



# Advancing Surveillance, Policies, Prevention, Care and Support to Fight HIV/AIDS Project

(October 2006 - September 2011)



## End of Project Report



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## **Submitted by**

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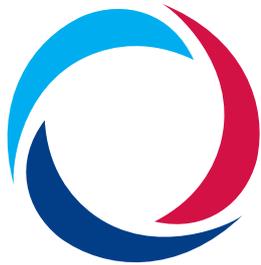
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## GLOSSARY OF ACRONYMS

AIDSCAP	AIDS Control and Prevention Project
AMDA	Association of Medical Doctors of Asia
ART	Anti-Retroviral Therapy
ASHA	Advancing Surveillance, Policies, Prevention, Care and Support to Fight HIV/AIDS
APRO	Asia Pacific Regional Office
CABA	Children Affected by AIDS
CB-PMTCT	Community Based-Prevention of Mother to Child Transmission
CCU	Consistent Condom Use
CHBC	Community and Home-Based Care
CM	Community Mobilizer
COFP	Comprehensive Family Planning
CS&T	Care, Support and Treatment
DACC	District AIDS Coordination Committee
DBS	Dried Blood Spot
DHO	District Health Office
DIC	Drop-in Center
DoHS	Department of Health Services
DPHO	District Public Health Office
DQA	Data Quality Audit
EID	Early Infant Diagnosis
EPC	Essential Package of Care
EQAS	External Quality Assurance System
FHD	Family Health Division
FSW	Female Sex Worker
FY	Fiscal year
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GIPA	Greater Involvement of People with AIDS
GIS	Geographic Information System
HSCB	HIV/AIDS and STI Control Board
HQ	Headquarters
IA	Implementing Agencies
IBBS	Integrated Biological and Behavioral Surveillance
IDU	Injecting Drug User
IHS	Integrated Health Services
IMPACT	Implementing AIDS Prevention and Care Project
M&E	Monitoring and Evaluation
MARP	Most At Risk Population
MIS	Management Information System
MoHP	Ministry of Health and Population
MSM	Men Who Have Sex with Men
NAP	National Action Plan
NAP+N	National Association of People Living with HIV/AIDS in Nepal

NCASC	National Centre for AIDS and STD Control
NHSP-II	National Health Sector Implementation Plan II
NPHL	National Public Health Laboratory
OE	Outreach Educator
OI	Opportunistic Infection
PCR	Polymerase Chain Reaction
PE	Peer Educator
PEP	Post Exposure Prophylaxis
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
QIP	Quality Improvement Project
QoL	Quality of Life
S&D	Stigma and Discrimination
SI	Strategic Information
SOP	Standard Operating Procedure
STI	Sexually Transmitted Infection
TA	Technical Assistance
TIP	Trafficking in Person
ToT	Training of Trainer
TUTH	Tribhuvan University Teaching Hospital
TWG	Technical Working Group
UCAAN	Universal Access for Children Affected by AIDS in Nepal
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
UNODC	United Nations Office of Drugs and Crime
USAID	United States Agency for International Development
USG	US Government
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

## EXECUTIVE SUMMARY



The Advancing Surveillance, Policies, Prevention, Care and Support to Fight HIV/AIDS (ASHA) Project, funded by the United States Agency for International Development (USAID) and implemented by FHI 360 Nepal, the

Association of Medical Doctors of Asia (AMDA) Nepal, Futures Group (2006-2009), and more than 70 other national and local NGO partners, supported Nepal's National HIV and AIDS program from October 2006 to September 2011. Operating under USAID Cooperative Agreement #367-A-00-06-00067-00 for Strategic Objectives #9 and #11, ASHA Project operated in close collaboration with the Government of Nepal and other key stakeholders by working actively to respond to the country's concentrated epidemic. The total USAID funding for the five-year period was US\$ 21,714,948.

ASHA Project's goal was to contain the HIV/AIDS epidemic in Nepal and to mitigate the effects of HIV on those infected and affected by HIV and AIDS, while its main objective was to increase the availability and use of HIV prevention and care services by those most at risk and people living with HIV (PLHIV). Programming was based around five result areas:

- Reduce HIV transmission through targeted prevention interventions within specific high-risk and vulnerable populations.
- Build capacity of Government of Nepal and civil society to manage and implement HIV and AIDS activities and to inform policy formulation at national, local and community levels to reduce stigma and discrimination and enable access to services.
- Improve planning, collection, analysis and use of strategic information by stakeholders to facilitate a more effective and targeted response to the HIV/AIDS epidemic.
- Increase access to quality care, support and treatment services through public, private and nongovernmental sources for PLHIV and their families.
- Create linkages among stakeholders and support national coordination of Nepal's cross sectional

HIV and AIDS supported program.

The project design supported Nepal's National HIV and AIDS strategy 2006-11 and the National HIV and AIDS Action Plan (NAP) and was implemented in collaboration with the Government of Nepal, local NGOs and community based organizations and networks to strengthen their capacity to manage targeted HIV interventions for most at risk populations (MARPs) to HIV infection including prevention, care, support and treatment activities, specifically female sex workers (FSWs) and their clients, injecting drug users (IDUs), migrant workers and their spouses and PLHIV. The geographic focus crossed all five designated regions and covered 30 districts in the Terai and mid-hills. A total of 38 districts were covered over the life of the project.

Overall collaboration and coordination with the government - Ministry of Health and Population (MoHP), Division of Health Services (DoHS), National Center for AIDS and STD Control (NCASC) and Family Health Division (FHD) - at both national and district levels has contributed to a strengthening of country ownership over the past five years.

Many people have benefitted from the direct and indirect interventions of the USAID-supported ASHA Project, which have substantially contributed to the decreasing trend in HIV and an increasing number of people with access to voluntary counseling and testing (VCT), sexually transmitted infections (STIs), anti-retroviral therapy (ART) and prevention of mother to child transmission (PMTCT) services at community level. The close collaboration that ASHA Project maintained with the government was key to the success of new interventions and innovations being adopted by NCASC and adapted into the national government system, in particular, community-based mother to child transmission, early infant diagnosis, pre-exposure prophylaxis, external quality assurance, medical waste management, community and home-based care, positive prevention and data quality audit.

Over the past five years (October 2006- September 2011) ASHA Project was able to:

- Reach 342,730 individuals (female 157,359; male 185,371) through community outreach. Of these 46,809 were FSWs; 121,953 were clients of FSWs; 5,959 were IDUs; 148,655 were male migrant workers and their spouses and 67 were men who have sex with men (MSM).
- Reach 1,466 PLHIV through positive prevention activities (778 males and 688 females).
- Provide STI screening and diagnosis services to

93,530 people and treatment to 37,251 individuals. Of those who received treatment 20,110 were FSWs; 4,769 were clients of FSWs; 349 were IDUs; 4,937 were migrant workers and their spouses; 6,761 were other female and 289 were other male.

- Provide HIV counseling, testing and results to 91,834 individuals, of whom 3,068 were HIV positive. The disaggregated data of those testing positive for HIV show 242 FSWs, 568 clients of FSWs, 369 other females, 76 other males, 593 male migrant workers, 500 spouses of migrant workers, 505 IDUs, 19 MSM and 196 children.
- Provide Palliative Care Services to 10,919 PLHIV and Essential Package of Care (EPC) services to 7,915 PLHIV.

The percentage of people diagnosed with HIV against the number of people who received VCT at ASHA Project service sites decreased from 6.8 percent to 1.7 percent over the five year period. Data show that the percentage of people who tested positive for HIV at ASHA Project sites decreased in all MARPs. The percentage of migrant workers and their spouses who tested positive for HIV decreased substantially from 16.3 percent in 2007 to 2.3 percent in 2011. Similarly, the percentage of IDUs who tested positive for HIV decreased from 14.3 percent in 2007 to 1.9 percent in 2011. The percentage of FSWs diagnosed with HIV showed a slight decrease from 1.8 percent in 2007 to 0.8 percent in 2011 and clients of FSWs also decreased from 2.1 percent in 2007 to 1.2 percent in 2011.

According to the Integrated Biological Behavioral Surveillance (IBBS) survey data, over the same period the trend in HIV prevalence among FSWs has remained fairly stable at around 2 percent in both Kathmandu valley (2004-2011) and the 22 Terai highway districts (2003-2009), while among FSWs in Pokhara valley the HIV prevalence fluctuated from 2 percent in 2004 and 2006, to 3 percent in 2008, to 1.2 percent in 2011. Consistent condom use (CCU) among FSWs in Kathmandu valley and Pokhara valley is now 75 percent (IBBS, 2011) and the data also show that 84 percent of FSWs in Kathmandu valley and 79 percent of FSWs in Pokhara valley are being reached by HIV prevention programs (IBBS, 2011). However, the data also revealed the high number of new FSWs entering sex work; about 40 percent in Kathmandu valley and 47 percent in Pokhara had begun sex work in the past 12 months, thus reinforcing the importance of prevention programs that reach these newcomers early.

The HIV prevalence among the IDUs in Kathmandu (IBBS, 2011) shows a significant decreasing trend from 68 percent in 2002 to 6.3 percent in Kathmandu valley in 2011. The Eastern Terai also show a significant decreasing trend in HIV prevalence from 35 percent in 2003 to 8 percent in 2011 and in the Western and Far-Western Terai districts there is a reported decrease from about 12 percent in 2005 to 8 percent in 2011. These optimistic trends are redefining programming for IDUs and indicate the importance of reaching new IDUs with prevention activities.



# 1. INTRODUCTION

The Advancing Surveillance, Policies, Prevention, Care and Support to Fight HIV/AIDS (ASHA) Project, funded by the United States Agency for International Development (USAID) and implemented by Family Health International – FHI 360 Nepal, the Association of Medical Doctors of Asia – AMDA-Nepal, and more than 70 other national and local partners, supported Nepal's National HIV and AIDS Program from October 2006 to September 2011. Operating under USAID Cooperative Agreement #367-A-00-06-00067-00 for Strategic Objectives #9 and #11, ASHA Project operated in close collaboration with the Government of Nepal and other key stakeholders by working actively to respond to the country's concentrated epidemic. The total funding for the five-year period was US\$ 21,714,948.

In Nepal, USAID has been a major contributor to the national HIV response for over a decade and half. Through AIDSCAP I & II, IMPACT and ASHA Project, USAID's contributions have consistently provided technical and financial support to the national HIV response and resulted in the development of epidemic-tailored interventions.

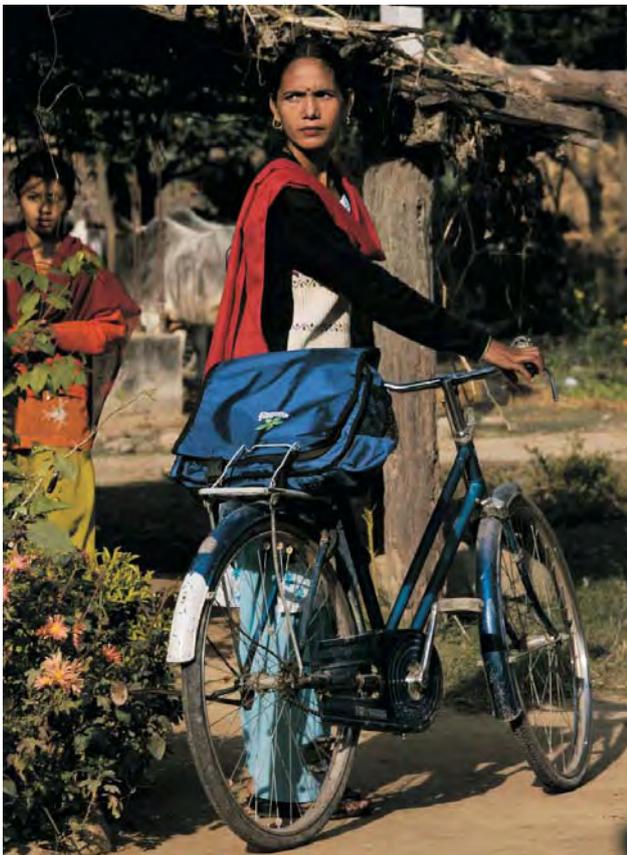


Photo: Thomas Kelly

USAID supported program contributions have been crucial for the provision of technical assistance, an epidemic-focused national strategy, generation and use of information to better understand the epidemic, development of national protocols and guidelines to standardize the HIV response and capacity building of government systems, counterparts and NGOs to better equip coordinated and concerted contributions to the national program.

ASHA Project's goal was to contain the HIV/AIDS epidemic in Nepal and to mitigate the effects of HIV on those infected and affected by HIV and AIDS, while its main objective was to increase the availability and use of HIV prevention and care services by those most at risk and people living with HIV (PLHIV).

The program focused on five main areas of intervention to:

- Reduce HIV transmission among specific high-risk and vulnerable populations.
- Strengthen capacity of Nepal Government and civil society in policy formulation.



- Provide technical leadership to improve the planning, collection, analysis, and use of strategic information.
- Work with the Government of Nepal and partner organizations to improve access to HIV services for PLHIV and those at high risk for HIV transmission.
- Facilitate collaboration at the national level with Government of Nepal and all stakeholders in planning, implementing, and monitoring HIV programs in Nepal.

The project design supported Nepal's National HIV and AIDS strategy 2006-11 and the National HIV and AIDS Action Plan (NAP) and was implemented in collaboration with the Government of Nepal, local NGOs and community based organizations and networks to strengthen their capacity to manage targeted HIV interventions for most at risk populations (MARPs), specifically female sex workers (FSWs) and

their clients, injecting drug users (IDUs), migrant workers and their spouses and PLHIV, to HIV infection including prevention, care, support and treatment activities. The geographic focus crossed all five designated regions and covered 30 districts in the Terai and mid-hills. A total of 38 districts were covered over the life of the project wherein ASHA Project provided technical support to the District AIDS Coordination Committee (DACC) in the development of the District AIDS Period Plan, 2009. In addition, three districts (Saptari, Siraha and Parbat) were discontinued from the first phase after 2009. With partner NGOs, ASHA Project implemented behavior change interventions through peer education and outreach services for MARPs, integrated health services (IHS) with on-site management of sexually transmitted infections (STIs), provision of voluntary counseling and testing (VCT) and pre-antiretroviral therapy, along with the provision of home-based palliative care for PLHIV and their families.



Photo: Thomas Kelly

ASHA Project also provided technical assistance to the Government of Nepal and other key stakeholders in key HIV technical and programmatic areas. Technical assistance for clinical services included laboratory services, logistics and supply, early infant diagnosis (EID) and pediatric ART, VCT, community-based prevention of mother to child transmission (CB-PMTCT), HIV clinical management, community and home-based care (CHBC), along with the development of a range of national guidelines and standard operating procedures. Technical assistance for monitoring and evaluation (M&E) included the national M&E plan and support for the incorporation of 'Unique ID', second generation surveillance, the estimation and projection of HIV infection (2007, 2009, 2010), development of a reporting format for the national HIV database, mapping and size population estimation for MARPs, data quality auditing (DQA), the targeted intervention of MARPs in M&E, and generating geographic information service (GIS) mapping of service sites in the country.

ASHA Project's contribution to research has also been considerable, especially through its technical assistance to the Integrated Biological and Behavioral Surveillance (IBBS) surveys conducted among MARPs - FSWs, transport workers, IDUs, migrant workers, wives of migrant workers - as well as specific research components carried out with government in the case of CB-PMTCT.

Overall collaboration and coordination with the government - Ministry of Health and Population (MoHP), Department of Health Services (DoHS), National Center for AIDS and STD Control (NCASC) and Family Health Division (FHD) at both national and district level has contributed to a strengthening of country ownership over the past five years. ASHA Project technical assistance ensured sufficient data and information on the HIV epidemic and key indicators were used during the development of the NAP 2008-2011 and supported the preparation of Nepal's National Strategic Plan for HIV 2011-2016, as the way forward.

Many positive changes have resulted from the direct and indirect interventions of USAID-supported ASHA Project and have contributed substantially to the decreasing trend in HIV and an increasing number of people with access to VCT, STI, ART and PMTCT services. The close collaboration that ASHA Project maintained with the government was key to the success of new interventions and innovations being adopted by NCASC and adapted into the national government system, in particular, community-based mother to child transmission, early infant diagnosis, pre-exposure prophylaxis, external quality assurance, medical waste management, community and home-based care, positive prevention and data quality audit.



## 2. CURRENT CONTEXT

In Nepal, all organizations working in HIV are required to operate in accordance with the National Interim Plan 2009-2011, which provides priority one (P1) program status to the National Planning Commission and the Ministry of Finance with the mandate to prioritize financial support to line ministries for HIV programming. The National Health Sector Implementation Plan (NHSP) I (2004-2009) committed to reduce the spread of HIV and STI and their impact, to prevent a generalized epidemic and to care for those already infected with HIV to maintain a healthy lifestyle. Further to this, NHSP II, 2010-2015 has committed to halt and reverse the current HIV transmission trend by maintaining or scaling up the current level of intervention under the essential health care package, within the framework of communicable disease. It also supports the scale up of sexual and reproductive health services as well as the integration of HIV into sexual and reproductive health services and the role of non-state actors, including international and national non-government organizations (I/NGOs) through public-private partnerships.

Within this country context, Nepal is also obligated to fulfill several international commitments - UNGASS, Millennium Development Goals (MDGs) 5 and 6, universal access (UA), International Conference on Population and Development or ICPD (Cairo convention); the Convention on Rights of Children (CRC) and optional protocol; Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW); Elimination of Discrimination - Employment and Occupation Convention, 1958 (No. 111); Convention on Worst Forms of Child Labor 1999; the International Health Partnership (National Compact); Alma Ata, the Stockholm Convention, the Paris Declaration (2005) and the Accra Agenda for Action (AAA 2008) - which each have direct and indirect influences on the investments and the progress made in addressing the HIV epidemic. Nepal is a concentrated HIV epidemic due to a prevalence of more than five percent among people who inject drugs. The National HIV and AIDS Strategy (2006-2011) identifies people who inject drugs, female sex workers and their clients, migrant workers and their spouses and men who have sex with other

men as most at risk populations (MARPs). According to the latest figures released by the National Center for AIDS and STD Control (NCASC, 2011), the cumulative reported number of HIV cases has gradually increased to 18,396 (11,884 male and 6,512 female) between 1988 - 16 July 2011 with the majority of HIV infections among the 25 - 49 year olds. The 2010 national HIV estimates indicate that 55,626 adults and children in Nepal are infected with HIV, with an estimated overall adult HIV prevalence of 0.33 percent (NCASC, 2011); a promising change in HIV prevalence from 0.39 percent in 2009.



### **Socio-economic context**

Despite a growing awareness about HIV, stigma and discrimination has remained a barrier to MARPs and PLHIV receiving information and services and choosing to disclose their HIV status and sexual orientation. Refusal to provide education, exclusion from social events and delayed treatment are a few commonly cited discriminatory practices. Women and children are often more affected because of their frequent need to access health and education facilities. According to the latest National Size Estimation report (HSCB, 2011) a reported 14,466 children are orphaned and many others have only one parent, often their mother, and have little access to social protection through the national system - family support services, early childhood care, education, special health care needs, livelihood and legal guidance support. The extra costs for care faced by families affected by HIV often pushes them further into poverty and the demand for livelihood opportunities and long-term employment is an expressed concern of many PLHIV eligible for work.

The need for employment among young people living in rural areas has also led to a substantial increase in migration over recent years and poverty, low education and lack of access to resources have driven them into migrating abroad for work. Despite the large numbers of men and a growing number of women migrating to East Asia and the Gulf States, labor migration to India continues and is further fuelled by its industrial growth, which is providing additional employment opportunities for Nepali workers. Epidemiological evidence shows that Nepali men who work in India and visit sex workers, particularly in states with higher HIV prevalence such as Maharashtra and Gujarat, are at greater risk of HIV. As a consequence, HIV in women is higher among wives of migrant workers to India and as widows they may be blamed for transmitting HIV and ostracized by their families and/or their communities.

Internal migration to towns and cities by young people in search of employment has also continued over the past several years. A qualitative assessment showed that due to lack of education and experience women may end up in sex work as a means of survival or due to coercion by their employers (Needs Assessment of Most At Risk Adolescents; UNICEF, 2011). The challenge remains in addressing the myriad of consequences of the severe forms of work exploitation they are often forced to endure. According to the most recent MARP size estimations (HSCB, 2010) the FSW population ranges between 24,629 and 28,359 with an average of 26,504. According to the 2010 IBBS survey, about 87 per cent of the respondents in Kathmandu valley reported being born outside the survey districts. In 2011, a reported 40 percent of the FSWs in Kathmandu valley had begun sex work within 12 months of the survey

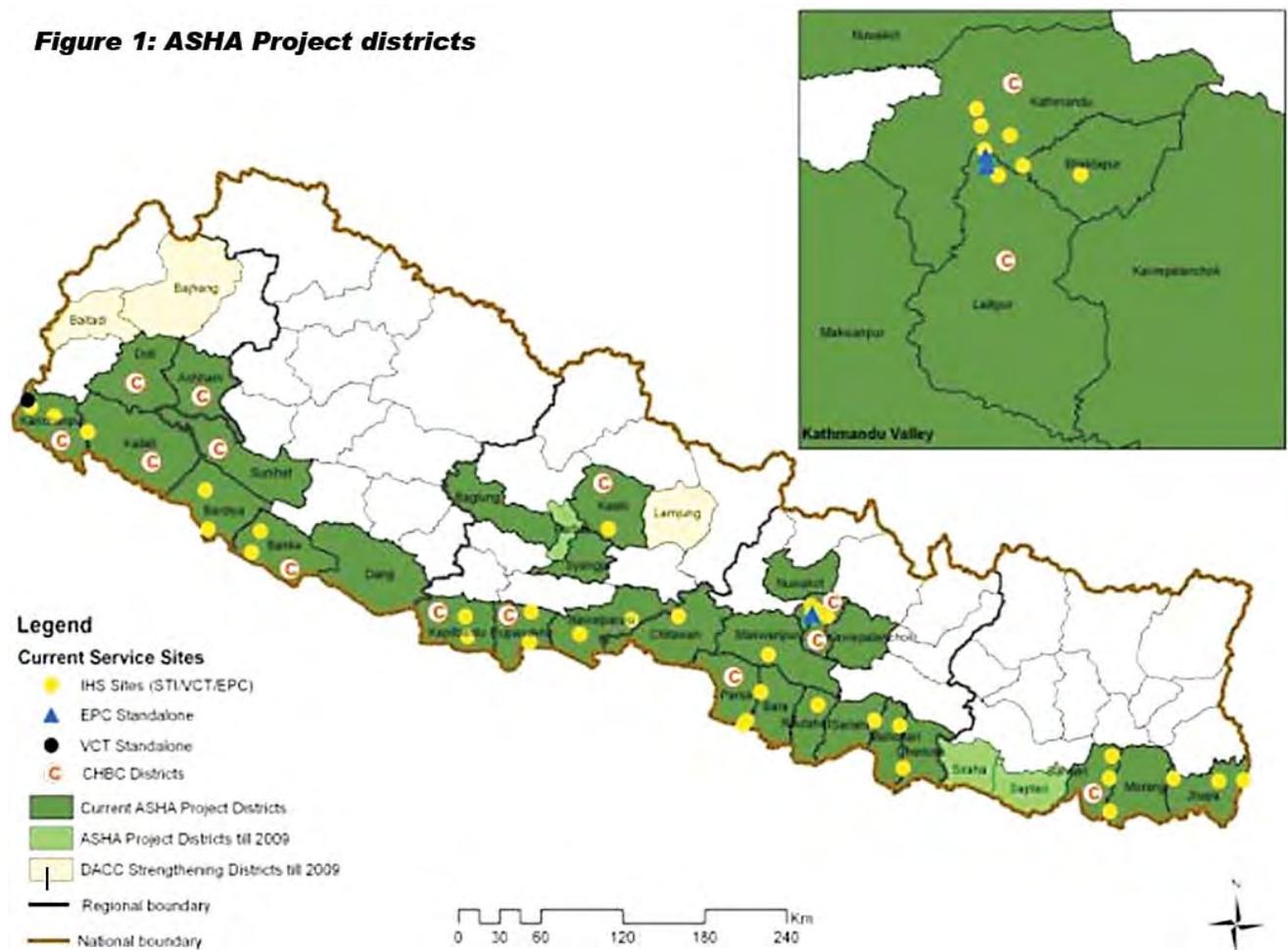
(FSW IBBS, 2011). Many of these women are married; almost half of the FSWs in Kathmandu valley and one third in Pokhara reported being currently married and about 40 percent in both sites had ever terminated pregnancies. Further analysis of FSW survey data from Kathmandu valley (IBBS, 2008) show that many reported being subjected to violence and that violence and abuse occurred more frequently among street-based FSWs (23% (N=500) street 30%, establishment 18.3%), coercion (35% (N= 500) street 41%, establishment 21%) and forced unacceptable acts (37% (N=500) street 46%, establishment 31%). Trafficking in persons also affects a large number of vulnerable women and girls and estimates suggest that many thousands are trafficked into India every year where they are further exploited, sold or forced into the sex trade.



# Map of ASHA Project districts and services 2006-2011

The Map of ASHA Project (Figure 1) indicates the project phases, the program interventions and the districts covered over the five years of program implementation. Three districts, Siraha, Saptari and Parbat were included up to 2009 only, as were Lamjung, Baitadi and Bahjyang. The districts are coded for where IHS sites provided STIs diagnostics, VCT and the essential package of care (EPC); where only EPC or VCT services were provided and districts where the project operated CHBC services.

**Figure 1: ASHA Project districts**



### 3. PROGRAM STRATEGIES AND ACTIVITIES

ASHA Project strategies and activities are based on five result areas that include prevention, capacity building, use of strategic information, care and treatment and coordination and collaboration. Each result area is described in the activities outlined below along with an outline of the learning gained from the project interventions.

#### RESULTS AREA 1: Reduce HIV transmission through targeted prevention interventions within specific high-risk and vulnerable populations

The activities in results area 1 promoted protective behaviors, helped high risk groups overcome barriers to behavior change and developed environments conducive to maintaining positive behaviors. These interventions created demand for STI and VCT services.



Local implementing agencies (IAs) provided evidence-based targeted and tailored STI and HIV prevention activities among MARPs, primarily to FSWs and their clients, migrant workers and their spouses,

IDUs and at risk populations such as prisoners, children infected with HIV and PLHIV. Adherence to HIV prevention guidelines improved understanding and clarity on the prevention strategies and activities and standardized quality for prevention.

#### 3.1 Reducing HIV Transmission in Female Sex Workers and Clients

Recognizing that effective STI and HIV prevention programs for MARPs must be targeted, community- and peer-based, enabling and comprehensive, a variety of behavior change strategies and activities were introduced using a positive health impact framework. The three-tiered approach focused on individual risk perception, self/solution efficacy, peer and community support and linkages to quality services and products. This approach helped to build the capacity of FSWs and their clients to protect themselves and others from transmission of STIs and HIV through correct and consistent condom use, partner reduction and utilization of STI and VCT services.

BISHWAS was developed as a brand that signified trust by emphasizing reliability, dependability, friendly, secure and comfortable services for FSWs. The BISHWAS brand helped to integrate prevention programs and care, support and treatment (CS&T) services by providing a seamless continuum from community outreach to clinical care for FSWs, while guaranteeing confidentiality.

- **Promoted safer behaviors** through community- and peer-based outreach education using information, education and communication (IEC) materials with one-on-one and small group contacts.
- **Promoted condoms** including distribution (free and socially-marketed) and building skills in negotiation and use. Condom negotiation training with special focus on condom use strengthened the ability of FSWs to persuade their partners about condom use and safer sex. It also helped increase awareness on the importance of condom use among FSWs. After the training, outreach educators (OEs), community mobilizers (CMs), and peer educators (PEs) were more adept at educating FSWs on alternative sex practices, bargaining skills, effective communication skills, and negotiating





with confidence. FSWs reported being able to improve their sexual relationships with clients through regular use of condoms. Availability of various brands of condoms attracted and prompted DIC visitors to discuss the importance and correct use of condoms and increased condom purchasing and carrying practices. Community information points (CIPs) were also set-up in strategic locations for the dissemination of STI and HIV - related information and the distribution of condoms.

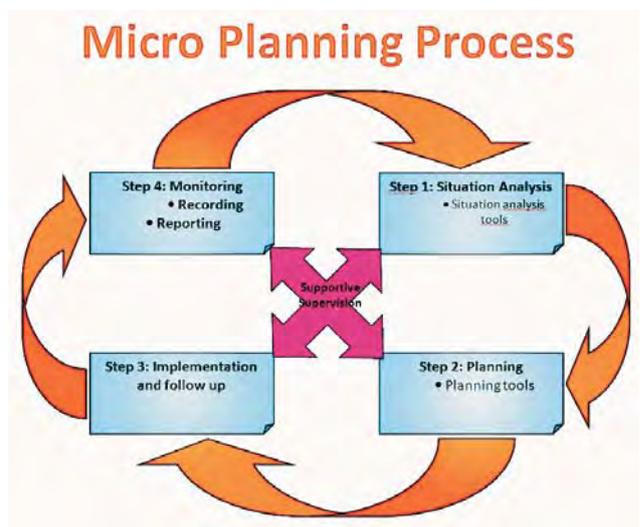
- **Operated Drop-in Centers (DIC)** as safe places that provided FSWs with somewhere to relax and access HIV- and STI-related information in audio/visual and print and have access to products, arts and crafts and condoms. DIC Operator training, involvement of FSWs in the DIC management committees, organization of creative activities along with HIV and STI messages contributed to an increased number of FSWs and their clients visiting the centers. The management committees regularly met and discussed achievements and



issues and the way forward for DIC activities. Consequently ownership of the DIC, DIC activities among FSWs and local community involvement also improved. The majority of DICs was co-located within integrated health services (IHS) sites which increased availability, accessibility and utilization

of prevention, STI and VCT services, improved the management of the facilities and reduced the waiting time.

- **Piloted web-based short message services** to reach hard-to-reach and under served FSWs using mobile phones to contact their clients. These women at risk were not reached through ongoing prevention activities in Kathmandu and Pokhara valley. The initiative was designed based on the findings from a qualitative study conducted by ASHA Project, which indicated that FSWs in Kathmandu and Pokhara are using mobile phones to solicit clients and maintain their networks. The study also indicated that comprehensive knowledge on STI, HIV, safer sex practices and access to treatment for STIs was low among high-end FSWs and needed to be strengthened, along with condom use.
- **Conducted micro-planning for prevention** with five IAs in five districts Kathmandu, Lalitpur, Kaski, Parsa, and Morang. This participatory process helped the OEs and CMs to analyze the risks and vulnerabilities of FSWs, prepare plans and implement outreach activities. It also enabled project staff to track each FSW's behavior change and maintenance overtime and to prioritize and



monitor outreach activities. Maintaining the FSW profile contributed to improved understanding of the risks faced by FSWs, including mobility and safer behaviors, and planning, implementing and monitoring outreach activities. The process helped to track the education, number of condoms provided, referrals for STI and VCT services and service utilization. It also increased ownership and the sense of responsibility among CMs and OEs. The number of FSWs reached by outreach activities increased after the implementation of the micro-planning process.

- **Conducted training, community events and advocacy to reduce stigma and discrimination** at national, regional and local level. The Project, through these activities contributed to an enabling environment by close collaboration with other sectors such as law enforcement agencies, local



government, local leaders and establishment owners (hotel, lodge and restaurant) to reduce harassment, change social norms, and help keep FSWs safer. The S&D toolkit developed by ASHA Project in close collaboration with NCASC and National Association of PLHIV in Nepal (NAP+N), is used during these trainings. Local communities are more supportive of local prevention initiatives. Improved self-esteem and confidence was observed among FSWs, which has also contributed to increased access to prevention to care and treatment services.

- **Stakeholder collaboration to further support FSWs** through effective networking and linkages. In line with USG’s Unified Policy on HIV/AIDS and Trafficking in Persons (TIP), ASHA Project developed a mechanism to address TIP cases identified by implementing partner agencies in their working areas and referred FSWs to anti-trafficking agencies so they could access their services. Similarly, IAs also offered prevention to care and treatment services to clients referred to them by anti-trafficking agencies. ASHA Project also piloted (at two IHS sites) direct linkages with family planning service providers to address the reproductive health needs of FSWs.

**Challenges**

- FSWs can be highly mobile, often changing their place of work. They may also change their identity and mobile phone numbers making follow-up difficult. Reportedly, their mobile phones are often stolen by their clients and they sometimes lose their ID cards or do not want to retain them for

fear of disclosure.

- New and young sex workers are entering sex work every year. Identifying and reaching them early with prevention activities is difficult when they are hidden.
- Many FSWs drinks alcohol frequently and some inject drugs, which creates an over lapping risk for condom negotiation. Condom use with regular partners is also low among FSWs as they find it more difficult to negotiate with them.

**Lessons learned**

- Increasing individual risk perception, self/solution efficacy, peer and community support and creating linkages with quality services and products encourages positive behavior change among MARPs.
- Mobilization of peers is effective in increasing the coverage and motivating FSWs for positive behavior change.
- Physical access to friendly and confidential service sites is an important factor in improving health seeking behavior
- Integration of behavior change interventions with IHS helps increase access to services and co-location with drop-in-centers increases utilization
- Commodity security (condoms, STI drugs, and HIV and STI rapid test kits) is crucial to maintaining an effective HIV prevention and CS&T program.
- FSW programming needs to adapt to the needs of FSWs, which may change due to a variety of external factors
- Coordination with external partners on gender issues and income generation activities should be considered for FSWs

**3.2 Prevention among IDUs**

ASHA Project worked closely with other donor funded programs for IDUs to ensure collaboration and complementarity. Three ASHA Project IAs implemented programs for IDUs -Bijam in Parsa district, Youth Vision in Kathmandu and Lalitpur districts and Naulo Ghumti in Kaski district. They



primarily focused on HIV prevention services through community outreach and drop-in centers and provided IHS services for STI and VCT and EPC for those who were diagnosed HIV positive.

Recognizing the importance of addressing the particular needs of female IDUs, a prevention strategy was designed for female IDUs in 2011. The strategy development included a literature review, interactions with female IDUs (FIDUs) and FSWs on the issues and concerns they face, particularly the overlapping risks among FSWs who inject drugs and FIDUs who engage in sex work.

### 3.3 Prevention among migrants and their spouses

Prevention programs for migrants and their spouses focused on the Far Western region districts of Kailali and Kanchanpur. Comprehensive HIV prevention activities included outreach and peer education, the availability of IHS sites for STI and VCT and co-located drop-in centers that provided an opportunity to mix with other MARPs and to discuss and learn about HIV prevention as part of safe migration.

Migrant workers were reached during their home-stay periods, especially during major festivals and during crop cultivation and harvest times, while their spouses received ongoing prevention education from local outreach workers.

### 3.4 Engaging PLHIV in Positive Prevention (PP)

Positive Prevention has been a cornerstone program



for ASHA Project addressing the prevention needs of PLHIV and their families to adopt safer sex and injecting behaviors. As most prevention strategies have been directed towards people who are uninfected with HIV or who do not know their status and only a few strategies and messages were designed specifically targeted for HIV positive people. Evidence also showed that a large proportion of HIV infection occurs among discordant couples, and as only a small proportion of them know their HIV status, they need to know how to prevent transmission. Using a multi-tiered approach that targets different levels of intervention - individual, couple, community and wider advocacy - PP offered counseling on safer sex to prevention from STI and HIV transmission; S&D reduction through mobilization of positive speakers bureau; disclosure of HIV status among discordant couple; access to HIV testing and ARV therapy have benefited from comprehensive HIV prevention. PP also aims to increase the self-esteem, confidence and to avoid passing on the infection to others.

#### **Major PP activities included in their regular outreach are listed below:**

- Education/counseling for safer sexual and injecting behaviors.
- Promotion of healthier life styles including condom use.
- Counseling for sero-discordant couples and dealing with partner disclosure.
- Referral to HIV service such as testing and treatment of for sexually transmitted infections, HIV counseling and testing, home based and EPC services.
- Formation and mobilization of Positive Speakers.
- S&D reduction activities including self-stigma.
- Support to post-test clubs and advocacy for greater involvement of PLHIV to create a better supportive environment.
- Support to PLHIV support groups and networks for active and meaningful involvement of PLHIV in planning, implementation, monitoring and evaluation of PP activities.
- Promotion of linkages to PP services with treatment, care and support services to ensure that PLHIV have access.

#### **Lessons learned**

- The meaningful involvement of PLHIV in program management such as increased skills in communication and presentation, technical knowledge on HIV and AIDS, organizational development, representational and leadership and documentation and reporting strengthened PLHIV ownership of PP programs and led to effective PP program implementation.
- Mobilization of PLHIV as community mobilizers

helped build instant rapport and inspires new PLHIV to disclose their status and access available services.



- Training and mobilization of positive speakers for sharing their real life experiences has been a cornerstone to disclosure by PLHIV and led to increased utilization of services and reduced stigma. This has shown PLHIV how they can play an expanded and meaningful role upholding the principal of greater involvement of people with AIDS (GIPA).
- Addressing the needs of discordant couples and the difficulties faced by couples because of a positive test result are important components of PP programming. Supporting partner disclosure and planning risk reduction strategies is essential to HIV programming.
- PP programs can be replicated and scaled-up by engaging local PLHIV in their communities to meet the special needs of PLHIV.

**RESULT AREA 2: Build capacity of Government of Nepal and civil society to manage and implement HIV and AIDS activities and to inform policy formulation at national, local and community levels to reduce stigma and discrimination and enable access to services**

Capacity building was central to the effective implementation of the HIV prevention to care activities at all levels. ASHA Project adopted two principles

1. Human resource development and mobilization of its partners and staff and
2. Input to the organizational development to strengthen management systems, structures, processes and procedures improve performance and deliver programs more effectively and efficiently with a view to sustainability.

**3.5 Strengthening capacity of Government and civil society in policy formulation to reduce stigma and discrimination and enable equitable access to services.**

Mitigation of HIV related stigma and discrimination targeted multiple stakeholders. IAs engaged local community members in supporting HIV prevention, care and support activities at local level and helped to create an enabling environment for stigma and discrimination reduction and garner support for MARPs and PLHIV. Community mobilization training, training in stigma reduction, caregiver training for PLHIV family members, and training in managing the positive speaker’s bureau for PLHIV were all incorporated into the outreach capacity building efforts.



IA management and organizational performance was a focus of the sustainability planning. A range of activities included basic and refresher orientations for program and organizational management; quarterly reviews; program monitoring (onsite coaching, mentoring and supportive supervision); use of the management information system (MI) and data analysis for planning and decision making all helped to strengthen the capabilities of the NGOs.

### Activities for effective capacity building of IAs:

- Ensuring that the gaps/needs identified in pre-award assessment and physical verification of selected IAs are addressed in initial orientation and regular monitoring visits.
- Providing specific pre-service, on the job and refresher training including exposure visits for IA staff and service providers by utilizing standardized training curricula.
- Conducting regular onsite coaching/mentoring and monitoring visits.
- Developing and implementing monitoring systems and providing follow up and support to monitor practices for all training conducted by ASHA Project.
- Promoting organization-wide thinking on a comprehensive approach to capacity building that goes beyond basic training and working only for the specific project and components.
- Organizing regular supportive supervision and monitoring visits
- Jointly identifying issues and actions for improvement using the issues and action matrix.
- Strengthening NGO management systems including governance, transparency and commitment to quality services. For example, periodic audits, use of software (management information system, accounting, use of technology) and use of information for decision making.

**Government partners** were engaged in capacity building as both trainers and recipients and capacity building activities were designated for technical skills, monitoring and evaluation, research and management. Government led program and technical planning meetings for guideline and standard operating procedure development and revisions were conducted as required. Ensuring the application of all tools, guidelines and standard operating procedures (SOPs) in program management, monitoring and supportive supervision and producing documentation based on available knowledge and evidence all contributed to a stronger national HIV program.



At district level, the government designated District AIDS Coordination Committees (DACC), were encouraged to conduct regular meetings in the districts and supported for promoting the DACC role in coordination and monitoring.

### 3.6 Strengthen the capacity of Government to plan, manage and implement an effective HIV response.

#### *Technical Working Groups (TWGs)*

Both technical and strategic information training were provided to the government during the course of the project to support government leadership and management in addressing the HIV epidemic. Key mechanisms for achieving this are the technical working groups. NCASC provides technical guidance to the national HIV response activities through these technical working groups which include ART, STI, VCT, pediatric care, PMTCT, CHBC, laboratory and logistics and SI. ASHA staff participation was critical in several national reviews of various programs including ART, PMTCT and STI as well as many technical national HIV workshops, seminars, round-table series and conferences.

ASHA Project staffs were members in all TWGs and provided technical assistance to the government of Nepal by conducting mentoring and coaching for the ART sites. During the early part of ASHA Project an over-arching national TWG for HIV Care and Support was also operational.

#### *SI related capacity building activities to Government and other stakeholders*

The following activities were conducted to strengthen the capacity of NCASC in SI related activities:

**Transfer of skills on IBBS** and the processes used for data analysis and for the presentation and

dissemination of IBBS survey data were transferred during each round of IBBS. During the last year of ASHA Project, support was provided on the selection and supervision of capable research organizations for conducting IBBS studies in future rounds managed by the government. With funding from Global Fund, an orientation was provided to develop capacity for managing quality of the surveys based on accepted standards of IBBS design and implementation and to develop a framework for monitoring the quality of IBBS.

**Development of TOT skills for M&E** included M&E training, MIS training, data analysis training with the focus aimed at streamlining the generic concepts relevant to other project activities. Support to M&E system included the development and use of forms and formats for the M&E system specifically for collection of SI related data from the field.



**Capacity building on basics of HIV infections estimation and projection:** ASHA Project provided technical assistance to NCASC during their workshop for government staff and M&E and research personnel from networks and research agencies and universities.

**Strengthening SI to guide an effective response to HIV recording and reporting** was conducted in collaboration with NCASC and WHO to orient and sensitize the DHO/DPHO/DACC and implementers on the National HIV/AIDS M&E system and to refresh and train them on the use of the current recording and reporting formats for ART/OI, VCT, PMTCT and DACC.

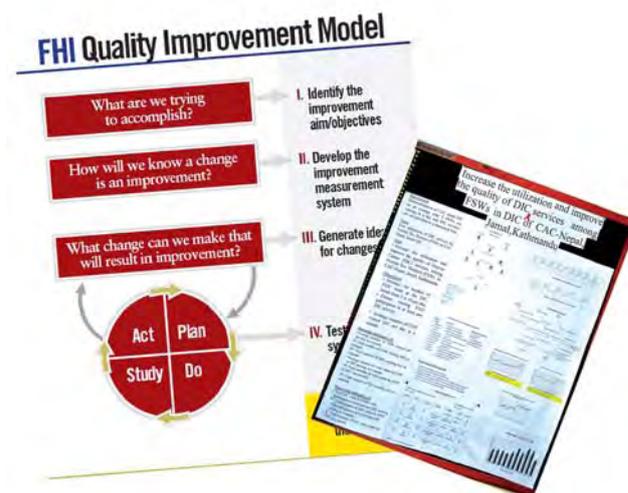
**Respondent driven sampling analysis tool (RDSAT)** training was provided to NCASC and other stakeholders for analyzing data collected in the 2007 rounds of IBBS among IDUs in Kathmandu and Pokhara and MSM in Kathmandu.

**3.7 Building local capacity and sustainability by strengthening local NGOs and Networks to effectively respond to the HIV epidemic.**

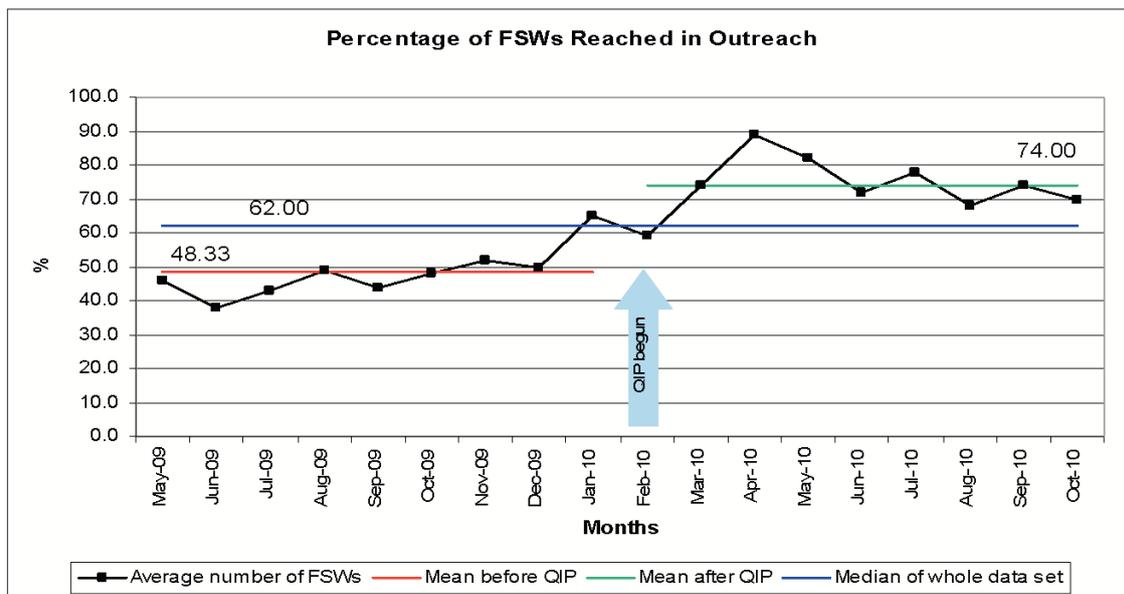
A variety of trainings were provided with follow on activities and implemented through local partners by engaging local community members in supporting HIV prevention, care and support activities at local level and to create an enabling environment for stigma and discrimination reduction and to garner support for MARPs and PLHIV. Community mobilization training, training in stigma reduction, caregiver training for PLHIV family members, and training in managing the positive speaker’s bureau for PLHIV were incorporated into the outreach capacity building efforts by IAs.

**Financial documentation systems** were designed to strengthen the financial management capacity of IAs by not only safeguarding the project assets but also providing continuous support to improving their systems so that gaps were addressed. As a result they have become more capable of handling resources and their financial systems are more robust. This investment has also helped partners to diversify their portfolios and in some instances, to show substantial budgetary growth.

**Quality Improvement Projects (QIPs)** were implemented between August 2009 and February 2010, by seven ASHA Project partners. In 2009, Association of Medical Doctors of Asia, BIJAM-Student Awareness Forum, Naulo Ghumti, Nepal National Social Welfare Association and Youth Vision worked to improve the utilization of EPC services for better health outcome of their clients. The specific objectives of the QIPs were to enroll all HIV diagnosed people into EPC services; improve the linkages between EPC and CHBC (community and home based care) team in order to have effective cross-referral; and provide regular EPC follow-up services to clients. Community Action Center and Rural Development



**Graph 1: Increase in the percentage of FSWs reached through QIP**



Foundation focused on FSW visits to DICs to increase the average number of FSWs (both new and old) visiting DICs; ensure that FSWs participated in at least one DIC activity; and increase the number of FSWs reached through outreach activities. People diagnosed with HIV were enrolled into EPC services and linkages were made between EPC and CHBC that improved after the implementation of change ideas. The QIP process improved the quality of DIC utilization, helped build a sense of ownership and strengthened the support by management. The seven QIPs found that the following approaches could be sustained and implemented across ASHA Project:

- Provide follow-up appointment dates for EPC services and use CHBC team members to remind them of the dates.
- Share complete information to FSWs in order to encourage them to visit DICs.
- Emphasize the standardization of DIC activities across the ASHA Project.

Seven more QIPs began with the same partners in December 2010 with the objective of improving the utilization of IHS and DIC services. Specific objectives included increasing the number of follow up visits of FSWs at an IHS clinic, increasing clinic attendees of FSWs referred by prevention for STI services and increasing average number of both old and new FSWs visiting DIC. The QIPs showed it is possible to increase utilization of IHS services and increase follow-up services by FSWs.

**Civil society and community mobilization**

ASHA Project supported five beneficiary-led Federations and Networks - NAP+N, Federation of Women Living with HIV/AIDS (FWLHA), Dristi Nepal,

Federation of Sexual and Gender Minorities (FSGMN), Recovering Nepal (RN) - to strengthen their institutional capacity. The purpose of working with the civil society networks was to build their capacity to effectively reach beneficiaries, including PLHIV, to improve their quality of life and access to care and treatment services. Support groups were mobilized at district level to coordinate with local government bodies on improved services for MARPs. They were able to consolidate loose local networks and coordinate activities and support mechanisms within districts. Their interventions focused on stigma reduction, advocacy, and strengthening their national network of members - both people and organizations. The civil society capacity building was conducted at national, regional and district levels. The networks held dialogue and interacted with government and non-government stakeholders to advocate for the concerns of beneficiaries and have been able to influence the government decision making process and advocate for policy change. In May 2011, they led a national level consultation on the reduction of stigma and discrimination, where they shared their activities, challenges and learning and discussed areas of action and recommendations to more firmly address the issues of HIV stigma and gender-based discrimination, including stigma-related negligence and abuse. Recently, they have been actively involved in drafting the HIV Bill and the National Action Plan, the National Strategic Plan and the dissemination of information through the UNGASS report.

**Lesson learned**

- Mobilizing competent and trained strong IA staff in developing the capacity of new and small IAs was found to be effective.
- Carefully planned and implemented activities

## RESULT AREA 3: Improving planning, collection, analysis and use of strategic information by stakeholders to facilitate a more effective and targeted response to the HIV/AIDS epidemic

### 3.8 Support to the collection, analysis and use of research, surveillance and strategic information



Nepal has made considerable advances in the management of strategic information over the project period. ASHA Project staff from the SI and program units continued to work closely with NCASC and contributed to the quality of the IBBS surveys and a range of behavioral biological and ethnographic studies. There were also considerable gains made in the effectiveness of the data management system at national and the collection, analysis, dissemination and use of data.

#### **National government level support**

ASHA Project provided technical assistance to NCASC at national level as a member of the SI technical working group and directly to the SI/M&E unit at NCASC to further strengthen the national system. Major contributions were made in the following areas:

**A national M&E plan** was developed with the National M&E Technical Working Group and in support of the UNAIDS three ones plan, which included one National M&E Plan and required support to an annual planning process. ASHA Project helped ensure that sufficient data and information on the HIV epidemic and key indicators were incorporated to enable successful use of the GOALS resource allocation model. Support was also provided to NCASC to develop training module 7, for

incorporating targeted interventions (TI) into the National M&E Training Manual.

**National SI planning** was discussed in a round table meeting on the development of HIV surveillance. ASHA Project provided historical information and guidance to NCASC and other stakeholders on IBBS surveys and the emerging need to review the studies that are planned and agree on the intervals between surveys. This support culminated in the development of the National SI plan (HIV Surveillance, Program Monitoring and Evaluation and Research) 2011-15. Discussions were also held on the STI Sentinel Surveillance Protocol.

**A national review of the second generation surveillance system for HIV/AIDS** adopted by Nepal was conducted by UNAIDS, with assistance from WHO and FHI 360 and additional technical support from the FHI 360 Asia Pacific Regional Office.

**Estimation and projection of HIV infection** in Nepal was conducted in 2007, 2009 and 2010. ASHA Project was a member of the Estimation Technical Team (ETT) for each estimation round.

**National mapping and size estimation of MARPs** was supported through technical input and guidance to HSCB and in collaboration with NCASC and UNAIDS.

**GIS mapping** support was provided to NCASC to generate GIS mapping of service sites including ART and PMTCT sites in the districts.

**A national HIV database** was developed and ASHA Project contributed to reviews of the outline, discussions on the reporting format and assistance for the development of reporting forms to be used.

**Data quality audit** and its use in the national system was introduced to NCASC as a mini-pilot project to assist them with quality monitoring to ensure that the M&E data they are generating are accurate, complete, consistent and reliable. ASHA Project helped NCASC pre-test their DQA.

#### **M&E support to NGOs**

ASHA Project partner NGOs received on-going support for the management of their M&E recording and reporting systems to ensure the quality of data generated. DQAs were introduced and conducted semi-annually with IAs to audit the quality of the data being reported and to support data quality improvement as a continuous process. The DQA process helped to increase NGO staff commitment to quality recording and reporting of monthly data.

**Participatory process evaluations** were also conducted regularly with support from the ASHA Project M&E and Program staff. A revision of IHS sites for reporting for MARPs was based on feedback from users on the current forms and recommendations from the DQA studies. A process was also initiated to integrate the ASHA Project MIS with the National HIV M&E Strategy and Plan requirements.

**A pilot participatory sustainability process** was conducted with one IA to identify the best practices of the project, its strengths/weaknesses and to assess the overall internal dynamics of the project implementation.

### IBBS surveys

**Twenty one Integrated Biological and Behavioral Surveillance (IBBS) surveys among MARPs** were conducted between 2007 and 2011 in collaboration with NCASC (listed under Annex C). The IBBS surveys were conducted at regular intervals of two to three years. The primary objective of IBBS surveys was to track the trend in HIV and STI prevalence as well as to assess the risk behaviors related to HIV among the



MARPs. The findings of all IBBS surveys were dissemination at the community, regional and national level. In addition, long reports and fact sheets of the IBBS surveys were shared with NCASC and other key stakeholders.

Technical support to IBBS surveys included:

- **IBBS survey methodology and monitoring** for the 2010 IBBS among male labor migrants conducted by NCASC and Save the Children under Global Fund Round 7.
- **A round table meeting** was held on the secondary analysis of the IBBS survey data from the IBBS conducted among female sex workers

(FSWs) from the Terai Highway Districts (2009) and Wives of Migrant Laborers (2010). Program and M&E personnel from the network agencies, IAs and donor agencies discussed the data and suggested program implications and guidance for policy.

- **A round table meeting was held on the ‘Drop in HIV prevalence among IDUs: Possible Explanations and Program Implications’.**



Key findings of the analysis done to study the drop in HIV prevalence among IDUs was shared and discussed to clarify understanding and align programming in the future.

### Studies and Assessments

- **Study on the Situation and needs assessment of HIV and AIDS in Birgunj and Central Prison.** The primary objectives of the needs assessment were to assess the current general health care system in the prisons, to assess the current health care delivery mechanisms of HIV services for inmates and document the effectiveness, accessibility and quality of services to prisoners in Kathmandu and Birgunj prisons. The study protocol included the general prison environment, infrastructure, current programs, prison health service delivery, resources, stakeholder analysis, risk behavior and its drivers, flow of IDUs in and outside of prison, knowledge and information on STI and HIV. The assessment also included a rapid stakeholder analysis and the development of a stakeholder mapping. The assessment also studied the existing risk behaviors that may contribute to acquiring HIV among the prison population.
- **Study on Delivery of Community Based Prevention of Mother to Child Transmission Services in Achham District.** Under the leadership of NCASC with the FHD and UNICEF, ASHA Project conducted a study entitled “Delivery of Community Based Prevention of Mother to Child Transmission



(PMTCT) services including take-home mother and infant nevirapine in Achham District of Nepal". The study component included take home nevirapine for HIV positive mothers and their newborns in Achham as part of the Community-Based Prevention of Mother to Child Transmission (CB-PMTCT) Program in the district. The data collection began in April 2009 and the data collection phase closed on April 23, 2011. The findings were shared with key government and non-government stakeholders and recommendations were discussed and agreed upon for possible replication in other similar districts.

- **Study on the "New Dynamics in Female Sex Workers and Potential for Use of New Technology for HIV Prevention Program".** This qualitative study was conducted in Kathmandu and Pokhara valley among FSWs who use modern technology to solicit their clients. The findings from this study helped develop the web SMS program where these hard to reach FSWs can obtain HIV and STI related information/service via modern technology like SMS.
- **Assessment of ASHA Project Community and Home Based Care (CHBC) program.** The assessment covered all the 13 districts with ART and CHBC programming and included three control districts with ART but without CHBC. All



those interviewed in the districts were enrolled in ART. The primary objective of the study was to assess the coverage, quality and client related quality of life (QoL) outcomes of CHBC services and includes the objectives to measure the extent of CHBC program service coverage and client retention; assess the extent of CHBC service quality; and measure physical and psychosocial well being of and differences between CHBC clients and non-CHBC clients. The findings from this study were shared with the CHBC Technical Working Group and helped inform better planning for CHBC programs.

**Support to research conducted by other agencies:**

- Collaborated with UNAIDS and provided technical assistance to design and implement the qualitative study on MSM in Nepal
- Participated in the steering committee meeting on BCC formative research, BCC campaign and IEC for Global Fund program organized by Family Planning association of Nepal (FPAN).
- Provided technical assistance to the Nepal Health Research Council (NHRC) on the draft study proposal "Research to Policy: Strengthening the National Processes for Evidence-based Policy in the Health Sector of Nepal".

**Issues and challenges**

- Reaching consensus on research concepts and priorities among stakeholders.
- Moving evidence into practice.

**Lessons learned**

- Including NCASC in key phases of research, including data analysis, write-ups and sharing of findings increases responsibility and builds ownership.
- Round table discussions on research findings is a useful for secondary data analysis and as a means of moving from evidence to program and can be integral to the IBBS process.
- Government systems need adequate and timely preparation before taking on new innovations and processes, including training and coaching for staff.

## RESULT AREA 4: Increase access to quality care, support and treatment services through public, private and non-governmental sources for PLHIV and their families



ASHA Project provided technical support to the Government of Nepal in strengthening the national systems that need to be in place to support the national roll-out of ART- the National Hospital System, the National Public Health Laboratory System, the National Logistics System and the National HIV Training Program. Key aspects in strengthening the public hospital systems included training hospital staff in HIV clinical management, development of SOPs and guidelines, reducing stigma and discrimination, strengthening supply chains to zonal hospitals and LMIS in hospital pharmacies, providing mentoring and monitoring and strengthening hospital laboratories. ASHA Project provided technical assistance to the NCASC throughout the project period, contributing to the development of a wide range of national guidelines, curriculums and SOPs for quality service delivery (Annex A).

CBOs played an important role in providing access to treatment and care for PLHIV including social support, treatment advocacy, CHBC, referral, basic health assessments, clinical staging, TB screening, OI prophylaxis, diagnosis, and treatment, and treatment adherence support. Active and effective referral networks between the CBOs, private health practitioners, and the public health system still need strengthening and monitoring.

### 3.9 Collaboration with GoN to strengthen capacity of the national health system to provide quality care and treatment services to PLHIV

#### Technical assistance to government

The technical expert team at ASHA Project provided support in a range of HIV technical areas through:

#### Development of guidelines, tools and SOPs for Clinical Quality Service Delivery:

Examples include revised national



pediatric ART guidelines, national PMTCT guidelines, clinical management of HIV SOPs, opportunistic infection guidelines, HIV and nutrition guidelines, and post exposure prophylaxis (PEP) flow chart and national CHBC guidelines.

#### Development of the National HIV-related curriculum

required support on a range of HIV technical areas. The national curriculum on clinical management of HIV, a national training manual on STI case management, a national refresher training curriculum on STI, a national CHBC refresher training, a curriculum for ART, a national ART adherence training curriculum and the HIV counseling resource package are some examples. ASHA Project also provided extensive technical support in the development of other national curriculums including pediatric, PMTCT, HIV-TB training, IDU/ART curriculum, COFP Counseling, and various laboratory training courses. Other contributions included the National HIV/AIDS M&E training curriculum development and PMTCT curriculum development.

#### Provision of Technical training:

ASHA Project provided training in a range of HIV-related areas primarily through AMDA-Nepal, as part of their role



as a core partner. The training concept was based on a national perspective for the roll-out of HIV prevention to care continuum. Training was provided to Government and NGO staff and included Clinical Management of HIV, Management of Sexually Transmitted Infections, Counseling and Testing, Laboratory Diagnosis of HIV and STI, CHBC, Clinical Practicum on HIV and Logistics Management Training.

Technical support was also provided for the following Training of Trainers:

- Clinical Management Training (CMT) for IDUs
- Counseling and Testing
- PMTCT

### Support to the national HIV logistic system

included the distribution of HIV test kits, ART and HIV related equipment to government ART centers and other health institutions. ASHA staff provided essential support during critical situations such as political strikes with drafting of plans to avoid ART interruption and during near-stock-out situations. At the end of the third year of ASHA Project, national HIV logistics was successfully taken over by NCASC with the support of GFATM and other stake holders. Logistics support was also provided to NPHL for



equipment, test kits and supplies required for the establishment of the DBS-EQAS program. ASHA Project also facilitated the securing of supplies for HIV related commodities required by the national program through partnerships with other international organizations. PMTCT related supplies were received through Direct Relief International from Abbott PMTCT and the Viramune Donation Program.

### Support to National Public Health Laboratory systems

An External Quality Assessment Scheme (EQAS) needs to be in place to ensure the quality of HIV testing in the country. A reference laboratory was needed in the country for establishing the EQAS of HIV testing.

NPHL is the central government laboratory under DoHS, Ministry of Health and Population with a mandate for organizational and administrative responsibilities for clinical laboratory services throughout the country. Janet Robinson, Director of Laboratory Services FHI 360 APRO conducted an assessment of NPHL in June 2007. The assessment pointed out areas of support required to NPHL for the establishment of EQAS of HIV testing.

The following were the areas of support provided to NPHL:

- Human resource support
- Capacity building of staff
- Infrastructure development
- Quality improvement initiative
- Guidelines and training curriculum development
- Standardization of HIV related laboratory trainings
- Logistics support
- Onsite technical assistance
- Dissemination and publication

ASHA Project's support to NPHL also included the establishment of a national external quality assurance system (EQAS) for HIV diagnosis in the peripheral laboratories, a validation study using the dried blood spot (DBS) method for collection and transport of the blood samples for quality control and refurbishment of the HIV laboratory at national level where all HIV related tests are carried out. Support was provided for the development of SOPs on DBS-EQAS for Rapid HIV Testing, the National Laboratory Guidelines on HIV Diagnosis, Laboratory Monitoring of ART, and National Laboratory ART Monitoring Guidelines.

### TB/HIV activities

ASHA Project technical staff provided support to TB/HIV Collaborative activities including development of National TB/HIV Strategy, National TB/HIV Guidelines, Nepal TB Program Manual, TB/HIV Training curriculum and Isoniazid Preventive Therapy Protocol. ASHA Project piloted the establishment of a TB screening protocol in HIV care settings with a referral system and linkages with the National Tuberculosis Program for treatment.

### Initiation of the first Early Infant Diagnosis program in Nepal

Early Infant Diagnosis (EID) services, introduced by the ASHA Project, enabled HIV-exposed babies between six weeks and 18 months old to be accurately tested for HIV infection for the first time. Those found to be HIV-infected could now access lifesaving ART and other treatments, greatly



increasing their chances of survival. The program included HIV polymerase chain reaction (PCR) tests and rapid testing as appropriate. Samples were collected by dried blood spot technique and sent to the FHI APRO laboratory in Bangkok for PCR testing. ASHA Project's implementing partners provided EID services from five centers and offered specialized voluntary counseling and testing that included extensive counseling on infant diagnosis, the HIV window period and breastfeeding, care of HIV-exposed babies, cotrimoxazole preventative therapy, immunization counseling, and ongoing infant feeding counseling. All HIV-exposed babies were offered EPC services, which include both clinical care and referral to other health facilities as needed for additional services. Babies found to be HIV-infected are referred to the closest ART site. During ASHA Project a total of 152 babies benefited from EID services and of them 131 were under had a PCR sent and 22 HIV-infected babies were identified and linked to appropriate services and 17 are on ART. The average age of the EID babies when they were enrolled for EID services was 5.8 months and their ages ranged from 1 month to 18 months.

With ASHA Project's successful introduction of EID, the government of Nepal is now focused on scaling up services country-wide. At the close of project efforts were underway to develop a DNA PCR laboratory in Nepal, which will allow accurate testing to be carried out within the country. The government and key stakeholders are in the process of developing national EID guidelines and a rollout plan. This will enable scale-up of a sustainable EID program, with accurate and timely test results that will help save lives.

### 3.10 Strengthen Capacity of NGOs to Provide Quality Treatment and Care Services for PLHIV and their Families.

The technical unit was responsible for ongoing technical support to the NGO partners who worked

as implementing agencies (IAs) over the project period. Their responsibilities for ensuring quality services through technical support included:

- Regular onsite coaching/mentoring and monitoring visits to all partners and their staff in the field.
- Development of a sound evaluation process, follow up and monitoring practices for all trainings provided to IAs and their staff for the range of HIV services and outreach.
- Logistics management for HIV and STI commodities, ensuring a continuous supply and proper shelf-life management.



- Collaboration with NPHL to establish an EQAS of rapid HIV testing in all ASHA Project supported IHS sites. HIV EQAS was established in all IHS sites starting with two in May 2008. All sites collected all positive and 10 percent of the negative samples for EQAS using DBS filter paper.
- Development and implementation of SOPs for all services provided at IHS sites. For example, the Essential Package of Care Operational Guidelines were updated during the project to stay in line with latest international recommendations and national guidelines and SOPs. These included all aspects of clinical management including cotrimoxazole preventive therapy, OI management, TB screening, referral for ART, nutritional care and psychosocial support.
- Provision of Post-Exposure Prophylaxis (PEP) evaluation and starter pack initiation on site by following algorithms and protocols. ASHA Project led the country in PEP programming.
- Assessment of health care waste management led to the roll-out and establishment of health care waste management throughout ASHA Project IHS sites. Health care waste management practices require that:
  - All sites have a waste management committee
  - Waste collection, segregation at origin with standard color coding and sharps



management are incorporated in the health waste system

- Waste treatment following environment friendly methods using autoclave before final disposal

### Issues and challenges

- Regular follow up of the FSW is a challenge as around 40 percent of the FSW are entering into the profession every year and older FSWs are moving to other places to seek new clients. Usually people seek the health services when they have symptoms. A large number of people, mainly women remain asymptomatic and do not think it's necessary to seek STI services. The resistance pattern of available antibiotics in this community is unknown.
- A major challenge for EPC services is ensuring follow-up of all clients. Some come from remote areas without CHBC teams and are difficult to reach for return visits. A variety of measures were taken to increase the follow-up of clients in the clinic, including providing appointments and reminders. In addition, the expectations of PLHIV are very high. EPC sites strive to coordinate with other agencies and ensure linkages to provide as many services as possible, but in some districts the services that are needed are not available.
- Dealing with very complicated cases at EPC centers is often a challenge and managing complicated OIs is a challenge often faced by practitioners. EPC sites strive to ensure close linkages with referral hospitals and timely referral to meet these challenges.
- Providing CHBC in difficult geographic areas is

another challenge, especially in the Far Western region where CHBC team members must walk long distances on foot. Clients are lost to follow up because of migration for work.

- Fulfilling the needs and often high expectations of PLHIV at door step is challenging for requirements such as nutritional support, schooling of the children, employment etc.
- EID challenges are related to the limitations of geographic coverage and the issue of a one month delay in obtaining the results. Families often travel long distances to access one of the four EID sites and they struggle to return for post-test counseling visits most often due to financial constraints. Follow-up of those missing their return visit is often difficult due to the distance. Linkages and referral networks with other facilities and NGOs is essential.

### Lessons learned

#### HIV services

- Integrated services have resulted in better utilization of services by the MARPs compared to stand-alone services such as STI clinics. Integrated clinical services blended with a strong outreach program in the community should be implemented. FSWs and IDUs feel more comfortable if the services are provided outside the general clinic to ensure that their identity remains confidential. STI management services can be provided by middle level health workers provided they are properly trained and mentored.
- Integrating HIV counseling and testing with STIs management services increased the intake of the HIV counseling and testing services. Integrating EPC services with HIV counseling and testing has provided the opportunity for quick and timely enrollment to care and support services and tightened the linkage between testing and care.
- Enhanced syndromic approach for STI management is effective for proper diagnosis and treatment of STIs
- Quality HIV care can be provided even in limited resource settings by establishing EPC services in remote and central locations. These can be replicated elsewhere by linking with the referral service centers for ART, TB, and advanced medical services. Health workers providing individualized care and ongoing counseling in a family-centered approach can ensure good health for those PLHIV before and after requiring ART, in coordination with government ART sites. Linkages to CHBC and social services are also essential.
- PEP provision via protocols, algorithms and starter packs is feasible even in remote locations

### Community and home-based care

- CHBC services are effective in providing door-to-door services and linking PLHIV to health services in geographical and resource constraint settings



- FP Counseling will be more effective if outreach workers also provide information of and referral for FP services.

- CHBC services can easily be integrated with other HIV related services. It can be a part of continuum of care to PLHIV when it is integrated with HIV counseling and testing and EPC services. CHBC can be integrated with PMTCT services, CHBC involvement in community based PMTCT in Achham is an example.
- PLHIV can run CHBC programs and can be active members of a CHBC team. PLHIV work effectively with dedication and passion. Health conditions rarely affect the quality of the work carried out by PLHIV.
- CHBC service compliments ART services- major role of CHBC in ART is the defaulter tracing and support for ART adherence. ART services collaborating with CHBC has higher adherence and low loss to follow up.

### Early infant diagnosis

- Early infant diagnosis of HIV increases access to services and saves life. Lessons learned from this pilot EID program will be very useful to inform and advise the national program on issues pertinent to the Nepali setting as guidelines and protocols are developed and a national EID program is rolled out.

### Family planning

- Health workers with clinical backgrounds can provide effective FP counseling services.
- Availability of FP commodities such as oral and injectable contraceptives at IHS sites would encourage or increase the use of FP services as many IHS clients are reluctant to visit FP centers due to fear of disclosure and long waiting time.
- Providing FP services along with STI, VCT and EPC services would provide a one-stop service for users.

## RESULT AREA 5: Create linkages among stakeholders and support national coordination of Nepal's cross sectional HIV and AIDS supported program

### 3.11 Support to national coordination with GoN, donor agencies, INGOs and NGOs

ASHA Project played a major role in building productive collaborative relationships with key organizations and HIV actors at national, regional, district and local levels, across programs and sectors. Commitment to maintaining a high level coordination



created strong relationships with government and non-government agencies and among civil society groups and networks.

#### Collaboration at National level

##### National Center for AIDS and STD Control - NCASC

ASHA Project worked in close collaboration with NCASC supporting the development of national policies, plans and programs at the leadership level as well as to their core areas of operation – technical, program, monitoring and evaluation and strategic information. The consistent participation of ASHA staff in technical working groups, at technical presentation and review meetings, strategic planning sessions and in discussions to address challenges contributed to a strengthened partnership and capacity over the five years of ASHA.

##### National Public Health Laboratory - NPHL

Collaboration with the NPHL led to a range of developments within NPHL and coordination with NPHL and UNDP led to resource mobilization for refurbishing the HIV laboratory. Working closely on the training and follow-up of laboratory technicians

across the country was also essential to the provision and improved quality of the HIV services provided at A sites, hospitals and PHCs.

##### HIV/AIDS and STI Control Board – HSCB

Despite disruptions due to funding and management and a changing role and function of the HSCB, ASHA Project continued to collaborate with the Board, attending coordination meetings, consulting them on a range of cross-cutting issues. Opportunities for collaboration included the drafting of the National Action Plan and the development of the National Strategic Plan for HIV. In 2008, ASHA Project supported the secretariat responsible for the planning and implementation of the 3<sup>rd</sup> National AIDS Conference under the leadership of HSCB. In 2010-11 ASHA Project provided financial and technical support for 'Mapping and Size Estimation of MARPs'.

##### Family Health Division - FHD

The opportunity to work in collaboration with FHD came with the introduction of CB-PMTCT. The CB-PMTCT pilot projects in Achham, Kailali and Sunsari were implemented through the existing health system, engaging their district hospital, primary health care center, and health post and sub health post staff in CB-PMTCT programming and utilizing the logistics system to ensure constant availability of HIV test kits and drugs.

**Hospitals** that provide HIV services to people living in Kathmandu valley, and to those who come from



outside for treatment, provide important support to PLHIV in the country. ASHA Project worked in close collaboration with the ART center at the Infectious Diseases Hospital in Teku, the Tribhuvan University Teaching Hospital (TUTH), the national maternity hospital *Prashuti Griya*, Kanti Children's hospital and Bir Hospital. Collaborative efforts included creating stigma and discrimination free services at these sites. Clinical Practicum Training was provided to TUTH and Teku hospitals to ensure standardization of treatment and care services for PLHIV.

## UN Agencies - UNAIDS, UNDP, UNFPA, UNICEF, UNODC and WHO

The UN agencies were national level partners throughout ASHA Project. Their various HIV focused interventions required collaborative efforts in Universal Access, CB-PMTCT, EID, programming for FSWs, IDUs and prisoners, logistics and supply and M&E, MARP size estimation and HIV prevalence.



Collaboration was maintained through meetings, workshops, joint programming as well as joint participation on technical reviews, study teams, evaluations etc.

### HIV-focused Projects

During this reporting period, coordination of activities was conducted to reduce project overlap and to maximize resources for HIV in-country. Under Global Fund Round 7, collaboration included implementation districts and program interventions, and for donation of drugs and supplies. Collaboration resulted in the Pooled Fund allocating support to avoid overlap and to enable continued support to selected MARPs in identified districts. Condom social marketing opportunities and the promotion of STI kits for clients was supported through ASHA Project collaboration with the AED-CRS partnership and cross-border migration collaboration with CARE Nepal was initiated during the project period.

## Collaboration at regional level

**Ministry of Health and Population regional reviews.** ASHA Project participated in the Annual Review Meetings held by the MOHP in each region and contributed the Annual Reports compiled and published by the regional offices. During field visits to the regional district sites program offices met with the regional directors and kept them updated on project activities.

**Regional bi-annual coordination meetings.** Regional bi-annual Coordination Meetings (BCMs) were conducted during ASHA Project at sites in Kathmandu, Biratnagar, Pokhara and Dhangadhi for ASHA implementing agencies and district-level government and I/NGO stakeholders. The BCMs included all partner IAs working in districts under each region. The meetings were designed to bring together government and nongovernment organizations working in HIV to strengthen the collaboration and coordination at both district and regional level. The objectives of the BCMs were to share and review progress; discuss issues and challenges in project implementation; review coordination and collaboration issues between and beyond ASHA Project implementing partners and; generate increased support from participating district



level partners/stakeholders in the implementation of ASHA Project activities. Presentations were shared by ASHA Project partners, representatives from the District AIDS Coordination Committees and other I/NGO organizations, UN agencies, Donors and community-based organizations working in HIV in the region. The meetings also provided an opportunity to provide technical and strategic information updates to the participants. The meetings were well attended with an approximate range of 40-60 participants.

## Collaboration at district level

**Collaboration with District AIDS Coordination Committee (DACC)/District Public Health Office (DPHO).** At district level ASHA Project staff and IA teams worked closely with the district government bodies, NGOs and CBOs to develop and maintain district level coordination and networking with other stakeholders. They participated in regular stakeholder meetings and annual reviews organized by the government, conducted monitoring visits with the

DACC and DPHO representatives and submitted regular reports according to the national DACC reporting procedures.

**Commemoration of special days and events.** ASHA Project continued to support the commemoration of special events both at national level with the



government and other stakeholder organizations and at district level through their IAs. The key events supported were National Condom Day, World AIDS Day and International Candlelight Memorial Day.

**INGOs/NGOs/CBOs.** Regular collaboration and coordination of activities were facilitated by ASHA Project field teams to facilitate information sharing and reduce overlap of activities and geographical locations of HIV services. Referral for additional services was an important component of district level



collaboration and ASHA Project and their IAs developed referral directories for related referral services for health care, counseling, legal services, income generation opportunities etc.

**Universal Access for Children Affected by AIDS in Nepal (UCAAN)**

Children affected by AIDS (CABA) had been an unheard voice in the national HIV and AIDS response

until recent years. The latest national estimates (NCASC, 2011) show there 4,715 (age 0-14 years); HIV-infected numbers which have risen considerably from 1,857 in 2007. Many children have also been orphaned due to HIV related deaths of one or both parents.

The Government of Nepal has demonstrated its commitment to the issues of CABA by ensuring a programmatic response to the National Action Plan and Strategy. Despite these gains, these children are still marginalized and suffer due to stigma and discrimination. Some are forcibly removed from schools because of their positive HIV sero-status, while others are removed simply because they are living in households with HIV positive relatives. It was against this backdrop that Universal Access for Children Affected by AIDS in Nepal (UCAAN) was formed in 2007 by United States Agency for International Development (USAID), FHI 360, UNICEF and NAP+N as a joint collaboration for children in Nepal. UCAAN was conceptualized as a means of leveraging CABA awareness at all levels and strongly advocating for the fulfillment of the rights of CABA to receive basic social services inclusive of HIV prevention, treatment, care and support.



Since its initiation, UCAAN aimed to let all Nepali children fulfill their dreams of living a healthy and dignified life. To do so, it incorporated a multi-sectoral approach wherein the partnership has grown to 61 members comprising of representatives from government agencies, I/NGOs, media and private sector. The successful incorporation of a multi-sectoral approach has assisted in making this partnership a national forum for all to come together and advocate collectively to prioritize CABA-issues and building national awareness that counters the prevailing stigma and discrimination towards CABA in Nepal.

Four years since its launch, UCAAN has been successful in establishing itself as a national partnership forum that has assisted in greatly influencing the national and local policies to address CABA-related issues. Organizing multiple awareness

programs, UCAAN assisted in sensitizing government, media and communities to work together to help these children. Also with the successful incorporation of private sector in its partnership, UCAAN managed to address gaps in CABA programs through effective resource mobilization such as education supplies, medicines and clothing for CABA. Over the years, UCAAN has also been able to establish itself as a CABA information repository and monitors all local, national and global media for CABA-related coverage. The forum has also helped organizations to share their experiences, hurdles and successes and create linkages for all to work together and streamline CABA programming for Nepal to ensure access to services and essential care and support, reduce duplication and promote sustainability.

### **Protection against human trafficking– TIP alerts for women and girls**

Based on the guidance from USAID Nepal Unified Policy on HIV/AIDS and TIP, ASHA Project continued to report on possible cases of trafficking in person cases. This involved the orientation and sensitization of all IA staff, the development and management of a rigorous reporting system and follow-up and close collaboration with district level anti-trafficking agencies as part of a referral system. The IAs providing prevention and IHS services were required to provide TIP alerts to all FSWs less than 18 years of age and other FSWs who reported being vulnerable to or victims of trafficking. This involved the referral of cases to collaborating organizations, based on service directories and the services required by the victim including counseling, legal support, protection from harm etc. A total of 289 TIP cases were reported by partner agencies in FY10 and 404 in FY11, all of whom were underage and who are also vulnerable to HIV.

At the national level, ASHA Project participated in national coordination meetings on combatting trafficking and initiated collaboration on TIP for the prevention of trafficking by forging stronger linkages with anti-trafficking programs. Collaboration with USAID supported partners The Asia Foundation (TAF) and World Education helped to identify key issues related to HIV and trafficking and to establish linkages for referral. The organizations exchanged lists of their local implementing partners and agreed to continued collaboration between organizations and within districts.

### **Media**

ASHA Project arranged media interactions and press releases, to highlight events and information dissemination and to support local advocacy



throughout the project. Press releases with the media were used to ensure wider dissemination of ASHA Project activities/achievements and press releases and data dissemination from IBBS studies and surveys was organized with the dissemination of each round of IBBS. Information related to ASHA Project activities was shared based on requests made by media personnel to prepare news pieces or special feature articles. The regular publication of ASHA newsletters continued to keep partners and stakeholders informed and each issue was distributed to media personnel.

To further strengthen the capacity of the media in HIV and AIDS reporting, a workshop was organized in August, 2009. The 2-day workshop was attended by 35 representatives from major national newspapers, television and radio. The workshop aimed to provide background information to media personnel on HIV and AIDS in Nepal, sensitize Nepali media on socio-economic, gender and cultural issues related to HIV and AIDS, provide information to media persons about the clinical and treatment aspect of HIV and AIDS and strengthen and enhance capacity of media persons to develop investigative, analytical and regular reports on HIV and AIDS

## 4. PROGRAM RESULTS

ASHA Project activities resulted in the following achievements against the indicators established under the project for the period October 2006 - September 2011.

**342,730 individuals (female 157,359; male 185,371) reached through community outreach** that promotes HIV prevention through other behavior change beyond abstinence and/or being faithful. Of those reached, 46,809 were FSWs; 121,953 were clients of FSWs; 5,959 were IDUs; 148,655 were male



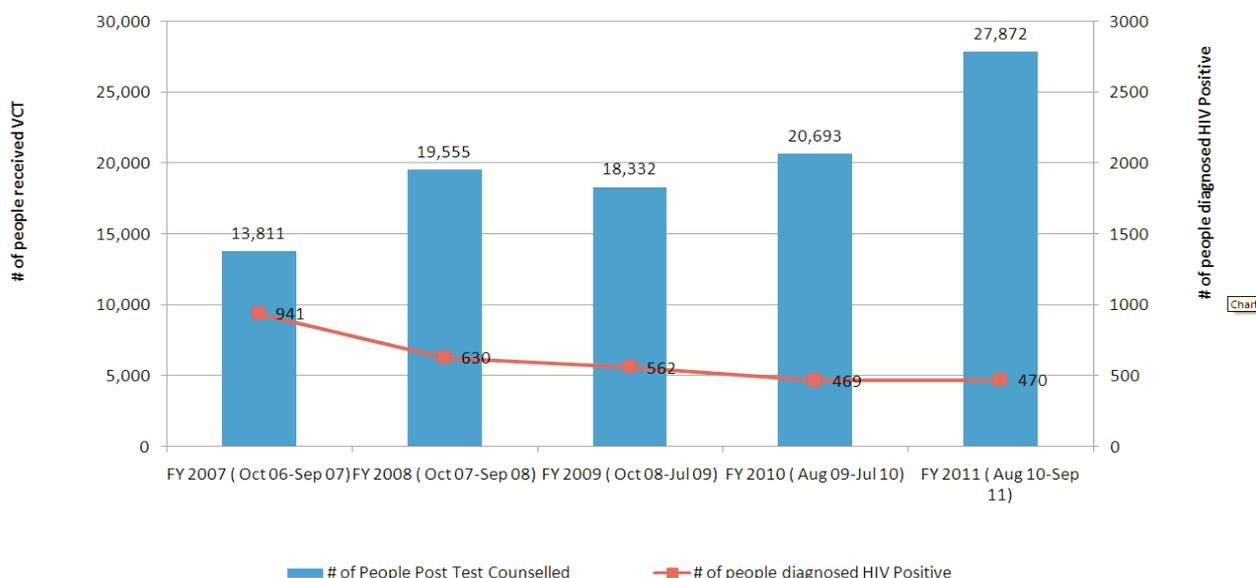
migrants and their spouses; and 67 were MSM. The prevention activities were found to be most effective when they are targeted and tailored to specific groups, when peer educators are mobilized, when linkages are made with other services and products and when the Drop-in Centers are co-located with IHS sites.

**1,466 PLHIV(778 males and 688 females)were engaged in Positive Prevention** programming activities. These activities have empowered them as individuals and strengthened their collective ownership. They have also contributed to increased disclosure as well as access to care, support and treatment as well as for lessening HIV related stigma and discrimination in the areas where they work.

**63 service sites were ever functional** during the course of the project. A total of 60 sites provided VCT services, 59 provided VCT, STI and EPC services; and three provided EPC services only. In 2007 and 2008, there 33 functioning service sites and this number increased to 37 in 2009, 39 in 2010 and reached 41 in 2011.

**93,530 individuals (female 45,206; male 48,297; TG 27) received STI services and 37,251 received treatment.**Of those who received treatment 20,110 were FSWs, 4,769 were clients of FSWs, 349 were IDUs, 4,937 were migrants and their spouses, 6,761 were other female and 289 were other male. The project

**Graph 2: Number of people who received VCT and were diagnosed with HIV at an IHS site**



found that enhanced syndromic case management is effective for diagnosis and treatment of STIs and FSWs diagnosed for STI remained high over the five years, (86.3% in 2007 and 97.4% in 2011).

**91,834 individuals received HIV counseling and testing and their results** of whom 3,068 were found to be HIV positive. The disaggregated data show that 242 were FSWs, 568 were clients of FSWs; 76 were other males and 369 were other females. Male migrants were 593 and spouses of migrants were 500; IDUs were 505, MSM were 19; and children were 196. This number dropped from 941 diagnosed in 2007 to 470 in 2011. All people diagnosed with HIV were enrolled in EPC services.

**10,919 PLHIV received Palliative Care Services and 7,915 received EPC services.** A reported 5,881 were for EPC services only, 3,004 were for CHBC services only and 2,034 received both services. Apart from providing health care and support at door-step, the CHBC services were found to be particularly

effective for linking PLHIV to other health and support services, especially in geographically and resource constrained areas.

The percentage of people diagnosed with HIV against the number of people who received VCT at ASHA Project service sites decreased from 6.8 percent to 1.7 percent over the five year project period (October 2006 to September 2011) as shown in graph 2. Data show that the percentage of people who tested positive for HIV at ASHA Project sites decreased in each of the MARPs. The percentage of migrants and their spouses who tested positive for HIV decreased substantially from 16.3 percent in 2007 to 2.3 percent in 2011. Similarly, the percentage of IDUs who tested positive for HIV decreased from 14.3 percent in 2007 to 1.9 percent in 2011. The percentage of FSWs diagnosed with HIV showed a slight decrease from 1.8 percent in 2007 to 0.8 percent in 2011 and clients of FSWs also decreased from 2.1 percent in 2007 to 1.2 percent in 2011.

**Table 1: Summary of the training achievements by key indicators**

Training	FY 2007 (Oct 06-Sep 07)	FY 2008 (Oct 07-Sep 08)	FY 2009 (Oct 08-Jul 09)	FY 2010 (Aug 09 - Jul 10)	FY 2011 (Aug10-Sep 11)	TOTAL
Prevention	929	1,061	571	999	664	4,224
Palliative Care	43	88	76	62	147	416
Counseling and testing	17	70	99	66	45	297
CMT	60	66	96	54	83	359
Lab	34	52	37	43	59	225
Strategic information	198	337	195	299	178	1,207
Institutional capacity building	388	596	641	498	359	2,482
Stigma & discrimination reduction	6,386	10,288	12,186	11,003	11,145	51,008
Community Mobilization	1,174	495	778	2,086	1,697	6,230
Medical injection safety	48	78		26	36	188

The number of health care workers who successfully completed an in-service training program was achieved or exceeded in most training components each year. Overall, 4,224 were trained in prevention skills, 416 in palliative care, 297 in counseling and

testing, 359 in clinical management, 225 in laboratory techniques, 1,027 in strategic information, 2,482 in institutional capacity building, 51,008 in stigma and discrimination reduction, 6,230 community mobilization and 188 in medical injection safety.

## 5. PROGRAM OUTCOMES AND IMPACT

Access to treatment, care and support services for people living with HIV (PLHIV) has increased significantly over the years with the decentralization of ART and PMTCT services and the increase in voluntary counseling and testing (VCT) services and pre ART services such as clinical staging, OI prophylaxis, TB screening and treatment, positive prevention and community and home-based care (CHBC) programs.

IBBS survey data provided information on the outcomes and impact of the project activities and are an indication of the success of the interventions carried out by the government and IAs over the project period among MARPs and in particularly among FSWs, IDUs and migrant workers and their spouses.

### Female sex workers

- **The HIV prevalence among FSWs** in the most recent rounds of IBBS surveys conducted in three clusters is 1.7 percent in Kathmandu valley (2011), 1.2 percent in Pokhara valley (2011) and 2.3 percent in the 22 Terai highway districts (2009). The prevalence among FSWs in Kathmandu valley is close to the 1.4 percent estimated by ASHA Project for 2011 and in Pokhara valley is somewhat lower than the estimated 2 percent. The trend in HIV prevalence has remained fairly stable over time at around 2 percent in both Kathmandu valley (2004-2011) and the 22 Terai highway districts (2003-2009), while among FSWs in Pokhara valley the HIV prevalence fluctuated from 2 percent in 2004 and 2006, to 3 percent in 2008, to 1.2 percent in 2011.



- **Condom use is increasing among FSWs** and according to the IBBS, 2011 is about 75 percent among FSWs in Kathmandu valley and Pokhara valley, which is well above the 60 percent ASHA Project estimated target for 2011. Using condoms consistently with all partners has continued as a major focus of all prevention interventions and community outreach activities. While consistent



condom use with both regular clients and 'other sex partners' has shown a significant increase over the past four rounds, using condoms with non-paying partners is still relatively low and is declining in Kathmandu valley.

- **FSWs reached with HIV prevention programs**, which was 60 percent in 2010 was reported to be 84 percent in 2011 in Kathmandu valley and 79 percent in Pokhara valley (IBBS, 2011).
- **IBBS surveys conduct among truckers**, a sub-group of clients of sex workers show a declining HIV prevalence trend as it was 1.8 percent in 2003, 1 percent in 2006 and no HIV cases were reported in 2009.

### Injecting Drug Users

The National Size Estimation of MARPs in 2010 (HSCB, 2011) suggests that the estimated population for IDUs is in the range of 29,161 to 32,584.

- **The HIV prevalence among the IDUs** in Kathmandu (IBBS, 2011) shows a significant decreasing trend from 68 percent in 2002 to 6.3 percent in Kathmandu valley in 2011, which is substantially lower than the estimated 20 percent by 2011. In Pokhara valley, the trend shows that prevalence went from 22 percent in 2003 down to 4.6 percent in 2011, which is close to the 5 percent estimated by the end of ASHA Project. The high annual turnover of among IDUs may be contributing to the decrease in the prevalence of



HIV and may suggest that there is less exposure to HIV among new users.

- Comprehensive knowledge about HIV transmission** in the 2011 IBBS was 61 percent in Kathmandu valley, which is lower than the estimated ASHA target of 70 percent, and was 71 percent in Pokhara valley. The high turnover in IDUs is probably a contributing factor and continued strengthening of outreach is required to ensure access to information, especially to new IDUs. Knowledge of transmission from contaminated needles was 99 percent in Kathmandu valley and 100 percent in Pokhara valley.
- Consistent condom use (CCU) among IDUs when having sex with a sex worker** was estimated under ASHA to be 60 percent by 2011. The IBBS 2011, reported that 24 percent from Kathmandu valley had unprotected sex with a sex worker in the past year, while Pokhara valley reported a less positive result of 30 percent against an estimated ASHA Project target of 80 percent CCU with a sex worker.
- The IBBS surveys among people who inject drugs in the Eastern Terai** also show a significant decreasing trend in HIV prevalence from 35 percent in 2003 to 8 percent in 2011. The HIV prevalence among people who inject drugs in the Western and Far-Western Terai districts show a decrease from about 12 percent in 2005 to 8 percent in 2011.

### **Migrant workers and their spouses**

The IBBS surveys among male labor migrant workers returning from India was conducted in two clusters – in the Western region for two rounds and the Mid-Far Western regions for three rounds.

- The HIV prevalence among migrant workers** in the Mid-Far Western region shows no specific trend with fluctuations from 2.8 percent in 2006, to 0.8 percent in 2008 and 1.8 percent (unweighted) in 2010. In the Western region, the HIV prevalence was 1.4 percent in 2008 and decreased slightly to 1.1 percent in 2010. Male labor migrants to India still need to be reached in Nepal before they migrate or during their visits to their home districts when they return and before they re-migrate.

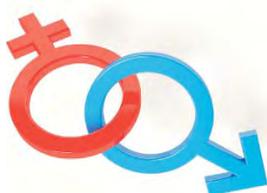


- Two rounds of IBBS were also conducted among the wives of migrant workers** in the Far-Western region districts of Achham, Doti, Kanchanpur and Kailali. The surveys showed the HIV prevalence in 2008 was 3.3 percent, which by 2010 had fallen to 0.8 percent.

## Cross-cutting issues addressed through ASHA Project

### Increasing gender equity

ASHA Project has supported the PLHIV women networks to strengthen their voice and their professional development through leadership skills and decision making processes. The program has also focused on services designed particularly for the needs of women. Studies conducted under the IBBS have provided information to community beneficiaries to enhance knowledge and improve their health by accessing services. Women-led organizations have also been a focus for ASHA Project. Human resources policies focus on workforce diversity, gender equality and transparent recruitment. All services provided through the ASHA Project partners are gender friendly and respect the privacy and confidentiality of all MARP beneficiaries, including female sex workers and female IDUs.



ASHA Project strived to achieve a gender balance in all activities wherever possible and included third gender groups in trainings, interactions and periodic project reviews. Orientations and interactions with community members usually included equal male and female participation and of those reached through ASHA Project 46 percent were women and 54 percent were men. Similarly, of those who received STI services 48 percent were women and 52 percent were men; 27 of the 93,530 were transgender. Of the PLHIV trained and engaged in Positive Prevention, 47 percent were women and 53 percent were men (688 female; 778 male). Furthermore, of ASHA Project staff at community level, about two-thirds of the community mobilizers operating through partner NGOs at local level were women.

### Reducing gender based violence and exploitation

ASHA Project collected information on violence against FSWs in the IBBS studies and shared that from the concerned community members national and district level stakeholders. According to the IBBS, 2011 findings, 18 percent of FSWs in Kathmandu valley were physically assaulted in the past year; 21 percent among street-based and 16 percent among establishment-based FWS. The findings from Pokhara were similar and reported 20 percent of FSWs physical assaulted in the past year. Training on condom negotiation skills for FSWs was incorporated into all FSW training and coaching through outreach activities to help address this issue. Violence issues and personal safety were also addressed during the training and support was provided as needed through linkages with TIP referral agencies.

### Reaching youth

Although ASHA Project does not have a specific youth component, key target age groups among MARP sub groups are young people aged 15-19 and 20-24. The IBBS 2011 found that 28 percent of the FSWs from Kathmandu valley were below 20 years of age; in Pokhara it was 42 percent. A substantial number of the FSWs and IDUs reached through ASHA Project were from these age groups and were therefore direct beneficiaries of the prevention to care services, which included awareness raising, knowledge building and prevention of HIV.

The IHS sites were frequently used by MARPS of these age groups where they received free and confidential services for VCT, STI and EPC. Of the people examined for STI and for those who received VCT services the percentages of young people who received these services were the same - 44 percent were aged 15-

**Table 2: HIV service indicators by age group**

Indicator	Age Group		
	15-19	20-24	Total (15-24)
# of individual examined for STI	13,780	27,176	40,956
# of individual treated STI	5,260	9,460	14,720
# of individual received VCT Service	13,392	27,109	40,501
# of individual diagnosed HIV +ve	73	392	465
# of individual received EPC services	113	621	734
# of individual received CHBC services	52	253	305
# of individual received Palliative Care	137	731	868



24, of whom 33 percent were 15-19 year olds. About 39 percent of the individuals treated for STIs were aged between 15 and 24 years and of those diagnosed with HIV from this age group, it was 15 percent.

## 6. OVERALL PROGRAM MANAGEMENT

### Implementation

ASHA Project was the main partner for USAID Nepal in supporting the GON's program for HIV and AIDS. The strategies and activities were designed specifically to support the national strategy and program priorities and primarily implemented through local partner NGOs in ASHA Project districts across the country. The IAs operated under sub agreements, which were developed collaboratively based on the assigned objectives, strategies and activities. Between 2006 and 2011, ASHA Project worked in partnership with 71 national and local organizations that included NGOs, research agencies, federations and networks, among others. See Annex D for details.

### Management

FHI 360 Nepal worked under the decentralized system with technical and administrative support from the FHI 360 Asia Pacific Regional Office (APRO) in Bangkok. Contracts and grants were managed in-country.

During ASHA Project, the Nepal country office was staffed by 46 full time employees. Staff members were provided with capacity-building opportunities based on professional development plans and attended training, workshops and presented at conferences in the region. The senior management team included the ASHA Project Chief of Party, Associate Director for Finance and Administration and Deputy Director. The office was managed through two main units – Finance and Administration Unit and Program and Technical Unit. The Finance and Administration Unit operated through two sub-units, Administration/Finance and Contracts and Grants. The Program and Technical Unit operated through three sub-units: the Strategic Information Unit, which included research, M&E and MIS/GIS; the Program Unit, responsible for project implementation and the Technical Unit, which covered clinical services and community initiatives, as well as laboratory and logistics support. Each sub-unit was managed by a team leader, under the direct supervision of the deputy director for program and technical operations. Annual work plan and budget development was participatory and the process involved identifying outcomes for the coming year, reflection on the previous year's achievements and gaps and program

and technical requirements for the year ahead. Partner IAs also operated according to annual work plans and the country office monitored them through quarterly reviews to track progress against expected achievements, identify and address issues, discuss challenges and revise plans and activities based on allocated time frames and resources.

### Communication and information sharing

ASHA Project provided the opportunity to further strengthen the communications and information sharing mechanism and procedures between staff, partners and collaborating agencies. A repository of resource materials, publications and documentation was maintained at the FHI 360 office for ASHA Project and internal documents were managed through intranet and a common folder for easy access to all staff. Regular technical updates were shared in-house and with USAID Nepal.

For IAs and external audiences, key program documents and global publications were shared as they became available to ensure updated information at country and field level. Information, research results and technical updates were shared via e-mail, through disseminations, roundtables and interactive meetings. Findings from IBBS surveys were conducted and disseminated in collaboration with NCASC at national and regional level and with the study population communities at local level.

### Monitoring and coordination

Monitoring was an integral part of ASHA Project's management. The project used various opportunities to inform program strengthening and routinely reviewed district-level performance data with partner implementing agencies (IAs) to identify areas where program implementation could be more effective and efficient. FHI 360 trained IAs on data use and assisted them to utilize the M&E processes as a



management tool. The ASHA Project management information system (MIS) was in place across the sites and units to collect, process, analyze and use the data generated in the project. A central database system was used to store project data for reporting and dissemination purposes. Data was collected, recorded and reported to FHI 360 office on a monthly basis by NGOs and collated quarterly using the set of ASHA Project indicators. Updates on achievements against targets were shared and discussed with IAs during their quarterly reviews.

BCMs provided a forum to share IA achievements and challenges, along with district data from the DACC and other national data available for sharing more widely and for strengthening coordination among regional and district stakeholders.

The DQA guideline was introduced through ASHA Project as a participatory tool for gathering information from IAs to provide evidence for informed decision-making at the program level. The DQA process enables the IA staff to review the quality of the data they are recording and reporting, using checklists to assess the validity, reliability and integrity of these data, and to in turn to identify concerns that reflect on the quality of the project and make decisions on areas for improvement.

### **ASHA Project evaluations**

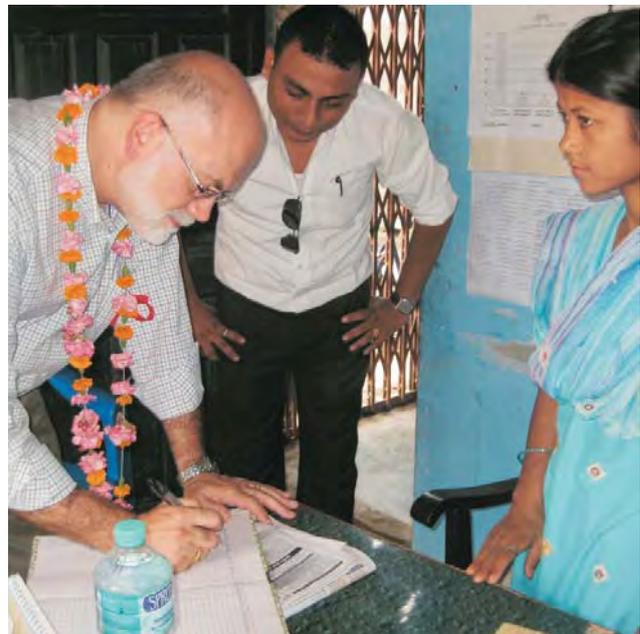
During 2009, a mid-term evaluation was conducted with ASHA Project by a USAID selected evaluation team. The suggestions made by the team were incorporated into the future planning for the project. As a result, Drop-in Centers were co-located with IHS sites to promote utilization of the services and facilities; analysis of data by gender was incorporated into the MIS, and strengthening IAs for sustainability through capacity building included improved financial and M&E management in NGOs and development of their skills in proposal writing.

In 2011 a DQA was conducted by USAID with ASHA Project for all OP indicators reported by OHFP in 2011 for HIV and AIDS. The DQA was a joint team exercise and included a selection of IAs representing the NGO partners in the field from the Eastern and Mid-Western Regions. Refinements in data collection at the community level were made based on the DQA findings.

An assessment of the CHBC in 13 districts was also conducted in 2011, to measure CHBC program service coverage and client retention, to assess the extent of CHBC service quality and the physical and psychosocial wellbeing of and differences between CHBC clients and non-CHBC clients.

### **USAID Coordination**

Monthly Meetings were held with USAID to maintain regular communication, provide updates on the project and to discuss program matters in the broader stakeholder context. Agendas were jointly developed and minutes were shared following each meeting. Technical and research updates were also held based on agreed topics on new research findings in HIV as well as in-country data and learning from ASHA Project. The ASHA Project directors and team leaders participated in the Semi-annual and Annual Health Partners Meetings organized by USAID Office of Health and Family Planning where they organized to share and discuss program priorities, targets and achievements and challenges. The meetings also helped to identify cross-cutting issues and promoted



coordination among USAID health partners. ASHA Project also prepared and submitted Semi-Annual Reports to USAID covering the key activities and achievements for each reporting period. ASHA Project also contributed to presentations at USAID organized events such as NGO Day and World AIDS Day.

### **Field visits**

Field visits with US government representatives working in the Nepal Mission and visitors from Washington and other USAID Missions in the region were arranged as required and were coordinated through the HIV AOTR at USAID. Field visits during ASHA Project included US Ambassador Ordway, US Ambassador Scott H. DeLisi, US Government Principle Deputy Assistant Secretary, Patrick Moon, USAID Mission Director, David Atteberry director, US



Government Global Health Initiative team, representatives from the O/HFP, Outreach Bus Tour for Students, Journalists and USAID Mission staff, AME-State of the Art (SOTA) representatives from US Missions, American Peace Corps and a joint visit with USAID, NCASC, FHD, UNICEF and WHO.

## Finance

The Nepal country office maintained a strong financial and administrative system and annual audits were performed through an independent auditing firm T.R. Upadhyaya & Co.

NGO management systems were supported for governance, transparency and commitment to quality services. Support to strengthen IAs management systems continued throughout the project period with the maintenance of a robust internal control system. Financial reviews were conducted for all implementing partners and limited scope audits were conducted for selected partners each year and issues were subsequently addressed. To strengthen governance and accountability, findings were shared with Board members and discussed through interactive sessions. Informal staff discussions were also encouraged to ensure proper systems were in place and being maintained.

ASHA Project's support to the financial monitoring of sub-agreements was also regular and robust. Pre-award audits were performed for new sub-recipients and areas that required strengthening were subsequently addressed through financial management training with periodic follow-up and on-site support when needed. The limited scope audits for selected implementing agencies were conducted in accordance with the AICPA's standards

and approved by external auditors, Ernst & Young. Cost analysis tools were applied periodically to monitor expenditure status and to maintain project budgeting within annual budgets and across the project period. FHI 360 staff participated in financial management workshops at regional sites to update and refine skills and to ensure the required level of financial expertise in-country. The country office also provided annual inventory reports of non-expendable property to USAID at the end of each fiscal year and a Federal financial report (SF 425) was submitted by FHI 360/HQ to USAID every quarter.

## ANNEXES

### Annex A: National guidelines, standard operating procedures (SOPs) and training resources developed with ASHA Project support and technical Assistance

ASHA Project List of Guidelines and SOPs		
SN	Name of Technical Documents/Materials	Month and Year of Publication
1	Clinical Management of HIV - Operational Guidelines	Sep-07
2	Essential Package of Care operational Guidelines	Aug-08
3	Standard Operating Procedures for STI Clinics	Sep-07
4	Standard Operating Procedure for HIV Counseling and Testing	Aug-07
5	Community and Home Based Care Standard Operating Procedure	Aug-07
6	Standard Operating Procedures for Laboratory Services at Integrated Health Service Centers	Dec-08
7	IHS guidelines for program managers	Dec-09
8	National Clinical Management of HIV-Standard Operating Procedures	May-08
9	Pediatric Antiretroviral and Cotrimoxazole Dosing Tool	Jan-09
10	National Guidelines on CHBC & Standard Operating Procedures - Nepali & English	Feb-09
11	HIV Infection and Nutrition training package	Feb-09
12	PEP flow chart - flex poster	Jan-09
13	EID flow chart - flex poster	NA
14	Manual of Standard Operating Procedures for Community Based Prevention of Mother-to-Child Transmission of HIV (CB-PMTCT) Program and Research Study	Jul-09
15	Community Based PMTCT Nepal Training Package Participants Manual	Sep-09
16	Community Based PMTCT Nepal Training Package Facilitators Manual	Sep-09
17	Standard Operating Procedure for FP Counseling Services at IHS Centers	Mar-10
18	Community and Home Based Care for Adults and Children Living with HIV Standard Operating Procedures	Aug-10
19	National guidelines on HIV Diagnosis and Laboratory Monitoring of Antiretroviral Therapy	Apr-11
20	National training manual on Management of Sexually Transmitted Infections	Jun-11
21	National Training Manual on Clinical Management of HIV & AIDS -Participants manual	Sep-11
22	National Training Manual on Clinical Management of HIV & AIDS -Facilitators manual	Sep-11
23	National Training Manual on Community and Home based care of Adults and children with HIV and AIDS in Nepal	Sep-11
24	HIV Counseling Resource Package - HIV Counseling Handbook	Sep-11
25	HIV Counseling Resource Package - HIV Counseling Trainers manual	Sep-11
26	HIV Counseling Resource Package - HIV Counseling Toolkit	Sep-11
27	National Guidelines on CHBC & Standard Operating Procedures - Nepali & English (Reprinted with one page addendum)	Sep-11
28	National HIV Training Plan	Sep-11
29	National HIV Testing and Counseling guidelines	Sep-11

**Annex B:  
Program documents developed under ASHA Project**

SN	Name of Documents/Materials
<b>Program Related</b>	
1	S&D toolkit
2	Daily diary
3	Coverage register
4	Memory Jogger
5	PE Manual Print/CD
6	BISHWASSStrip - flex poster
7	Positive framework - flex poster
8	Microplanning - Coverage Register
9	Microplanning - Daily Diary
10	Microplanning - Target Group Profile
11	Microplanning - Daily Planning Format
12	Treatment Literacy Training Curriculum
13	Technical Briefs (Two pagers)
14	District Plans
15	District Inserts
16	ASHA IA flyers
17	Prevention guidelines
18	BISHWASSstrategy (DIC guidelines) (Revised)
19	SOP on Positive Prevention
20	Mapping guidelines for prevention and CHBC
21	IEC materials use guidelines
22	Supportive supervision checklists (prevention, positive prevention and CABA)
23	District plans (full) (2010/2011)
24	District plan inserts (2010/2011)
25	Guidelines for obtaining consent
26	Consent form for photo
27	Consent form for success stories
28	Lessons learned prison program
29	A review report on positive prevention (2007-2009)
30	Training manual on outreach and peer education (Nepali)
31	Training manual on negotiation skills (Nepali)
32	Training manual on positive prevention (Nepali)
33	Training manual on community mobilization (Nepali)
34	Training manual on DIC operation (Nepali)
35	Success story booklet 1-6
36	Good practice and lessons learned documentation guidelines (Nepali and English)
37	S&D reduction workshop report
38	Analysis of MARP Integration into DIC and IHS
39	Prevention strategies for FSW-IDU and FIDU-SW
40	Training manual – Training on HIV and AIDS-related topics for media personnel

SN	Name of Documents/Materials
<b>IEC Materials</b>	
1	Sundarta Brochure
2	Information on STI - brochure
3	Nutrition brochure
4	ART Treatment: Managing Side Effects- brochure
5	Information on Syphilis- brochure
6	Anti-Retroviral Treatment - brochure
7	5 Care series booklets with guideline and folder
8	Brochure: Do you know about HIV?
9	Brochure: Do you know the difference between HIV and AIDS?
10	Brochure: How to reduce stigma and discrimination (S&D)?
11	Brochure: How to remain healthy after getting HIV?
12	Brochure: How to remain peace and happy after getting HIV?
13	Brochure: General information about OI
14	Brochure: General information about OIs and its treatment
15	Brochure: Information on skin related infections
16	Brochure: How to remain physically healthy after getting AIDS?
17	Brochure: What to do to remain happy and calm after developing AIDS?
18	Brochure: What to plan for future after developing AIDS?
19	Brochure: General information about OIs during AIDS
20	Brochure: Things to consider while providing care and treatment to AIDS patient
21	Information on service sites - brochure (WAD 2009)
22	Nevirapine insert
23	EID booklet for parents
24	EID poster
25	Things to know about OI - brochure
26	Maya coloring book
27	Bihani KoAagaman - Part 1, 2 and 3
28	You Are Special booklet
29	Sayapatri - music video (DVD)
30	Asha Ko Geet - Nepali (audio CD)
31	Outreach bag
32	Wooden dildo and its bag
33	Condom Negotiation Skills Dice (1 piece with 6 sides)
34	Condom Negotiation Wheel (1 wheel)
35	Avoiding Alcohol & Drug use Negotiation Wheel (1 Wheel)
36	Playing Cards (48)
37	HIV/AIDS True/False Cards (13 cards)
38	Bagchal
39	Snakes and ladder
40	Ludo - prevention

SN	Name of Documents/Materials
<b>IEC Materials</b>	
41	Ludo - care and support
42	Risk assessment card
43	A set of Bottles with Litmus paper (2 bottles & 5 pkt of Litmus)
44	Love Garden Game board with a set of badges (8 badges in a set)
45	Eikrit Swasthya Sewa Kendra Ma Ke Garincha (IHS flip chart)
46	Puzzle game (1 set of puzzle contains 6 different puzzles)
48	HIV and AIDS Flip Chart
49	CHBC Photo Journal Part 1, 2, 3, 4 (presentation) and 1,2,3 (Narration)
50	Condom Display Rack – Wooden
51	Condom Dispenser Box – Metal
52	Electric Shot Game – Wooden
53	CHBC Photo journal part 1, 2, 3 and 4
54	Promoting health seeking behavior- Poster
55	Condom use promotion
56	Thank you and follow up referral slip
57	Web-based SMS leaflet
58	Hepatitis B Brochure
59	Clean needles and syringes brochure
60	ASHAKA Kiran Haru - Documentary
61	ASHAKA Kiran Haru – Photo journal series Part 1-4

## Annex C: Research and assessment reports produced during ASHA Project

List Of Research And Surveillance Conducted During Asha Project			
SN	Research Title	Research organization	Year conducted
1	FHI Nepal CHBC Program Assessment	CMDN	2011
2	IBBS survey among Female Sex Workers (FSWs) in Kathmandu valley (Round IV)	New ERA & Intrepid Nepal	2011
3	IBBS survey among FSWs in Pokhara valley (Round IV)	New ERA & Intrepid Nepal	2011
4	IBBS survey among Injecting Drug Users (IDUs) in Kathmandu valley (Round V)	New ERA & Intrepid Nepal	2011
5	IBBS survey among IDUs in Pokhara valley (Round V)	New ERA & Intrepid Nepal	2011
6	New Dynamics in FSW and potential of use of new technology for HIV prevention program	RDN	2010
7	IBBS survey among Wives of Migrant Laborers in four districts of Far Western Nepal (Round II)	New ERA & Intrepid Nepal	2010
8	Situation and Needs Assessment of HIV&AIDS in the Prison System in Nepal	FHI 360	2009
9	IBBS survey among FSWs in 22 Terai highway districts, (Round III)	AC Neilson & SACTS	2009
10	IBBS survey among truckers in 22 Terai highway districts (Round IV)	AC Neilson & SACTS	2009
11	IBBS survey among IDUs in Kathmandu Valley, (Round IV)	New ERA & SACTS	2009
12	IBBS survey among IDUs in Pokhara Valley, (Round IV)	New ERA & SACTS	2009
13	IBBS survey among IDUs in Eastern Terai, (Round IV)	New ERA & SACTS	2009
14	IBBS survey among IDUs in Western to Far Western Terai (Round III)	New ERA & SACTS	2009
15	IBBS survey among Men who have sex with Men (MSM) in Kathmandu Valley (Round III)	New ERA & SACTS	2009
16	Delivery of CB-PMTCT services including take-home mother and infant NVP in Achham District of Nepal	FHI 360	2009-2011
17	IBBS survey among FSWs in Kathmandu Valley (Round III)	New ERA & SACTS	2008
18	IBBS survey among Wives of Migrant Laborers of Four Districts of Nepal (Round 1)	New ERA & SACTS	2008
19	IBBS survey among Female Sex Workers in Pokhara Valley (Round III)	New ERA & SACTS	2008
20	IBBS survey among Male Labor Migrants in 11 Districts in Western and Mid to Far Western Regions of Nepal (Round II)	New ERA & SACTS	2008
21	IBBS survey among IDUs in Kathmandu valley (Round III)	New ERA & SACTS	2007
22	IBBS survey among IDUs in Pokhara valley (Round III)	New ERA & SACTS	2007
23	IBBS survey among IDUs in Eastern Terai (Round III)	New ERA & SACTS	2007
24	IBBS survey among IDUs in Western to Far Western Terai (Round II)	New ERA & SACTS	2007
25	IBBS survey among MSM in Kathmandu Valley (Round II)	New ERA & SACTS	2007

## Annex D: Implementing Agencies under ASHA Project

SN	FCO/ID	Name	Organizational Type	Geographic Location	Target Population	Project Title	Intervention	LOP Budget US\$	LOP Payment US\$	Project Start Date	Project End Date
1	605114/0141.0080	AC Nielsen Nepal Pvt. Ltd.	Private Corporation	Nationwide	FSWs and Truckers	IBBS among FSWs and Truckers in Terai Highway Districts	Research	74,998	68,587	11/15/2008	6/30/2009
2	605118/0141.0086	Arunodaya Youth Club (AYC)	NGO	Central	Prisoners	Prevention of HIV and AIDS Among Prisoners in Birgunj Jail	SBC/prevention	34,734	34,734	3/1/2009	9/30/2010
3	605096/0141.0059	Asha Kiran Pratisthan, Kailali	NGO	Far western	PLHIV and their families	CHBC Services for PLHA in Kailali District	Care and Support	114,076	114,076	3/16/2007	9/30/2011
4	605050/0141.0013	Association of Medical Doctors of Asia (AMDA)	NGO	Nationwide	FSWs, clients, PLHIV and IAs	AMDA ASHA Project	STI, VCT, treatment and care and capacity building	344,344	337,385	9/1/2006	9/30/2007
5	605101/0141.0064	Association of Medical Doctors of Asia (AMDA)	NGO	Nationwide	FSWs, clients, PLHIV and IAs	AMDA ASHA Project	STI, VCT, treatment and care and capacity building	957,073	956,642	10/1/2007	9/30/2011
6	605133/0141.0102	Center for Molecular Dynamics Nepal (CMDN)	NGO	Nationwide	PLHIV and their families and IAs	FHI Nepal CHBC Program Assessment	Research	23,235	23,235	2/1/2011	6/15/2011
7	605102/0141.0068	Chhahari Mahila Samuha	NGO	Western	PLHIV and their families	Positive Prevention in Chitwan	Positive Prevention	47,631	47,631	11/1/2007	9/30/2011
8	605100/0141.0063	Child and Women Empowerment Society (CWES)	NGO	Western	FSWs and their clients	HIV Prevention and Care Program in Kaski District	SBC/prevention	142,583	142,583	6/1/2007	9/30/2011
9	605063/0141.0026	Community Action Center (CAC-Nepal)	NGO	Kathmandu	FSWs, clients and PLHIV	Integrated Health Services for FSWs & Their Clients in Kathmandu Valley	SBC/prevention, STI, VCT and treatment and care	429,859	429,859	10/1/2006	9/30/2011
10	605117/0141.0085	Community Awareness Against HIV/AIDS & Drug Addiction (CAADA)	NGO	Central	Prisoners	Prevention of HIV and AIDS Among Prisoners at Central Jail, Kathmandu	SBC/prevention	32,207	32,207	3/1/2009	9/30/2010
11	605125/0141.0094	Community Development Forum	NGO	Far western	PLHIV and their families	CHBC Services for PLHA in Doti District	Care and Support	63,041	63,041	4/1/2009	9/30/2011
12	605062/0141.0025	Community Welfare Center (CWC)	NGO	Kathmandu	Clients of FSWs	HIV/AIDS Prevention Project among Clients in Kathmandu Valley	SBC/prevention	411,147	411,147	10/1/2006	9/30/2011
13	605119/0141.0087	Dang Plus, Dang	NGO	Mid Western	PLHIV and their families	Positive Prevention Program in Dang District	Positive Prevention	43,998	43,998	2/1/2009	9/30/2011
14	605091/0141.0054	Dharan Positive Group	NGO	Eastern	PLHIV and their families	Home Based Care and Support Program in Dharan	Care and Support	83,762	83,762	3/16/2007	9/30/2011
15	605106/0141.0069	Dhaulagiri Positive Group (DPG)	NGO	Western	PLHIV and their families	Positive Prevention Program in Baglung and Parbat Districts	Positive Prevention	48,857	48,857	11/1/2007	9/30/2011
16	605055/0141.0018	Digital Broadcast Initiative, Equal Access-Nepal	NGO	Nationwide	Migrants and their spouse	Safe Migration Radio Program	SBC/prevention	231,402	231,402	10/1/2006	6/30/2009

SN	FCO/ID	Name	Organizational Type	Geographic Location	Target Population	Project Title	Intervention	LOP Budget US\$	LOP Payment US\$	Project Start Date	Project End Date
17	605127/0141.0096	Drishti Nepal	NGO	Nationwide	Female injecting drug users and their CBOs	Network Strengthening Among Former Female IDUs	Network capacity building	30,325	30,325	6/1/2009	9/30/2011
18	605105/0141.0067	Federation of Sexual and Gender Minorities Nepal	NGO	Nationwide	MSM and transgender	MSM/MSW Network Strengthening Program	Network capacity building	112,791	112,791	11/1/2007	9/30/2011
19	605078/0141.0041	Forum for Women, Law and Development	NGO	Nationwide	Policy makers, NGOs, Gos, IAs	Legal Reform of HIV/AIDS	Policy reform, advocacy	38,373	38,373	11/1/2006	9/30/2008
20	605095/0141.0058	Gangotri Rural Development Forum, Achham	NGO	Far western	PLHIV and their families	CHBC Services for PLHA in Achham District	Care and Support	190,155	190,155	3/16/2007	9/30/2011
21	605053/0141.0016	General Welfare Pratisthan (GWP)	NGO	Central	FSWs, clients and PLHIV	Safe Highway: Prevention to Care Services in Five Central Districts	SBC/prevention, STI, VCT and treatment and care	758,967	758,736	9/16/2006	9/30/2011
22	605116/0141.0082	Holier Association of Polite and Progressive Yough (Happy Nepal Red Ribbon and Friends)	NGO	Eastern	Children and their families	Care and Support Program for Infected and Affected Children	SBC/prevention, care, support and treatment	50,342	50,342	12/1/2008	8/31/2011
23	605067/0141.0030	Indreni Service Society (INSES)	NGO	Eastern	FSWs and their clients	Prevention Services in Siraha & Saptari Districts	SBC/prevention	127,890	127,890	10/1/2006	9/30/2009
24	605059/0141.0022	Institute of Community Health	NGO	Mid Western	FSWs and their clients	Safe Highway Initiative in Mid West Nepal	SBC/prevention	332,677	332,677	10/1/2006	9/30/2011
25	605066/0141.0029	International Nepal Fellowship (INF)	NGO	Western	FSWs, clients, PLHIV and their families	STI/VCT/Care Services in Pokhara	STI, VCT, care, support and treatment	248,315	248,315	10/1/2006	6/30/2011
26	605129/0141.0099	Intrepid Nepal Pvt. Ltd.	Private Corporation	Nationwide	Migrants and their spouse	IBBS among wives of migrants in four districts in the Far Western Region of Nepal	Research	10,061	10,061	5/1/2010	7/31/2010
27	605132/0141.0101	Intrepid Nepal Pvt. Ltd.	Private Corporation	Nationwide	FSWs, IDUs	IBBS Among FSWs and IDUs in Kathmandu and Pokhara Valley in Nepal	Research	21,807	21,128	1/1/2011	4/30/2011
28	605093/0141.0056	Jagriti Mahila Samaj (JMS)	NGO	Nationwide	FSWs and their CBOs	Network Capacity Building for Advocacy	Network capacity building	10,046	10,040	2/16/2007	2/15/2008
29	605098/0141.0061	Junkiri, Banke	NGO	Mid Western	PLHIV and their families	CHBC Services for PLHA in Banke District	Care and Support	76,086	76,086	6/1/2007	9/30/2011
30	605079/0141.0042	Local Development Training Academy (LDTA)	NGO	Nationwide	Government training centers and staff	Institutionalization of HIV/AIDS into Regular Training Program Of LDTA	Capacity building	19,356	19,189	12/1/2006	12/31/2007

SN	FCO/ID	Name	Organizational Type	Geographic Location	Target Population	Project Title	Intervention	LOP Budget US\$	LOP Payment US\$	Project Start Date	Project End Date
31	605104/0141.0066	Lumbini Plus	NGO	Western	PLHIV and their families	Positive Prevention in Nawalparasi	Positive Prevention	50,169	50,169	11/1/2007	9/30/2011
32	605086/0141.0049	Manabiya Srot Bikas Kendra (MSBK)	NGO	Western	NGOs/IAs	Capacity Building of Networks in the Far Western Region	Capacity building	20,757	19,937	2/1/2007	9/30/2007
33	605109/0141.0072	Management Association of Nepal	NGO	Nationwide	Government of Nepal, Ministries	Support to Integrate HIV/AIDS Activities in ministries of Nepal Government	Capacity building, Advocacy	37,144	36,770	11/1/2007	10/31/2008
34	605074/0141.0037	Management Support Service Ltd. (MASS)	Private Corporation	Nationwide	Government, NCASC	Support for National HIV/AIDS Program	National support	38,205	23,989	10/1/2006	9/30/2007
35	605075/0141.0038	Management Support Service Ltd. (MASS)	Private Corporation	Nationwide	Government, NCASC	Support for Logistic Component of National HIV/AIDS Program	Logistic support	25,215	25,215	10/1/2006	9/30/2007
36	605107/0141.0070	Management Support Service Ltd. (MASS)	Private Corporation	Nationwide	Government, NCASC	Support for Logistic Component of National HIV/AIDS Program	Logistic support	128,939	128,939	10/1/2007	6/30/2009
37	605128/0141.0097	Namuna Integrated Development Council	NGO	Western	FSWs, clients, PLHIV and their families	HIV Prevention and Care, Support and Treatment Project in Rupandehi and Kapilvastu	SBC/prevention, STI, VCT and care, support and treatment	151,855	151,855	10/1/2009	9/30/2011
38	605092/0141.0055	Nari Chetna Samaj (NCS)	NGO	Kathmandu	FSWs	Network Capacity Building for Advocacy	SBC/prevention	96,105	96,105	2/16/2007	9/30/2011
39	605077/0141.0040	National Association of PLHA in Nepal	NGO	Nationwide	PLHIV and their CBOS	Capacity Building of National PLHA Network	Network capacity building	204,594	204,594	11/1/2006	9/30/2011
40	605126/0141.0095	National Federation of Women Living with HIV and AIDS (NFWLHA)	NGO	Nationwide	Women living with HIV and their CBOs	Strengthening the National Women PLHA Networks	Network capacity building	51,895	51,895	6/1/2009	9/30/2011
41	605070/0141.0033	National Health Foundation	NGO	Far western	Migrants and their spouse	Radio Listeners Program for Migrants in Accham District	SBC/prevention	74,898	74,898	11/1/2006	6/30/2009
42	605094/0141.0057	National Reference Laboratory (NRL)	Private Foundation	Nationwide	MSMs	IBBS MSMs in Kathmandu Valley	Research	52,407	52,407	5/1/2007	11/30/2007
43	605113/0141.0077	National Reference Laboratory (NRL)	Private Foundation	Nationwide	MSMs	IBBS MSMs in Kathmandu Valley	Research	80,708	80,708	11/1/2008	6/30/2009
44	605060/0141.0023	Naulo Ghumti Nepal (NGN)	NGO	Western	IDUs, PLHIV and their families	Integrated Health Services of IDUs in Pokhara	SBC/prevention, STI, VCT and care, support and treatment	385,561	385,561	10/1/2006	9/30/2011
45	605120/0141.0088	Nava Deep Jyoti Center - Nepal (NDC)	NGO	Kathmandu	PLHIV and their families	Positive Prevention in Kavre District	SBC/prevention	23,154	23,154	2/1/2009	9/30/2010
46	605058/0141.0021	Nepal National Social Welfare Association	NGO	Far western	Migrants and their spouse, PLHIV and their families	Care and Treatment among Migrants in Kanchanpur	SBC/prevention, STI, VCT and care, support and treatment	372,457	371,945	10/1/2006	9/30/2011

SN	FCO/ID	Name	Organizational Type	Geographic Location	Target Population	Project Title	Intervention	LOP Budget US\$	LOP Payment US\$	Project Start Date	Project End Date
47	605056/0141.0019	Nepal Red Cross Society, Kanchanpur	NGO	Far western	FSWs and their clients	HIV Prevention in Kanchanpur for Migrants	SBC/prevention	186,424	183,523	10/1/2006	9/30/2009
48	605124/0141.0093	Nepal Red Cross Society (NRCS)	Multi-lateral Agency	Far western	PLHIV and their families	CHBC Services for PLHA in Kailali District	Care and Support	14,265	14,265	4/1/2009	9/30/2009
49	605065/0141.0028	Nepal STD & AIDS Research Center	NGO	Mid Western	FSWs, clients, migrants and their spouses and PLHIV	Prevention to Care Services in Western Districts	STI, VCT and care and treatment	452,867	452,866	10/1/2006	9/30/2011
50	605090/0141.0053	New ERA Ltd.	Research	Nationwide	IDUs and MSMs	IBBS among IDUs and MSMs in Kathmandu	Research	147,910	147,611	2/1/2007	1/31/2008
51	605110/0141.0073	New ERA Ltd.	Research	Nationwide	IDUs and MSMs	IBBS among IDUs and MSMs in Kathmandu	Research	283,161	283,161	4/23/2008	7/31/2009
52	605130/0141.0099	New ERA Ltd.	Research	Nationwide	IDUs and MSMs	IBBS among IDUs and MSMs in Kathmandu	Research	185,616	185,616	4/1/2010	6/30/2011
53	605115/0141.0081	Prerana	NGO	Western	Children and their families	Care and Support Program for Infected and Affected Children	SBC/prevention, care, support and treatment	56,592	56,592	12/1/2008	8/31/2011
54	605088/0141.0051	Recovering Nepal	NGO	Nationwide	IDUs and their Network and CBOs	Institutional Capacity Building for Recovering DU Network in Nepal	Network capacity building	154,571	154,571	2/1/2007	9/30/2011
55	605131/0141.0100	Right Direction Nepal Pvt. Ltd.	Private Corporation	Nationwide	FSWs, NGOs/IAs	New Dynamics in Female Sex Worker and Potential for Use of New Technology for HIV Prevention Program	Research	12,806	12,806	5/17/2010	8/16/2010
56	605064/0141.0027	Rural Development Foundation (RDF)	NGO	Central	FSWs and their clients	Prevention Program in Dhanusha & Mahottari Districts	SBC/prevention	242,802	242,802	10/1/2006	9/30/2011
57	605052/0141.0015	STD/AIDS Counseling and Training Services (SACTS)	NGO	Kathmandu	FSWs, clients and PLH	Integrated Health Services in Most at Risk Groups in Kathmandu	STI, VCT and care and treatment	307,138	307,138	9/16/2006	9/30/2011
58	605087/0141.0050	STD/AIDS Counseling and Training Services (SACTS)	NGO	Kathmandu	IDUs and MSMs	IBBS among IDUs and MSMs in Kathmandu	Research	49,379	47,567	2/1/2007	10/31/2007
59	605111/0141.0074	STD/AIDS Counseling and Testing Services (SACTS)	NGO	Nationwide	FSWs and migrants	IBBS among Female Sex Workers in Kathmandu & Pokhara Valley, among Labor Migrants in 11 Western to Far Western Districts; and Wives of Migrants in 4 Far Western Districts	Research	118,229	118,229	4/23/2008	6/30/2009
60	605084/0141.0047	Sahakarya	NGO	Nationwide	NGOs/IAs	Capacity Building of Networks in the Central and Eastern Region	Capacity building	37,484	31,431	2/1/2007	9/30/2007

SN	FCO/ID	Name	Organizational Type	Geographic Location	Target Population	Project Title	Intervention	LOP Budget US\$	LOP Payment US\$	Project Start Date	Project End Date
61	605097/0141.0060	Sahara Paramarsha Kendra	NGO	Kathmandu	NGOs/IAs	VCT Counselor Training & Supportive Monitoring Services	Capacity building	75,491	75,491	6/16/2007	6/30/2009
62	605089/0141.0052	Sahara Plus	NGO	Kathmandu	PLHIV and their families	Care and Support Services for PLHA in Kathmandu	Care and Support	28,290	28,290	2/16/2007	9/30/2009
63	605069/0141.0032	Sahara Nepal	NGO	Eastern	FSWs and their clients	Safe Highway: Prevention Program in Jhapa District	SBC/prevention	255,169	255,169	10/1/2006	9/30/2011
64	605082/0141.0045	SAHAVAGI	NGO	Western	FSWs, clients and PLHIV	Safe Highway Project in Chitwan and Nawalparasi	SBC/prevention, STI, VCT and care and treatment	284,390	284,390	12/1/2006	9/30/2011
65	605121/0141.0089	Sakriya Plus Nepal	NGO	Kathmandu	PLHIV and their families	Positive Prevention in Kavre District	Positive Prevention	47,603	47,603	2/1/2009	9/30/2011
66	605071/0141.0034	Sneha Samaj	NGO	Kathmandu	PLHIV and their families	Care & Support Project in Kathmandu for Women PLHA	Care, support and treatment	76,042	76,042	10/1/2006	9/30/2011
67	605123/0141.0092	Social Awareness Center	NGO	Mid Western	PLHIV and their families	CHBC Services for PLHA in Surkhet District	Care and Support	46,995	46,995	4/1/2009	9/30/2011
68	605068/0141.0031	Society Improvement and Development Center (SIDC)	NGO	Eastern	FSWs and their clients	Prevention Program in Sunsari & Morang Districts	SBC/prevention	115,464	115,464	10/1/2006	6/30/2009
69	605073/0141.0036	Sparsha Nepal	NGO	Kathmandu	PLHIV and their families	Care & Support Services to PLHA in Kathmandu	Care, support and treatment	141,356	141,356	10/1/2006	9/30/2011
70	605083/0141.0046	STEP-Nepal	NGO	Kathmandu	FSWs	Prevention Program for Establishment Based Female Sex Workers	SBC/prevention	189,057	189,057	12/1/2006	9/30/2011
71	605076/0141.0039	Student Awareness Forum (BIJAM)	NGO	Central	FSWs, clients, IDUs, Migrants and PLHIV and their families	Integrated Health Services for IDUs, Migrants and PLHA in Birgunj	SBC/prevention, STI, VCT, care, support and treatment	248,151	248,151	10/1/2006	9/30/2011
72	605122/0141.0090	Syangja Support Group (SSG)	NGO	Western	PLHIV and their families	Positive Prevention Program in Syangja District	Positive Prevention	47,512	47,512	2/1/2009	9/30/2011
73	605099/0141.0062	Thagil Social Development Association	NGO	Far western	FSWs and their clients	HIV Prevention and Care Program in Kailali and Kanchanpur	SBC/prevention	183,584	183,584	6/1/2007	9/30/2011
74	605051/0141.0014	The Future Group International LLC	Multi-lateral Agency	Nationwide	Government, Ministries, NGOs/IAs	Advancing Surveillance, Policies, Preventing, Care & Support to Fight HIV/AIDS	Capacity building, Policy reform, Advocacy	992,642	935,148	7/16/2006	6/30/2009
75	605103/0141.0065	Trisuli Plus	NGO	Central	PLHIV and their families	Positive Prevention in Nuwakot	Positive Prevention	56,704	56,704	11/1/2007	9/30/2011
76	605085/0141.0048	Vijaya Development Resource Center (VDRC)	NGO	Far western	NGOs/IAs	Capacity Building of Networks in the Far Western Region	Capacity building	19,950	14,214	2/1/2007	9/30/2007
77	605081/0141.0044	Voluntary Services Overseas Nepal (VSON)	INGO	Nationwide	NGOs/IAs, Networks	Building Capacity of Organizations Involved in HIV/AIDS	Capacity building	115,687	115,687	12/1/2006	11/30/2008

SN	FCO/ID	Name	Organizational Type	Geographic Location	Target Population	Project Title	Intervention	LOP Budget US\$	LOP Payment US\$	Project Start Date	Project End Date
78	605054/0141.0017	Women Acting Together for Change	NGO	Western	FSWs, clients, PLHIV and their families	Comprehensive Program on HIV/AIDS in Rupandehi & Kapilvastu	SBC/prevention, STI, VCT and care, support and treatment	278,211	278,211	10/1/2006	9/30/2009
79	605061/0141.0024	Youth Vision (YV)	NGO	Kathmandu	IDUs, clients of FSWs, PLHIV and their families	Prevention to Care Services to Most at Risk Groups	SBC/prevention, STI, VCT and care, support and treatment	298,844	298,844	10/1/2006	8/31/2011

## Annex E: Project Results

Standard Indicators	Disaggregation	2007 (Oct 07-Sep 07)		2008 (Oct 07-Sep 08)		2009		2010 (Aug09-July10)		2011 (Aug10-Sep11)	
		Targets	Results	Targets	Results	Targets (Oct 08-Sep 09)	Results (Oct 08-Jul 09)	Targets	Results	Targets	Results
Number of MARP reached with individual and/or small group level interventions that are based on evidence and/or meet the minimum standards required	<b>Total</b>	<b>45,500</b>	<b>55,668</b>	<b>52,500</b>	<b>71,984</b>	<b>62,000</b>	<b>79,369</b>	<b>93,000</b>	<b>119,095</b>	<b>99,750</b>	<b>1,55,739</b>
	<b>By MARPs</b>										
	FSWs	10,500	12,906	11,000	14,495	12,000	15,575	18,000	22,472	20,000	26,306
	Clients of FSWs	17,000	20,364	18,000	30,553	20,000	30,226	35,000	48,644	38,000	61,433
	IDUs	1,500	1,332	3,000	1,162	5,000	2,384	2,100	3,041	2,500	4,356
	Male migrants and their spouses-	14,000	18,653	17,000	20,705	20,000	24,955	35,000	40,843	38,500	61,665
Number of health care workers who successfully completed an in- service training program	<b>Total</b>	<b>7,200</b>	<b>8,009</b>	<b>7,825</b>	<b>12,518</b>	<b>8,450</b>	<b>20,653</b>	<b>11,220</b>	<b>15,161</b>	<b>11,665</b>	<b>14,413</b>
	<b>By training type</b>										
	Other than AB	700	929	750	1,061	800	571	900	999	600	664
	Palliative Care		43		88		76	60	62	120	147
	Counseling and testing	100	17	100	70	100	99	65	66	40	45
	ARV		60		66		96	55	54	80	83
	Lab		34		52		37	40	43	60	59
	Strategic Information	200	198	225	337	250	195	235	299	170	178
	Institutional capacity building	200	388	250	596	300	641	320	498	275	359
	S&D	6,000	6,386	6,500	10,288	7,000	12,186	8000	11,003	9000	11,145
	Community mobilization							1500	2086	1300	1,697
	PMTCT							25	25		
	Medical injection safety		48		78			20	26	20	36

Standard Indicators	Disaggregation	2007 (Oct 07-Sep 07)		2008 (Oct 07-Sep 08)		2009		2010 (Aug09-July10)		2011 (Aug10-Sep11)	
		Targets	Results	Targets	Results	Targets (Oct 08-Sep 09)	Results (Oct 08-Jul 09)	Targets	Results	Targets	Results
Number of service outlets for palliative care		26	33	28	33	30	37	36	39	36	41
Number of HIV- positive adults and children receiving a minimum of one clinical service		<b>1,500</b>	<b>2,559</b>	<b>2,000</b>	<b>3,314</b>	<b>2,500</b>	<b>4,337</b>	<b>4,000</b>	<b>5,269</b>	<b>4,500</b>	<b>6,136</b>
Number of outlets providing counseling and testing (C&T)		26	33	28	33	30	34	34	37	34	39
Number of individual who received C&T and their results		<b>7,000</b>	<b>13,811</b>	<b>7,500</b>	<b>19,555</b>	<b>8,000</b>	<b>18,332</b>	<b>22,000</b>	<b>20,693</b>	<b>26,000</b>	<b>27,872</b>
Number of individual who received C&T and their results Number of most-at-risk individuals receiving STI treatment within the context of HIV prevention at USAID-supported sites		8,000	7,264	8,500	8,900	9,000	8,030	9,000	8,324	10,000	10,160



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