingly, both the periodic and seasonal migrants are males most of them from the western part of Nepal. The periodic and seasonal migrants working in India, overseas countries and within the country itself live alone i.e. without their spouse, for a long time, which force them to come to or establish sexual relationship with FSWs. Most of these migrants do not have access to information, condoms, supportive services which enable them to have safer sex. They are likely to take the virus back to their wives who could transmit it to their babies and at the same time work as HIV/AIDS breeding populations. The poor and the illiterate are equally less able to cope with consequences of being infected with HIV.

3.1.2 Migrant Children

There are about 80,000 migrant children in Nepalese cities (ILO, 1995), who work in motor garages, restaurants, hotels, brick factories and as shoe shiners in the street, saw mill employees, street vendors, porters, carpet industry workers, rag pickers, stone quarry labours, domestic servants and tourism assistant etc (CWIN, 2000 and 2002). Especially the migrant girls are exploited sexually or under-pay, which again put them at, an increased risk of HIV infection (CWIN, 2000).

3.1.3 Migrant Students

About 100,000 rural students, both male and female, come to urban centers for higher education annually. They are barely supported by their parents with tiny incomes generated from subsistence agriculture, which are not enough for their living in the city centers. Thus, the female students are involved in other part-time works particularly in restaurants, hotels and tourist centers for extra money. Employed in part-time, they get very small amounts from their employers and, occasionally, they are involved in sex trade when they face financial crises. Besides, other female migrant students, who receive no enough support from the parents and unable to get part time jobs in the city center are involved in sex trade for subsistence living, which makes them vulnerable to HIV infection.

3.1.4 Mobile Transport Workers

Altogether there are 135,000 transport workers, 130,000 male and 5,000 female, in Nepal (CBS, 1999). The males are mainly drivers and conductors and female work at ticketing satiations. The drivers, conductors and cleaners plying vehicles on long routes are highly susceptible to HIV infection because they establish sexual relationship with commercial sex workers and hotel and restaurant girls/women at their night halt stations. Cash at hand collected on regular basis from the passengers increases their ability to pay for sex. Their sexual relationship at one station will carry HIV to the next that is why they are considered as breeding people. They are HIV susceptible to their wives as there is no practice of using condom during sex.

3.2 Female Sex Workers (FSWs)

Girls trafficking and flesh trade is highly associated with pervasive poverty in Nepal. It is estimated that about 5000-7000 rural women, mostly girls are trafficked to India across the open boarder. Altogether there are more than 200,000 Nepalese women currently engaged in flesh trade in India (CWIN, 2002). The practice of migration of Nepalese women to Gulf and other Asian countries is also increasing. It is estimated that about 60 percent of the Nepalese female sex workers at the brothels in Mumbai are infected with STI/HIV/AIDS. The brothel owners release them when they are infected, after which they return to Nepal to spread new infection among young adults. Similarly, there are about 20,000 female sex workers in Nepal of whom 7000 are in the Kathmandu valley (MEH and REGHED, 2000) and 500-1500 in other major regional towns. These FSWs are engaged in twelve types of professions in places such as cabin restaurants, massage parlors, dance restaurants, discos, business offices, factories, street-based prostitution, and so forth. The FSWs engaged in other professions get nominal salaries so they engage in sex works for extra money. The cabin girls are highly susceptible in group sex. Army personnel and drivers usually involve in group sex. Similarly, many kinds of sex business can be seen in different parts of Nepal. In the Western and Far Western Development Regions religionized women 'Jhumas' and 'Deukis' (they are consecrated to gods) often find themselves bound to the sex profession. Religiously, they are deprived of the right to marry and live in families. 'Badenis' the traditional dancers, are engaged in sex industries in the Mid western and Far western Development Regions in an organized way. Many other female sex workers are active in every geographic region and administrative zone in Nepal in various forms and their main concentration

could be found on highway routes, bus parks, hotels, lodges, parks etc.

3.3 Injecting/Intravenous Drug Users (IDUs)

IDUs with their high-risk behavior are most vulnerable to HIV/AIDS epidemic in Nepal. There are about 200,000 drug addicts in Nepal (CWIN, 2002), of whom 30,000 are injecting drug users, of whom again approximately 40 percent are HIV infected (MoH, 2002). The Kathmandu valley alone has 10-15 thousands IDUs and 50 percent of them are HIV infected. They are the main instruments of transmitting HIV to new people.

3.4 Bonded Children

Still there are 40,000 bonded children in Nepal kept by affluent families as domestic servants and farms laborers (CWIN, 2000 and 2002). Particularly the bonded girls are sexually exploited by the employers and other people increasing their vulnerability to HIV infection.

3.5 Street Children

Every year around 500 children are landed in the streets of Kathmandu. There are about 400 to 600 children living in the streets in the Kathmandu valley alone. The total number of street children in the country is 5000 (CWIN, 2002). Growing up without social background or kinship and without access to social service, they suffer from starvation, illiteracy, and non-information and become non-immune to violence and sexual exploitation. The street girls are more vulnerable to HIV infection because IDUs and other vulnerable groups abuse them sexually.

3.6 Refugees

There are more than 100,000 Bhutanese refugees living in six refugee camps in eastern Nepal- particularly in the Morang and Jhapa districts. The living conditions of the refugees are extremely poor and they survive on food assistance provided by international relief agencies. Their surroundings exacerbate the spread of diseases including HIV/AIDS but no surveillance research on HIV/AIDS epidemic among the refugees has yet been conducted. However, there is news in local newspapers on involvement of women and girls in prostitution. Therefore, refugee camps may turn into the centers of HIV/AIDS proliferation in adjoining districts if appropriate measures on HIV/AIDS prevention and control are not undertaken in due time.

3.7 Prisoners

Altogether there are about 8,529 prisoners in Nepal 6,268 male and 2,261 female, in the 73 prisons in Nepal (PMD, 2002). Isolate and destitute living make them susceptible to practice sex with same sex. There is no appropriate segregation of HIV and non-HIV inside the prisons. It is suspected that some of the prisoners imprisoned in criminal cases are already infected with HIV. While they establish sexual relationship with others there are a high chances of HIV transmission among the prisoners. Therefore, the prisoners in Nepal are at high risk and undoubtedly very susceptible.

3.8 Construction Workers

Altogether there are 344,000 construction workers, 292,000 male and 52,000 female, in Nepal (CBS, 1999). They work in a folk at construction sites, particularly in road, irrigation, hydro, and building construction project areas. They live in poorly managed temporary make-shift houses during the construction period. Some of the skilled workers move from one project to another with no change on the living style. Deprived of the means of entertainment they establish sexual relationship with multiple partners at night within and outside their communities. Sexual relationships with multiple partners make them susceptible to HIV infection.

3.9 Industrial Laborers

Altogether, there are 553,000 industrial laborers employed in 3,557 industrial establishments, of whom 366,000 are male and 186,000 female (CBS, 1998 and 1999). Both the males and the females work together, and many of them live alone inside and outside the industrial complexes. They are poorly paid- about Rs. 2700/month on an average (CBS, 1999), which is less for family living. They establish sexual relationship with outsiders and with their fellow workers for entainment and extra money. Yet surveillance study is not conducted on their vulnerability to HIV infection, even though there is a consensus among health professionals about this high-risk behavior. The low literacy profile of the workers and insufficient access to STI/HIV/AIDS preventive information and counseling expose them to vulnerability.

3.10 Hotel, Restaurant, Beauty Parlor and Massage Workers

Altogether there are 115,000 people, 63,000 males and 52,000 females working in hotels and restaurants, beauty parlors, massage centers, tourist offices and as trackers and porters in Nepal (CBS, 1999). They work 56 hours per week (average) and get nominal payments (below Rs 2,000/month) from the employers, which is not sufficient even for a single person in the urban areas. Especially the women workers establish sexual relationship with hotel and restaurant visitors and outsiders to generate extra income for their survival. It is expected that some of the visitors who sexed are already infected with HIV and could become high-risk people.

3.11 Adolescents and Youths

Adolescents and youths (aged 10-24) constitute the largest segment (32 percent) of the total population of Nepal. They carry boundless energy and infinite curiosities and opportunities to experiment, and conceptualize different aspects of human life such as sex, sexuality and relationship (Richoi Associates, 2000). A study conducted by FPAN (1998) in the Palpa district on adolescent sexuality reveals that about 44 percent of the adolescents (aged 13-15 years) and 56 percent of youths (aged 16-18 years) have had sexual relationship before marriage. The national data on pre-marital sex of the adolescents and youths are not available small scale independent researches claim the existence of pre-marital sex in Nepal. Pre-marital sexers are not adequately aware of precautionary measures such as the use of condom before sex. Therefore, they fall among the high-risk groups susceptible for STI/HIV infection.

3.12 Army and Police

There are more than 100,000 army and police service employment in Nepal (CBS, 1999). Juniors by post usually live in the barracks without their spouses for a long time. They are therefore interested to have extra sexual relationship even they had enough sexual experience with their wives during their home leave. Some of them establish sexual relationship with sex workers, hotel and restaurant workers, industrial laborers, street vendors, operators, migrant workers and women living in urban slums (based on their ability to pay) before leaving the barracks. Thus, the army and police people are at high risk for inviting HIV infection.

3.13 Urban Slum People

Out of 23 million people in Nepal, 3.2 million accounting 14 percent of the total population, live in urban centers (CBS, 2002). About 10-15 percent of the urban people live in slum areas in poor sanitation and housing conditions and with a low female literacy profile. Women and girls, whose husbands and fathers are unable to earn for the family, involve in sex trade for their subsistence earning as they have no better option in the off-farm sector due to their weak technical knowledge and persistent illiteracy. Thus, they are at high risk and vulnerable to HIV infection.

3.14 Men who Sex with Men

Some people, particularly males, are involved in same sex relationships in Nepal. Some of them are voluntarily engaged in homosexual relationships while others especially young boys and street children, are forced on it. Eventually they also establish sexual relationship with females, which further increase the chance of HIV infection. Some of the homosexuals are already infected with HIV/AIDS and others with STI. Their sex with multiple partners whether voluntary or enforced, puts them at high risk of HIV infection.

4. Knowledge and Practice of STI/ HIV/AIDS Prevention and Control in Nepal

There is no universal knowledge of STI/HIV/AIDS prevention and control in Nepal. About 50 percent of women and 72 percent of men have heard about HIV/AIDS, and 38 percent of women and 66 percent of men believe there is a way to avoid HIV/AIDS (DoH and New Era, 2002). The knowledge varies by geographic region and socio-economic background of the people. Knowledge on HIV/AIDS is higher in the hills than within Terai and mountain regions. Similarly, education has positive impact on HIV/AIDS knowledge in all segments of the population. For example, 99 percent of women with education (SLC and above) have heard of HIV/AIDS, while 37 percent of illiterate women have not. (DoH and New Era, 2002).

Various action researches were conducted to identify the knowledge and practice of condom to prevent the STI/HIV/AIDS epidemic in Nepal. All female sex workers insist that their clients wear condoms (New Era, 2002). A behavior surveillance survey on female sex workers showed that the knowledge of condom is as high up as 98 percent among them. (FHI and New Era, 2001). Previously the use of condom during sex soared up to 93 percent and last use was recorded at 86 percent though the consistent use condom was found to be only 51 percent among female sex workers. The use of condom ranges from 87 percent to 97 percent among the sex workers in the Kathmandu valley but the use was highly irregular and high incidents of STI were reported in the case of female sex workers (CREHPA, 2002). A large number of FSWs experienced problems like sore and itch around the genital area, and white discharge.

A study conducted on young factory workers (CREHPA, 2002) reveals that having girl/boy friends, physical contacts such as holding hands, kissing, petting, and even sexual intercourse are common among these people. Awareness of at least one contraceptive method is almost universal (95 percent) among them. Correct knowledge of the method is generally higher among boys than among girls. The use

of Condom is the most frequent method (90 percent) among boys. However, only 60 percent of the girls have ever seen a condom. A large majority of the young factory workers have heard about sexually transmitted diseases. Knowledge on STI is higher in boys (80 percent) than girls (62 percent). Knowledge of AIDS is higher in the boys than in girls.

HIV prevalence is high up among injecting drug users (from 2.2 percent in 1995 to nearly 50 percent in 1998), and nearly 50 percent of the country's drug users fall within the age group of 16-25 (UNICEF, 2001). Of the 200,000 drug users in Nepal, 30,000 intravenous drug users who live in urban areas, and about 40 to 50 percent of them are HIV infected (CREPHA, 2002). The use of condom by these people during sex is not regular and they transmit HIV/AIDS to new people.

A mini research conducted on risk behavior and knowledge and use of condom for STI/HIV/AIDS prevention among the migrant people in the far western district of Achham showed HIV prevalence of 3.7 percent among international migrants, 3 percent among migrants within the country and 0.7 percent among non-migrants (New Era, 2001). Similarly, STI prevalence is recorded at 19 percent among international migrants, 8 percent among the migrants within the country, and 8.9 percent among non-migrants. The use of condom with wives is recorded as low in all the stated segments of the population. About 76 percent of migrants knew condom as a means of STI/HIV prevention but the use is limited to 62 percent within the migrants and 29 percent with the non-migrants (New Era, 2001).

There are no other comprehensive studies covering all the segments of the population on STI/HIV/AIDS knowledge and precautionary measures. The situation outside the intervention areas is quite different and it does not represent the totality. It is believed that a large proportion of the population is unaware of HIV/AIDS and precautionary measures due to pervasive illiteracy, poverty and weak access to information and services in the country.

5. Government Policy, Plan and Priority

The HMG/N policy and plan have given more emphasis to foster partnership programs with NGOs and the private sector and its health sector development partners for STI/HIV/AIDS prevention, control and management. The policy, plan and priority areas of HMG/N are reviewed briefly below.

5.1 Long-term Health Plan of Nepal (1997-2017)

His Majesty's Government of Nepal (HMG/N) formulated the second long-term National Health Plan (1997-2017) in 1997, aiming to create a socio-economic environment for enabling Nepalese citizens to lead to a healthy life through preventive and curative health services. Importantly, the plan focuses on preventive aspect of all reproductive health services in a package. It places greater emphasis on community involvement, increasing access to PHC out-reach, Sub-health posts, Health Posts, PHCC and District Hospitals as well as establishing a functional referral linkages between all levels. The following targets were identified in the National Health Plan to be attained by the end of the Tenth Five-Year Plan and by the end of a twenty-year period.

Health Indicators	Situation 1997-1998	Situation at the end of 9th plan	Targets of the 10th plan (2002-2007)*	20 Years Target
Infant Mortality Rate/1000	74.7	64	45	34.4
Child Mortality Rate/1000	118	91	86.8	62.5
Total Fertility Rate	4.58	4.1	3.5	3.05
Life Expectancy	56.1	57.6	62	68.7
Maternal Mortality Rate/100,000	475	439	300	250
Contraceptive Prevalence Rate	30.1	39	50	58.2
Delivery by Trained Health Worker	31.5	36.3	55	95
Crude Death Rate/1000	11.5	-	8.1	6
Crude Birth Rate/1000	34.5	-	30.4	26.6

Source: Ministry of Health 1997, Ministry of Health & New Era, 2001, NPC, 2002
 Note:* These figures are taken from the 10th Plan Base Paper and could be changed in the final plan.

STI/HIV/AIDS prevention and control program is placed under the reproductive health package, which includes family planning, safe motherhood, child health, prevention and management of complication of abortion, human sexuality, sub-fertility management, adolescent reproductive health and life cycle issues and problems of elderly people. However, the plan does not pay much attention to the alarmingly growing epidemic of HIV/AIDS. The program activities for HIV/AIDS prevention and control are loosely integrated with the reproductive health package. The growing expansion of the HIV/AIDS epidemic was not realized during the plan formulation period.

However, the long-term plan of the government emphasized community participation, equitable access and inter-sectoral collaboration in all aspects of the reproductive health package. In order to ensure supplementary and complementary roles of the NGOs and private sector in the implementation of the reproductive health package in a sustainable way, and to expand coverage and quality of services, the plan has identified the need for strengthening NGO/private sector partnership with HMG/N.

The following strategies adopted by the plan for an effective and efficient provision of quality RH services have given enough scope for the NGO and private sector to supplement and complement the national RH program including STI/HIV/AIDS prevention and control.

- Implement Integrated Reproductive Health Package at Hospital, Primary Health Care Center, Health Post, Sub-health Post, and Primary Health Care Outreach, TBA, FCHVs, Mother's Group, and other community and family level activities based on standard clinical protocols and operational guidelines;
- Encourage non-governmental organizations and associations to provide health services under the prescribed policies of HMG/N;
- Encourage private parties interested to extend health services through the establishment of hospitals and health units without any financial liability to HMG/N to open and operate such health facilities based on prescribed standards;
- Encourage the establishment of an alternative health fund in the non-governmental sector to increase the per capita health expenditure from Rs. 538 in 1997;
- Decentralize the planning and program formulation system (from the centralized departmental decision making to the lowest tier of health facilities);
- Ensure effective management system by strengthening and revitalizing the existing committees working at various level;
- Develop a national RH research strategy, which outlines research priorities and work plans based on the information requirement of policy makers, planners, managers and service providers;
- Construct/upgrade appropriate service delivery and training facilities at the national, regional, district and health post levels;
- Review and update the existing training health curricula to include the missing RH components;
- Enhance the functional integration of RH activities carried out by different divisions within the Ministry of Health;
- Emphasize the advocacy for the concept of RH including the creation of an environment conducive to inter and intra-sectoral collaboration;
- Review and develop IEC/BCC materials to support all levels of intervention including rumor countering messages;
- Develop appropriate RH programs for adolescents;
- Support national experts and consultants; and
- Promote inter-sectoral and multi-sectoral coordination.

5.2 National Reproductive Health Strategy 1998

Following the Long-term Health Plan (1997-2017), the National Reproductive Health Strategy of Nepal, formulated in 1998 emphasized the prevention and management of STI, HIV, AIDS and other reproductive health issues through the Integrated Reproductive Health Package introduced at Hospitals, Primary Health Centers (PHC), Health Posts, Sub-Health Posts, Outreach Clinics, TBAs and FCHVs. The National Reproductive Health Strategy has no clear-cut policy, strategy or activities for HIV/AIDS prevention and control. It is loosely integrated with reproductive health package. However, it lays stress on some preventive aspects and syndromic treatment of STI/HIV/AIDS at various levels as follows:

- Awareness about STI/HIV/AIDS and the distribution of condoms at family level;
- Promotion of sex education, counseling and condom promotion/distribution at community level;
- Identification, treatment and referral for vaginal discharge, lower abdominal pain, genital ulcers in women, and urethral discharge, genital ulcers, swelling in the scrotum or groin in men along with condom promotion and distribution and implementation of IEC activities for preventive aspects at health post and sub-health post levels;
- Treatment and management of STIs based on syndromic approach (if diagnosis facilities are not available), condom promotion and distribution at Primary Health Center level; and
- Clinical diagnosis, laboratory diagnosis and treatment of STI, and condom promotion and distribution along with implementation of IEC/BCC activities for HIV/AIDS prevention at district and hospital levels.

The National Reproductive Health Strategy is relatively progressive compared to the long-term National Health Plan in addressing the STI/HIV/AIDS epidemic in Nepal. However, the strategy does not spell out in clear terms the intervention approach and programs required to fight the high risks and safeguard the vulnerable groups of people.

5.3 National Adolescent Health and Development Strategy 2000

Adolescent specific health services were virtually non-existent in Nepal before the International Conference on Population and Development (ICPD) 1994. However, selected programs focusing on drug abuse and HIV/AIDS prevention and control had been implemented by a few NGOs. Following the adoption of ICPD Program of Action (1994), the fourth International Conference on Women in Beijing (1995), WHO/South East Asia Regional Strategy for Adolescent Health and Development (1996), and the Second Long Term Health Plan (1997-2017) of Nepal, and the National Reproductive Health Strategy of Nepal (1998), HMG/N formulated a National Adolescent Health and Development Strategy in 2000. As in the National Reproductive Health Strategy, STI/HIV/AIDS prevention and control among adolescent is only loosely integrated with reproductive health package.

The strategy aims to increase access to and utilization of friendly health care services in order to reduce the incidence of STI/HIV/AIDS among adolescents through integration of adolescent health services into existing health care delivery system. It also seeks to involve and establish links with youth clubs, NGOs and the private sector to expand and improve STI/HIV/AIDS education and services.

The major activities proposed in the document are: to provide adolescent-friendly health services through existing static and outreach service outlets; to initiate peer counseling programs in schools/clubs and workplaces; to increase knowledge of STI/HIV/AIDS; to increase communication between parents and adolescents on STI/HIV/AIDS education; to increase STI/HIV/AIDS knowledge in adolescent (married 15-19) from 24.3 percent in 2000 to 50 percent in 2006 and 75 percent in 2011.

5.4 Tenth Five-Year Development Plan 2002-2007

The Tenth Five Year Plan of Nepal (2002-07) is at the final stage and is not yet officially out to stakeholders and implementing agencies till the preparation of this document. However, the Base Paper for the Plan circulated by the National Planning Commission (NPC) has realized the persistence of high infant, children, maternal mortality rates, fertility rates; growing incidence of HIV/AIDS cases; low life expectancy and poor access of people to RH services. Accordingly, HMG/N aims to improve these indicators through an integration of all RH components at all levels (from specialized hospitals at central level to sub-health post at village level). Greater emphasis has been placed on decentralization of health activities at village level; enhancement of management capabilities of health establishments at all levels; involvement of the private sector, NGOs, INGOs, and bilateral and multilateral partners in service delivery and resources; and human resource development to increase the efficiency of the health sector in Nepal. The major strategies for Tenth Five Year Plan for RH services and STI/HIV/AIDS prevention, control and management as follows :

- Increase access of people to RH services in access-difficult and backward areas, open new service centers, and enhance service providing capabilities of existing service centers at all levels;
- Given high priority to RH services and safe motherhood (to enhance the overall health status of women) and the fertility reduction;
- Make coordinated (Government, NGO and private sector partnership) efforts for STI/HIV/AIDS prevention and control and divert the resources for target groups;
- Extend HIV/AIDS programs into other ministries and development interventions and trainings;
- Strengthen the HIV/AIDS curriculum for school students through the Ministry of Education;
- Formulate a special policy to attract investment of the NGOs and private sector in specialized health services;
- Coordinate the Ministry of Education and the Ministry of Health to produce qualified health manpower in the country;
- Include the population component in all formal and informal education curricula and trainings and train teachers and instructors through the Ministry of Education;
- Promote the concept of health fund (to collect resources from various sources e.g. national health insurance and health tax for investment).
- Implement the FP programs effectively to ensure access of the people to FP services; and
- Maintain quality of health services in the private sector through effective supervision and monitoring.

5.5 National HIV/AIDS Strategy 2002-2006

In the past sexually transmitted diseases were diagnosed and treated by the department of venereal diseases in all major hospitals. As the STD problems arose in the country, a STD Control Committee was formed by HMG/N in 1986. The Committee was later upgraded to a semi-autonomous organization of National Center for STDS and AIDS Control (NCASC). HMG/N formulated a short-term AIDS control plan in 1988 and a medium-term plan (1990-1992). In 1992, a National AIDS Coordination Committee, chaired by the Minister for Health, was established bringing government and non-governmental organizations for STDs and AIDS prevention and control together. Reviewing the experience of both the short-term and medium-term plans, HMG/N formulated a second long-term (1993-1997) plan. The NCASC lunched a HIV/AIDS control strategic plan (1997-2001) in 1997. However, these short and medium term plans and strategic plans had no clear-cut objectives and programs for HIV/AIDS control at national level. The HIV/AIDS prevention and control programs were loosely integrated with the RH package. In 2000 NCASC had only a 1.4 million budget, which was too low and demonstrated that HMG/N took it as a symbol or token rather than real commitment (MEH and REGHED, 2000). To make up for the shortfalls of past plans and

strategies, HMG/N formulated a comprehensive National HIV/AIDS strategy in 2002, to bring all sectors into the mainstream and instructed the National AIDS Council chaired by the Prime Minister, to proclaim political commitment.

Overall, the National HIV/AIDS Strategy intends to expand the number of partners in the national response of controlling the HIV/AIDS epidemic and to increase the effectiveness of the response by focusing on priority areas. Due emphasis is given to the need of care and support for people already infected and affected by HIV/AIDS. Similarly, commitment is sought not only from the Ministry of Health but also from all concerned agencies within and outside the government, and better-coordinated support is likewise solicited from external development partners. Decentralization of HIV/AIDS programs and activities at local level is given enough emphasis. In response, local governments (DDC and Municipalities) are expected to include program activities from their own local development plans. INGOs, NGOs, CBOs, civil society as well as the private sector and external development partners are invited, openly, to supplement and complement the national HIV/AIDS control program .

The strategy sought multi-sectoral involvement for building an adequate response to the HIV/AIDS epidemic with primary focus on its prevention. Rights-based response is advocated with a specific focus on the rights of people infected and affected by HIV/AIDS, in particular the rights to confidentiality. Resource allocation will be made for defined priorities based on the vulnerability of various affected groups and communities. People and communities will be empowered to protect themselves from HIV infection within a supportive environment. Equal access to basic care and services is emphasized for all persons infected and affected by HIV/AIDS. Similarly, gender consideration has been considered central to the development of programs and interventions, and due consideration is given to universal precautions to counteract the possibility of HIV transmission through medical interventions.

HIV testing is considered as voluntary with guaranteed confidentiality and adequate pre- and post- test counseling both in the public sector and the private sectors. Emphasis is given to the participation of the people living with HIV/AIDS in the programs including formulation of policies, strategies, programs and projects. The major strategies of the government for STI/HIV/AIDS prevention, control and management are follows:

- Prevention and control of STIs and HIV infection among vulnerable people including female sex workers (FSWs) and their clients, injecting drug users (IDUs), mobile populations, (especially migrants to India), and men who have sex with men and prisoners;
- Prevention of new infections among young people;
- Ensuring the availability and accessibility of care and support services for all people infected and affected by HIV/AIDS;
- Expansion of the monitoring and evaluation frame-work through evidence-based effective surveillance and research; and
- Establishment of an effective and efficient management system for an expanded response

Action Areas

5.5.1 Prevention of STIs and HIV infection among vulnerable people

Female Sex Workers (FSWs) and their Clients

Four areas including, the creation of an enabling environment, STI management and behavioral change through better IEC/BCC activities (syndromic management of vaginal discharge and genital ulcers, and condom promotion); capacity building; and empowerment along with research as guide; and modification of potential intervention are identified for the prevention and control of STI/HIV/AIDS among female sex workers and their clients.

Injecting/Intravenous Drug Users (IDUs)

Major action areas (identified by HMG/N) of STI/HIV/AIDS prevention, control and management among IDUs are creating an enabling environment, harm minimization, demand reduction, and care and support services.

Mobile Populations

The major areas identified for STI/HIV/AIDS prevention, control and management among mobile population are research (on factors leading to economic migration and trafficking of girls and women, mobility pattern and vulnerability), address vulnerability and behavior change, and the creation of an enabling environment.

Men Who Sex with Men (MSM)

To create an enabling environment and to address vulnerability and behavioral change are the major areas identified with regard to the homosexuals.

Prisoners

Stress is laid on creating an enabling environment on a broad perspective and providing IEC/BCC and support services for STI/HIV/AIDS prevention, control and management among prisoners.

5.5.2 Prevention of New Infections among Young People

HIG/N HIV/AIDS strategy focuses on creating a supportive policy and community environment; awareness raising and behavior change through IEC activities; providing youth-friendly services through clinics and information through the establishment of youth information centers; and enhancing young people's knowledge of STI/HIV in formal and non-formal education settings, for the prevention of new STI/HIV infections among young people.

5.5.3 Ensure Availability and Accessibility of Care and Support for the HIV/AIDS Affected

The major action areas identified by the government are to reduce the stigma surrounding people living with HIV/AIDS; voluntary confidential counseling and testing for selected groups; community and home based care and support; medical services (establish regional centers for diagnostic treatment and care), prevention of mother-to-child transmission, (expand PMTCT facilities in selected locations); blood safety and expansion of voluntary counseling and testing (VCT) services.

5.5.4 Expansion of Monitoring and Evaluation Frame-work through, Evidence-based Effective Surveillance and Research

National HIV/AIDS strategy gives due emphasis to enhanced monitoring and evaluation including regeneration of surveillance, measure behavioral changes, and behavioral and contextual research on vulnerability to STI/HIV/AIDS.

5.5.5 Establishment of Effective and Efficient Management System for an Expanded Response

The major areas identified to expand the response are: development of HIV/AIDS leadership at the highest level (National AIDS Council chaired by the Prime Minister), establishment of public-private partnership at national level, and start of a Nepal trust fund to fight HIV/AIDS.

6. IPPF HIV /AIDS Policy

IPPF has demonstrated its commitment to fight HIV/AIDS in the mid 1980s and has established an HIV/AIDS Prevention Unit at its central office. It recognizes its member family planning associations as pioneers in sexual and reproductive health and claim that are in a key position to work in the field of HIV/AIDS. IPPF's Strategic Plan, (Vision 2000, developed in 1992) stressed the right of women, men and young people to the highest possible level of sexual and reproductive health. STI/HIV/AIDS has been an important part of SRH and a priority area of IPPF. It emphasizes men's role in the prevention and control of STI/HIV/AIDS .IPPF has reaffirmed its commitment to address the issue in its global STI/HIV/AIDS policy, which was amended by the Governing Council in May 2001. Congruently, IPPF published a HIV/AIDS advocacy guide in June 2001 and distributed to its member associations.

7. SARO Workshop on STI/HIV/AIDS

The South Asia Regional Office (SARO) of IPPF organized a South Asia Regional Workshop in India on 'Strengthening HIV/AIDS Programs in Family Planning Associations in November, 2001 as an immediate response to address the growing challenge of STI/HIV/AIDS in the region. The workshop-developed regional STI/HIV/AIDS strategies are as given below:

- Establishment of a SAR advocacy group to generate support from policy makers, decision makers, opinion leaders and the media, to address the multi-dimensional health, socio-economic, ethical and human rights issues related to HIV/AIDS epidemic;
- Enhancement of the capacities of FPAs to respond to the epidemic through upgraded advocacy and counseling services, behavior change communications programs, life skills education, and interventions for vulnerable groups and people with high risk behavior;
- Set-up of a regional mechanism for mobilizing resources which will involve the governments of SAR countries, the corporate sector and other donors; and
- Tightening the network linking FPAs, government and non-government organizations working in the field of HIV/AIDS.

8. STI/HIV/AIDS Prevention, Control and Management Experience of FPAN

The first case of HIV/AIDS in Nepal was reported in 1988. FPAN reacted immediately and translated a book entitled "AIDS," written by Gill Garden and Tony Clauda, into Nepali. The Nepali translation was reprinted (1990) and distributed to health workers, policy makers and general public to create awareness against HIV/AIDS. After this, HIV/AIDS prevention component was introduced, on a small scale though, into all training and counseling programs, FP/MCH/RH service delivery centers, and HIV/AIDS focused IEC materials were produced, distributed, screened, and broadcast through its network. The HIV/AIDS specific project was first introduced in the Chitwan district in 1996 and it was expanded to the Makwanpur, Rupandehi, Nawalparasi, Sarlahi, Saptari, Morang, Sunsari and Jhapa districts, targeting the vulnerable groups of people. Program activities are replicated in other districts based on experience gained from the pilot districts. However, shortage of resources has constrained the expansion of the program activities to untouched.

FPAN has been providing STI diagnosis and treatment services to 24,000 people since 1997 through its clinic outlets. It trained 1,300 clinical and non-clinical staff members (GOs, NGOs and its own) on STI case management 1997-2001. It provides FP services to 0.3 million couples, MCH education and services to 0.8 million people, HIV/AIDS education to 0.1 million, lab services to 0.05 million people, and counseling services to 0.05 million people annually. Similarly, it has published/produced 43 various print and audio-visual IEC materials including 5 on MCH, 13 on FP, 15 on human sexuality, 2 on safe abortion and 8 on STI/HIV/AIDS prevention and control. It produces 200,000 copies (approx.) of IEC materials covering FP, MCH, sexuality, safe abortion and STI/HIV/AIDS prevention.

9. Strategic Plan of FPAN

FPAN implemented some STI/HIV/AIDS projects jointly with AIDS Cap, FHI, UoH and a few independent projects supported by JTF in the selected districts. However, HIV/AIDS prevention and control was not a priority area in the past. It was integrated with reproductive health services as an integral component of RH. Program activities like STI diagnosis and treatment, general counseling, education and information dissemination existed in regular SRH programs which need to be consolidated and taken forward in a strategic manner for effective STI/HIV/AIDS prevention, control and management.

In the newly formulated 5 years' Strategic Plan of FPAN (2001-2005), there is no separate goal to be attained on STI/HIV/AIDS prevention, control and management. It is closely tied up with all the programmers of Sexual and Reproductive Health .

10. SWOT Analysis of FPAN

FPAN which has been a leading national NGO in SRH has strengths and weaknesses regarding STI/HIV/AIDS prevention, control and management. The strengths, weaknesses, and opportunities and threats are briefly examined below:

10.1 Strengths

- Good coordination among GOs, NGOs, INGOs through NGOCC chaired by FPAN
- Well developed infrastructures at national, district and grass-roots level (as of June 2002, it has 800 service outlets in 34 districts, one central and three regional stores for contraceptives and medicine storage, 32 vehicles (car, van, pick up, trucks), 111 motorbikes, 977 bicycle for supervision and monitoring)
- Large geographical coverage with a population of 8 million
- Volunteer mobilization at national, district and grass-roots levels (a strength of 13, 000 volunteers)
- Dedicated field workers (1,569 Reproductive Health Female Volunteers and Village Workers) who provide RH and HIV/AIDS education at doorsteps.
- Experience of staff members and volunteers of STI/HIV/AIDS prevention
- Well trained clinical staff for STI syndromic case management and testing facilities at district headquarters (in 9 districts)
- Committed staff and volunteers working on STI/HIV/AIDS prevention (a strength of 442 fulltime professional and clinical staff members)
- Long-term vision in the field of reproductive health including HIV/AIDS
- FPAN is working with 9 other donor agencies apart from IPPF, and the number of donor agencies supporting its program activities is growing.
- Clinic and office buildings of its own in the Capital and district headquarters (program districts)

10.2 Weaknesses

- Inadequate IEC/BCC material (on STI/HIV/AIDS) production
- Lack of HIV testing facility

- Inadequate counseling on HIV/AIDS
- Shortage of trained manpower in specialized areas of HIV/AIDS
- No clear-cut action plan on HIV/AIDS (in the past)
- No special section to deal with HIV/AIDS programs in the Association
- Shortage of resources for specialized HIV/AIDS services (to establish lab for testing services)

10.3 Opportunities

- HMG/Nepal formulated clear-cut policies and strategies for HIV/AIDS prevention and control in 2002 and has invited NGOs and the private sector to supplement and complement its national programs.
- There are some national level NGOs with extensive network at district level, working on HIV/AIDS, and FPAN is a leading NGO working in this field (apart from RH).
- Limited program intervention related to HIV/AIDS in the country
- Favorable environment to get technical back-up from Country Coordination Mechanism/Nepal (CCM/N) and IPPF
- FPAN has higher level of coordination and networking with more than 133 community-based organizations (CBOs) at field level it will be an advantage to mobilize them for HIV/AIDS prevention and control in the future.
- Potential donors are looking for partner organizations willing to work on STI/HIV/AIDS prevention, control and management.

10.4 Threats/Challenges

- RH and HIV/AIDS programs in the public and non-profit NGO sector are highly subsidized in Nepal due to the low economic status of the community people. Therefore, there is a great challenge for sustaining the HIV/AIDS programs after the external support is phased out.
- Low rate of literacy, specifically among rural women
- Seasonal migration of people from backward rural area to regional cities in the country and bordering cities of India proliferate HIV/AIDS in rural areas of Nepal because the migrants work as a breeding population in search of off-farm activities.
- The HIV/AIDS positive is fairly high among FSWs and IDUs in Nepal but it is difficult to identify their residence and to reach them with intervention programs.

11. Capacity Analyses of STI/HIV/AIDS Intervention Nepal

There are 10 INGOs, 13 national level NGOs, five UN agencies including UNAIDS working directly on HIV/AIDS prevention, control and management programs in Nepal. Similarly, a few aid agencies are co-operating indirectly by giving technical and financial support in this endeavor. Besides, the Ministry of Health and its National Center of AIDS and STD Control, and 16 other ministries have been participating directly and indirectly in the efforts for HIV/AIDS prevention and control. However, their participation is limited to attending workshops on HIV/AIDS. Some of the ministries have included HIV/AIDS as an integral part of population and reproductive health in their training programs. Some of them have prepared plans of action on HIV/AIDS but their implementation is constrained by shortage of budget. Besides these ministries and national level organizations, there are a good number of local NGOs and CBOs working on HIV/AIDS in small areas at village level but their exact number is not known. There are also 14 central level NGOs, consulting firm and research and teaching institutions related on population activities in Nepal but their activities are mainly centered on teaching and mini-scale research based on resources provided by the donor agencies.

About a dozen of HIV/AIDS prevention, control and management projects and their sub-projects funded by different donor agencies and INGOs operationalized at micro level were completed and about nine such short-term projects are currently being implemented in the country. However, their geographical coverage is too small and they have not been able to demonstrate much wider impact on a broad range of vulnerable and high risk people.

11.1 Organizations Working with Migrant People

There are a few organizations providing STI/HIV/AIDS education and services to migratory populations in Nepal. Government organizations include NCASC, Ministry of Local Development, and Ministry of Women, Children and Social Welfare, and non-governmental organizations include mainly FHI and NGO partners, UNAIDS, Save the Children/US and NGO partners, Save the Children/UK and NGO partners, Maitai Nepal and ABC Nepal have limited programs on HIV/AIDS prevention, control and management among migratory people in some selected pockets.

11.2 Organizations Working with Female Sex Workers (FSWs)

There are only a few organizations working with female sex workers (FSWs) for preventing them from HIV/AIDS infection in Nepal. The major organizations involved in this area are National Center of AIDS and STD Control (NCASC), FHD, FHI and its NGO partners, UoH and its NGO partners, Save the Children/US and UNAIDS. They have been implementing two types of programs, the first type is solely devoted to preventing and controlling STI/HIV/AIDS as is being done by NCASC, FHI, UoH and UNAIDS. The second type is integrated with the RH package including STI/HIV/AIDS prevention and control. The Department of Health Services is a leading agency for this type. The present capacity of the organizations is minimal. It is estimated that about 200,000 Nepalese girls and women work as FSWs India and 20,000 in Nepal including 7,000 in the Kathmandu valley (MEH and REGHED, 2000) and 500-1500 each in other regional towns of Nepal. It is reported that the intervening agencies had contracted and educated only 3,550 FSWs in campaigns against STI/HIV/AIDS in the past. Besides, the organizations involved in HIV/AIDS prevention and control among FSWs have been implementing awareness rising programs and trying to create supporting environments. Apparently, effective programs are required for their behavioral change and the clinical services thus have to be provided.

11.3 Organizations Working with Injecting Drug Users (IDUs)

There are four NGOs- namely, Life Giving and Life Saving, Freedom Center, Richmond Fellowship and Asara Sudhar Kendra- and one government agency in the Kathmandu Valley, Punarjivan Kendra in Dharan and Naulo Ghumti in Pokhara are directly involved in STI/HIV/AIDS prevention among IDUs in Nepal. There are about 30,000 IDUs in Nepal and they have reached only less than 5 percent of IDUs. Most of the efforts are concentrated in the Kathmandu valley, though limited information and services are provided also to IDUs living outside the valley. Since their existing capacity is not enough to meet the needs of this community, the program designed for them are restricted basically to harm reduction. There is shortage of trained manpower as well as resources in both the government and NGO sectors for the treatment and rehabilitation of this group.

11.4 Organizations Working with People Living with HIV/AIDS (PLWA)

Only a few PLWAs are receiving support from the government or NGOs. Some NGOs like Maiti Nepal, ABC Nepal and WOREC are reported to provide some degree of care and support to HIV/AIDS infected women. They provide such services on a temporary basis owing to the minimal resources available to them. Only Maiti Nepal has opened a small rehabilitation centre with a capacity of accommodating 30 women in the eastern district of Jhapa. There is a tremendous need to increase care and support services to PLWAs.

11.5 Organizations Working with Migrant and Bonded Children

There are a few organizations working for the welfare of migrant and bounded children. They advocate abolition of child labor and accentuate their rights, and improvement in their working conditions. A few organizations, e.g. CWIN, ILO, Save the Children/US, and Save the Children/UK are working with migrant and bonded children. However, their priority area is not STI/HIV/AIDS prevention and control among these target groups. There is need to address the requirements of these groups of people.

11.6 Organizations Working with Street Children

CWIN is working with street children on their rights to education and health and against sexual abuse and trafficking. It provides education and awareness to these children, with a limited rehabilitation capacity though, in the Kathmandu valley. However, there is no other organization dedicated to street children in other regional towns.

11.7 Organizations Working with Refugees

A few INGOs such as Save the Children/UK, International Red Cross, Amnesty International, Lutheran World Services, and national NGOs like Nepal Red Cross Society and United Nations Commission for Refugees are engaged in providing basic needs like food, shelter and health facilities. However, HIV/AIDS prevention and control does fall within their priority area in spite of the fact the refugees are vulnerable to HIV/AIDS infection.

11.8 Adolescents and Youths

In addition to regular programs of the Department of Health Services, NCASC, Ministry of Education, and Curriculum Development Center; a few NGO and INGOs including Nepal Red Cross Society, Save the Children/UK, Save the Children/USA, CEDPA, FHI, UoH, B. P. Memorial Health Foundation, Youth Power Nepal and Sport Federation Against Drugs and HIV/AIDS; and four other international agencies e.g. UNICEF, UNFPA, JICA and United Mission conduct some pocket programs which educate adolescents and youths on HIV/AIDS.

The Ministry of Education has introduced a basic course on STI/HIV/AIDS into the school curriculum and prescribed a textbook entitled "Our Health and Physical Education". The textbook includes brief descriptions of the modes of HIV/AIDS transmission, precautionary

measures to be undertaken to prevent HIV/AIDS infections, and symptoms of HIV/AIDS infection. The course is mandatory to Class 6 to Class 9 and is elective to Class 10. However, the course is compulsory for public schools and private boarding schools are not obliged to follow the course in the lower secondary curriculum. All boarding schools do not teach this course in the lower secondary grades and, as a result a large segment of the adolescent population enrolled in the private boarding schools in urban areas is deprived of information about HIV/AIDS.

11.9 Organizations for Other Vulnerable Groups

There are no particular organizations involved with other vulnerable and high risk groups of people such as construction workers, industrial laborers, urban slum dwellers, hotel and restaurant workers, armed force and police recruits, migratory students and job seekers in the city centers, and out-migrants and prisoners.

11.10 Condom Promotions and Distribution for STI/HIV/AIDS Prevention and Control

There are four channels identified for condoms promotion/distribution for STI/HIV/AIDS prevention and control in Nepal which include Department of Health Services and its service outlets throughout the country; social marketing through CRS and NGOs and their service outlets; and commercial channel, particularly medical shops and pharmacies.

12. Major Gaps in the Existing National Programs

The National HIV/AIDS strategy has paid special attention to high risk groups of people- particularly female sex workers (FSWs), injecting drug users (IDUs), periodic and seasonal job migrants, men who have sex with men, prisoners, and adolescents and youths. However, the national strategy is relatively silent on other potential high risk group of people vulnerable to HIV infection, e.g. migrant students, street children, bonded laborers, refugees, construction workers, industrial laborers, hotel/restaurant workers, army and police people, and women and girls living in urban slums. Similarly, the strategy does not address adequately the need of pre- and post- counseling for HIV/AIDS prevention, control and management at community and clinic levels. HIV/AIDS diagnosis and treatment services are expected to be made available in places where the government has already developed some infrastructure and where the role of the private sector and NGOs is sought for rehabilitation of people already infected with HIV/AIDS. The program activities conducted by the government sector are scattered with minimal rural coverage and the activities conducted by the NGOs and private sectors are localized in particular pockets due to resource constraint. There is a tremendous need to expand the HIV/AIDS prevention, control and management program to all segments of the population already vulnerable and potentially vulnerable to HIV infection.

SECTION B HIV/AIDS STRATEGY OF FPAN

FPAN's Goal, Objectives, Strategies and Action Areas on HIV/AIDS Prevention, Control and Management

1. Capacity Building of FPAN for STI/HIV/AIDS Prevention, Control and Management

The institutional capabilities of GOs, NGOs and the private sector to respond to the growing epidemic of HIV/AIDS are less than sufficient. The existing institutions in all sectors need to be streamlined in order to make them capable enough to respond to the growing demand for STI/HIV/AIDS services. FPAN also has to enhance its institutional capability to integrate STI/HIV/AIDS prevention, control and management programs on a larger scale into its existing service network.

GOAL 1

Improve the institutional capacity of FPAN to provide education, counseling and quality STI/HIV/AIDS services, and strengthen resource development for sustainability of its programs.

Objective 1

Boost the managerial capabilities of FPAN's volunteers and staff members and other partners (NGOs and CBOs) working on STI/HIV/AIDS for quality services.

Action Areas

- a. Identify the training needs of FPAN and other partner organizations to upgrade and develop specialized skills of concerned service providers

- b. Conduct exchange visits inside and outside the country to share experiences to replicate successful programs
- c. Provide knowledge and skills to stakeholders (adolescents and youths, peer and women groups, etc.) to promote STI/HIV/AIDS services
- d. Provide necessary knowledge and skills to the service providers (both clinical and non-clinical) for ensuring quality of the services

Objective 2

Strengthen resource development efforts for the sustainability of the programs.

Action Areas

- a. Identify additional possible sources of funding and initiate the cost recovery approach
- b. Implement partnership and collaborative programs with other agencies working in the field of STI/HIV/AIDS
- c. Encourage local participation for fund raising
- d. Initiate social marketing of condom

Objective 3

Develop FPAN's central office as a Counseling Training Centre to meet the training requirements of FPAN's branch/project on STI/HIV/AIDS

Action Areas

- a. Establish STI/HIV/AIDS a Counseling Training Centre at FPAN's central office
- b. Develop a core group of Master Trainers for counseling on STI/HIV/AIDS
- c. Promote voluntary counseling services on STI/ HIV/AIDS
- d. Develop and upgrade curriculums, manuals and guidelines for counseling training programs relating to STI/HIV/AIDS
- e. Provide counseling training to service providers of FPAN and other agencies

Objective 4

Review the organizational structure of the FPAN to ensure effective program implementation

Action Area

- a. Review the existing organizational structure at all levels and establish a new section at FPAN headquarters for effective implementation of STI/HIV/ AIDS programs

Objective 5

Strengthen supervision, monitoring, evaluation and information management systems and develop an appropriate feedback mechanism

Action Areas

- a. Develop a new Management Information System (MIS) relating to STI/HIV/AIDS and integrate it into FPAN's Information Management System
- b. Conduct surveys/studies to identify the training needs of FPAN staff members and volunteers, and partner organizations working on STI/HIV/AIDS
- c. Conduct periodic surveys and research studies to identify possible areas for program intervention
- d. Conduct KAP study for effective program implementation
- e. Conduct evaluation studies to assess efficiency and effectiveness of the programs
- f. Strengthen the supervision and monitoring systems and develop appropriate feedback mechanism

Strategies

1. Enhance the technical and managerial capabilities of FPAN staff members and volunteers by organizing trainings, workshops, seminars, observation and experience sharing.
2. Increase income generation by expanding charging schemes in different services and fund raising programs.
3. Lobby with HMG/N to recognize FPAN central headquarters as a STI/HIV/AIDS counseling training center and equip it with human and material resources.
4. Enhance the feedback mechanism through program and system reviews.

2. BCC, Advocacy and Counseling for Behavioral Change

The role of BCC (behavior change communication), advocacy and counseling is vital in bringing desired change in knowledge, attitude and practice of an individual or a group. As prevention and control is the only effective treatment for the rapidly growing HIV/AIDS, because it has no cure, good BCC can be extremely helpful. So the first thing that needs to be done is to identify the target groups. Depending on the age group, education, interest and needs of different groups of people, appropriate BCC messages should be developed. Use of appropriate language, pictures and a total desirable impression after putting all them together deserves a great effort. Specially in an area like STI/HIV/AIDS, which is related to emotions, sentiments and certain social, cultural compulsions of people, special care and attention is needed in counseling. Special skills need to be acquired by the counselors. They need correct and complete information and sense of security and empathy. Getting informed does not necessarily mean that people have changed their attitude and behavior. It is a process and so takes time and depends on the success of BCC materials, skill and behavior of the people involved in counseling. FPAN aims to focus its BCC activities particularly on adolescents and youths.

GOAL 2

Promote safer sexual practices and responsible behavior in all target groups.

Objective 1

Ensure behavioral change towards STIs / HIV / AIDS prevention, control and management

Action Areas

- a. Promote universal precaution against HIV/AIDS
- b. Focused program activities for different vulnerable and high risk groups of people including migrant populations (moving across and outside the country plus periodic and seasonal migrants) and people such as transport workers, army and police cadre members, female sex workers and their clients, adolescents and youths, intravenous drug users, industrial laborers, construction workers, street children, migrant and bounded children, refugees, hotel and restaurant employees, prisoners, trafficked women and girls, urban slums and migrant students. However, among these groups, adolescent and youth will be the primary target groups and others as the secondary target groups.
- c. Provide BCC skill to service providers clinical as well as non-clinical
- d. Review the existing BCC training and advocacy programs developed by various organizations and FPAN, and develop appropriate BCC for adolescents and youths
- e. Implement effective programs and messages for behavioral change supported with monitoring, follow-up and back-up services
- f. Select appropriate communication media and channels for message dissemination (e.g. electronic, print, audio-visual, etc.) for message dissemination.

Objective 2

Seek support, commitment and recognition from policy makers and the general public to overcome discriminatory policies and practices associated with STI/HIV/ AIDS prevention, control and management

Action Areas

- a. Review the existing discriminatory policies, practices and other barriers to STI/HIV/AIDS prevention, control and management to ensure conceptual clarity pertaining to advocacy issues, targeted audience and expected results.
- b. Strive for opinion building (in general people and policy makers) conducive to effective policies and program intervention.
- c. Encourage mobilization of resources and commitment to the implementation of the STI / HIV programs.
- d. Initiate and support campaigns for rising anti retroviral drugs widely and cheaply available.
- e. Encourage replication of good policies and practices in the field of STI/HIV/AIDS
- f. Minimize stigmatization of HIV / AIDS affected people and uphold the rights of HIV-positives
- g. Discourage sexual subordination of women and encourage responsible sexual behavior of men
- h. Strengthen the ties between concerned GOs, NGOs, CBOs and people living with HIV/AIDS
- i. Involve people living with HIV / AIDS in education and prevention and in control and management where they have a key role to play

Strategies

1. Advocate for safer sexual practices and responsible behavior through mass media, inter personnel communication and lobbying.
2. Advocate the abolition of discriminatory policies and practices and other hindrance to STI/HIV/AIDS prevention, control and management at all levels through media campaign, lobbying, workshop, seminars, and personal interactions.

3. STI/HIV/AIDS Diagnosis, Treatment, Care and Support Services

The present HIV/AIDS situation in Nepal has not reached the uncontrolled level. Even then HIV/AIDS incidence is increasing alarmingly. The current response to HIV/AIDS prevention, control and management from government, non-government and private sectors are limited compared to the growing demand for services. Realizing the threat, HMG/N has formulated National HIV/AIDS Strategy with an open invitation to NGOs and the private sector and its development partners to complement and supplement its national programs. FPAN has been a responsible National NGO committed to promote SRH services in the country. It also is committed to expand its service delivery, thereby supporting HMG/N to fight against STI/HIV/AIDS. Emphasis will be given to enhancing the referral system. Suspected cases in the rural hinterlands will be referred to appropriate health facilities.

GOAL 3

Contribute to reducing STI/HIV/AIDS incidence in Nepal.

Objective 1

Provide quality STI/HIV/AIDS services to vulnerable and high risk populations in Nepal.

Action Areas

- a. Improve and expand STI/HIV/AIDS diagnosis facilities to selected FPAN's clinics
- b. Bring up STI counseling services to sub-centers, outreach clinics and community clinics
- c. STI counseling, diagnosis and treatment services at branch/project clinics to district headquarters
- d. Initiate HIV voluntary counseling services in selected district level service outlets
- e. Provide care and support to people living with HIV/AIDS (PLWA) and link them with rehabilitation centers
- f. Prevent HIV transmission from mother to child
- g. Develop a referral mechanism in government and NGO facilities at appropriate level for HIV diagnosis and treatment services.

Objective 2

Provide quality STI/HIV/AIDS counseling services, in a gender and youth friendly environment to vulnerable and high risk groups.

Action Areas

- a. Insist on increase the use of condom as a STI/HIV preventive measure
- b. Condom programming for dual protection (Diseases and pregnancy)
- c. Promote gender equity among all segments of the population for responsible sexual behavior (between the sexes)
- d. Institutionalize STI/HIV/AIDS counseling services in educational programs at youth centers and work places

Strategies

1. Increase access to counseling, diagnosis, treatment, and support services by integrating STI/HIV/AIDS activities and programs into FPAN's existing service centers at all levels
2. Expand geographical coverage and STI/HIV/AIDS program activities, focusing on densely populated southern boarder areas, migrants and other vulnerable and high risk groups of people.
3. Provide quality STI/HIV/AIDS counseling services to the target groups by establishing counseling centers

Coordination and Networking

Sentinel Survey on HIV/AIDS Situation in Nepal (Richoi Associates, 2000) and Response Analysis on HIV/AIDS in Nepal (MEH and REGHED, 2000) have indicated that HIV/AIDS has grown from a "low-level epidemic" to a "concentrated epidemic" in Nepal. Inefficient functional coordination and networking of the government, non-government organizations and private sector interventions have demonstrated minimal impact on HIV/AIDS prevention and control. Proliferation of HIV/AIDS infection among new people, particularly the vulnerable groups with high risk sexual behavior, is underway and the burden of disease in the health sector is growing alarmingly. It has been extremely difficult to detect HIV/AIDS cases due to stigma of PLWHA on the one hand and the inadequacy of the efforts made by government and non-governmental sectors due to the limitedness of trained manpower and resources available in the country on the other. Therefore, a multi-sectoral effort has been a felt need for coping with the growing HIV/AIDS epidemic, optimizing the limited resources available in the country. FPAN will put every effort for coordinated intervention to reduce the growing HIV/AIDS incidence in Nepal.

GOAL 4

Establish multi-sectoral coordination, functional relationship and networking between different organizations and institutions within and outside the country at various levels. This will help share the resources and experiences and collaboration for the sustainability of HIV/AIDS prevention, control and management programs

Objective 1

Establish coordination and functional relationship with the central government and local governments for sharing resources and experiences on HIV/AIDS prevention, control and management

Action areas

- a. Identify and implement joint training programs essential for service providers to increase their knowledge of and skills in HIV/AIDS service delivery on a cost sharing basis
- b. Review and diagnose the expertise of FPAN and government agencies in IEC/BCC materials production (to improve the quality of HIV/AIDS related IEC/BCC materials)
- c. Review HIV/AIDS prevention and control activities implemented by FPAN and government agencies and replicate successful models/activities reciprocally.
- d. Integrate FPAN's service statistics into HIMS to calculate aggregate service statistics
- e. Identify and implement collaborative programs with local governments (particularly VDC, Municipality and DDC) on a cost sharing basis
- f. Sharing expertise in HIV/AIDS service delivery and research

Objective 2

Establish co-ordination and functional relationship with INGOs and national level NGOs working on HIV/AIDS prevention, control and management for sharing resources and experiences

Action Areas

- a. Identify possible areas of collaborative intervention with national level NGOs and INGOs to increase program coverage and reach with all vulnerable groups of people
- b. Identify the most successful model or activity, share experience and replicate appropriate model/activity
- c. Identify research needs in consultation/collaboration with involved organizations and send the research outcomes to all stakeholders and partner organizations
- d. Identify areas of expertise in IEC/BCC material production and produce effective IEC/BCC materials on a cost sharing basis

Objective 3

Establish relationship with local and international funding organizations, aid agencies, and research and training institutions for resources and technical assistance

Action Areas

- a. Report FPAN's experience of HIV/AIDS prevention and control to local and international funding organizations and aid agencies and request them for technical assistance and material and financial support for program intervention
- b. Establish relationship with international research/training institutions for technical assistance- particularly trainers, training manuals, and cross-country experience of HIV/AIDS prevention and control

Objective 4

Establish coordination, functional relationship and networking with professional organizations and institutions within the country for program implementation and research

Action Areas

- a. Establish functional relationship with professional organizations (e.g. labor, transport, teacher, women, lawyer, student/ youth) for advocacy and joint implementation of HIV/AIDS programs
- b. Establish linkages with research institutes and universities for research and surveillance

Objective 5

Establish functional relationship and networking with CBOs and local NGOs working at community level for the sustainability of HIV/AIDS prevention and control programs

Action Areas

- a. Identify the community level CBOs and local NGOs interested to work on HIV/AIDS prevention and control in FPAN's operational districts and establish functional relationship to implement preventive HIV/AIDS programs at community level
- b. Develop a federated networking among CBOs and local NGOs at district level for strong advocacy and exchange of idea and experience between them
- c. Develop the institutional capability of CBOs and local NGOs for preparing them to take over the program activities at community level after of the projects/programs will terminate

Strategies

1. Enhance coordination and functional relationship with the central government, local governments, INGOs, national and local level NGOs, CBOs, professional associations and groups through networking, correspondence, meeting, workshops, seminars, exchange visits, etc.
2. Increase the access to HIV/AIDS Coordination Council at the central level and HIV/AIDS Coordination Committee at the district level by lobbying
3. Increase the membership size and expand the role of the Non-governmental Organization Coordination Council (NGOCC), chaired by FPAN, for more collaborative programs reactivate the council.

5. Strategy Implementation Mechanism

FPAN will implement the strategy in an integrated way on a priority basis. STI/HIV/AIDS prevention, control and management will be integrated within the existing central, branch and project network. FPAN will give the first priority to institutional capacity building in order to enhance the knowledge and skills of its staff members to provide quality services through its network. Clinical facilities will be upgraded based on available resources in selected locations, to provide clinical services. The second priority will be given to BCC, advocacy, and counseling for behavioral change of the already vulnerable and potentially vulnerable groups of people. The third priority will be given to STI/HIV/AIDS diagnosis, treatment, and care and support services. Coordination and networking with GOs, INGOs, NGOs, CBOs, and other partner organizations and stakeholders will be strengthened at all levels in the implementation of the strategy. FPAN will try to identify additional donors for funding for the implementation of the proposed STI/HIV/AIDS strategy. It will continue the implementation of its existing reproductive health programs on the financial support being provided by IPPF and other bilateral donors. However, it will make an effort to integrate STI/HIV/AIDS programs into the existing service delivery system.