

Baseline Assessment - Nepal

Scaling up Programs to Reduce Human Rights-Related Barriers to HIV and TB Services

2018
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Disclaimer

Towards the operationalization of Strategic Objective 3(a) of the Global Fund Strategy, *Investing to End Epidemics*, 2017-2022, this paper was commissioned by the Global Fund to Fight AIDS, TB and Malaria and presents, as a working draft for reflection and discussion with country stakeholders and technical partners, findings of research relevant to reducing human rights-related barriers to HIV and TB services and implementing a comprehensive programmatic response to such barriers. The views expressed in the paper do not necessarily reflect the views of the Global Fund.

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List of Acronyms

AMDA	Association of Medical Doctors of Asia
ART	Antiretroviral Therapy
APN+	Asia-Pacific Network of People Living with HIV
ASHA	Advancing Surveillance, Policies, Prevention, Care, and Support to Fight
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
BCAN	Business Coalition on AIDS in Nepal
BDS	Blue Diamond Society
CBO	Community-based organizations
CBHTC	Community-based HIV Testing and Care
CCM	Country Coordinating Mechanism
CDO	Chief District Officer
DTLO	District Tuberculosis and Leprosy Officer
DOTS	Directly observed therapy, short course
FCHV	Female Community Health Volunteer
FGD	Focus group discussion
FHI 360	Family Health International
FSGMN	Federation of Sexual and Gender Minorities Nepal
FLWHA	Federation of Women Living with HIV/AIDS
FWLD	Forum for Women, Law, and Development
ILO	International Labour Organization
JANTRA	Japan-Nepal Health & Tuberculosis Research Association
JMMS	Jagriti Mahila Mahasang National Network
LGBTI	Lesbian, gay, bisexual, transgender, intersex
MDR-TB	Multi-drug resistant tuberculosis
MoH	Ministry of Health
MoHA	Ministry of Home Affairs
NANGAN	National NGOs Network Group Against AIDS, Nepal
NAP+N	National Association of People Living with HIV/AIDS
NCASC	National Centre for AIDS and STD Control
NCPI	National Commitments and Policies Instrument
NEHA	Nepal HIV/AIDS Alliance
NHRC	Nepal Health Research Council
NTP	National Tuberculosis Programme
SARDM	South Asia Regional Marketplace
STI	Sexually Transmitted Infection
TB	Tuberculosis
OCMC	One-stop Crisis Management Centers
OST	Opioid substitution therapy
PEPFAR	President's Emergency Plan for AIDS Relief
PMTCT	Prevention of Mother to Child Transmission
PLHIV	People living with HIV
PWID	People Who Inject Drugs
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WACT	Welfare Association of Children Tikapur
WHO	World Health Organization

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I. Executive Summary

Introduction

Since the adoption of its strategy, *Investing to End Epidemics, 2017-2022*, the Global Fund to Fight AIDS, Tuberculosis and Malaria has joined with country stakeholders, technical partners and other donors in a major effort to expand investment in programs to remove human-rights related barriers in national responses to HIV, TB and malaria¹. It has done so because it recognizes that these programs are an essential means by which to increase the effectiveness of Global Fund grants. The programs increase uptake of and retention in health services and help to ensure that health services reach those most affected by the three diseases.

Though the Global Fund provides support to all countries to scale up programs to remove human rights-related barriers to health services, it is providing intensive support to 20 countries to enable them to put in place comprehensive programs aimed at reducing such barriers. Programs are considered “comprehensive” when the right programs are implemented for the right people in the right combination at the right level of investment to remove human rights-related barriers and increase access to HIV and TB services.² Based on criteria involving needs, opportunities, capacities and partnerships in country, Nepal and nineteen other countries were selected for intensive support. This baseline assessment is the first component of the package of support Nepal will receive and is intended to provide the country with the data and analysis necessary to identify, apply for, and implement comprehensive programs to remove barriers to HIV and TB services. Towards this end, this assessment: (a) establishes a baseline concerning the present situation in Nepal with regard to human rights-related barriers to HIV and TB services and existing programs to remove them, (b) describes what comprehensive programs aimed at reducing these barriers would look like, and their costs, and (c) suggests opportunities regarding possible next steps in putting comprehensive programs in place.

A number of program areas involving several interventions and activities to reduce human rights-related barriers to services have been found effective in reducing barriers. Technical partners and other experts have therefore recognized them as key components of the response. For both HIV and TB, these program areas comprise: (a) stigma and discrimination reduction; (b) training for health care providers on human rights and medical ethics; (c) sensitization of law-makers and law enforcement agents; (d) reducing discrimination against women in the context of HIV and TB; (e) legal literacy (“know your rights”); (f) legal services; and (g) monitoring and reforming laws, regulations and policies relating to HIV and TB. In addition for TB, there is the need to: ensure confidentiality and privacy related to TB diagnosis, mobilize and empower TB patient and community groups, address overly-broad policies regarding involuntary isolation or detention for failure to adhere to TB treatment, and make efforts to remove barriers to TB services in prisons.³

¹ *The Global Fund Strategy 2017-2022: Investing to End Epidemics*. GF/B35/02

² This definition of “comprehensiveness » for the purpose of GF Key Performance Indicator 9 was developed with the Global Fund Human Rights Monitoring and Evaluation Technical Working Group.

³ See *Key Programmes to Reduce Stigma and Discrimination and Increase Access to Justice in National HIV Responses*, Guidance Note, UNAIDS/JC2339E (English original, May 2012); ISBN: 978-92-9173-962-2. See also *Technical Briefs HIV, Human Rights and Gender Equality* Global Fund to Fight AIDS, TB and Malaria (April 2017); *Tuberculosis, Gender and Human Rights* Global Fund to Fight AIDS, TB and Malaria (April 2017)Ss

Methodology

In June 2017 a review of formal and informal literature on the HIV and TB responses in Nepal was conducted, followed by an in-country assessment. This assessment involved a total of 22 face-to-face and 4 phone interviews carried out with 28 key informants and 26 key and vulnerable population members, and 8 female community health volunteers involved in TB care and control, participating in six focus groups in Kathmandu, Kailali and Parsa. A standard assessment protocol, developed to be used across the twenty country assessments, and standard tools for the key informant interviews and focus groups discussions were used. An Inception Workshop was held with key stakeholders at the beginning of the data collection process to discuss with them the assessment process and to consult with them on focus areas and key informants. This meeting was also used to fill any gaps in the literature review. Following the fieldwork, a follow-up meeting was held with the same key stakeholders to capture feedback on the proposed activities, including prioritization and implementation suggestions. Lastly, a validation meeting was held with the CCM to confirm the activities proposed for comprehensive response.

Summary of baseline assessment findings - HIV

Key and vulnerable populations

The key populations most affected by HIV in Nepal include: people living with HIV, men who have sex with men, transgender people, and people who inject drugs. Male labor migrants and their female spouses are considered as vulnerable populations. These populations are reflected in the Nepal HIVision 2020, which also includes female sex workers, transgender sex workers, male sex workers, clients of sex workers, incarcerated people, mobile, migrant and displaced populations, young people, uniformed services and all pregnant women. Adolescents are not included as a priority 'vulnerable' population in this assessment, as HIV prevalence is less than 0.1% among adolescents in Nepal⁴.

Human rights-related barriers to HIV services

The most significant human rights-related barriers identified were the following:

- a) Stigma and discrimination, based on HIV status alone, gender and/or on perceived or actual behaviors associated with key populations experienced in the community and at health facilities (i.e. inefficient and discriminatory practices in healthcare facilities, which is heightened for members of key and vulnerable populations)
- b) Gender inequality, including gender-based violence, lack of decision-making power, which influences gender-related vulnerabilities to HIV
- c) Outdated laws that hinder key population access to HIV services – the 2015 Legal Environment Assessment conducted by the Government of Nepal identified some problematic laws that should be updated or removed to remove barriers to health services access

⁴ UNAIDS. Nepal country fact sheet 2016. <http://www.unaids.org/en/regionscountries/countries/nepal>

- d) Illegal police practices against key populations - specifically men who have sex with men and transgender individuals and female sex workers; and

Other important barriers include poverty and geophysical barriers that make it difficult for vulnerable populations in hilly areas to access HIV services, as both time and financial resources are needed to reach health centers.

Programs to address barriers to HIV services – from existing programs to comprehensive programs

Currently, several non-government and community-based organizations, as well as government entities, are working to some extent to address these barriers to HIV services. However, the programs they implement do not fully cover each Program Area and lack the resources to be implemented at scale. Part of the assessment process involved examining the outcomes and evidence for effectiveness of these interventions, in order to determine which ones should be taken to scale.

For each of the seven program areas, this section summarizes the existing or recent programs that have been implemented in Nepal to remove human rights-related barriers to services and provides a summary description of what would be required to comprehensively address the barriers.⁵

PA 1: Stigma and discrimination reduction

Current and recent initiatives to reduce HIV-related stigma and discrimination include: (1) stigma-reduction training (i.e. curriculum development followed by extensive stigma-reduction training to strengthen the capacity of NGOs, CBOs and networks working with people living with HIV, sex workers, men who have sex with men, transgender people, people who inject drugs, migrants and their families, health workers, students, journalists, opinion leaders, and the general public to raise awareness about stigma and reduce harmful attitudes and behaviors. In total, over 100,000 people were trained across all 75 districts from 2007 to the present); (2) mass media campaigns to shift harmful attitudes towards people living with HIV; (3) group-based support for people living with HIV and other key populations to overcome stigma and discrimination; (4) advocacy and awareness raising; and implementation of the *PLHIV Stigma Index* in 2011.

A comprehensive program aimed at reducing stigma and discrimination would require continuation with refinements for some activities and at greater scale for others, as follows:

- Update existing NCASC stigma-reduction curriculum to include information on HIV, TB (including infection control for TB), non-discrimination, and violence, and to promote supportive, accepting, and responsive services. Roll out training-of-trainers on new curricula among key populations and NGOs.
- Institutionalize training on reducing stigma, discrimination and violence related to HIV and TB in professional schools for duty-bearers (i.e. teachers, doctors, nurses, social

⁵ Programs to remove human rights-related barriers to services are *comprehensive* when the *right programs* are implemented *for the right people* in the *right combination* at the *right level of investment* to be effective in removing human rights-related barriers and increase access to HIV, TB and malaria services.

workers, lawyers, judges, etc.) using updated curricula. Course curricula can be adapted from the standardized NCASC curriculum. Continue in-service trainings and community leader/stakeholder trainings.

- Increase frequency of mass media campaigns, both audio and visual, to reduce stigma and discrimination based on HIV and TB status, increase awareness on laws and policies protecting the rights of people living with HIV and/or with TB, and reduce fear of infection and subsequent avoidance behavior. Social media should also be used in this context.
- Continue funding for support groups, but consider adding more structure by integrating curriculum-based sessions on key issues of concern. In addition, combining support group interventions with economic and income-generation skills development should be considered.
- Support stigma-reduction programs that use cultural media delivered through large, public events, combined with advocacy and engagement led by key populations, and scale these up the country. Consider linking these events or running concurrently with mass media campaigns.
- Repeat the national *PLHIV Stigma Index* on a 3-5 year basis to provide updated data for assessing impact of programs to remove human rights barriers to HIV services.
- Establish a national-level monitoring system to capture stigma, discrimination and rights violations experienced by PLHIV, key populations and people with TB and support redress.

PA 2: Training of health workers on human rights and medical ethics

Current and recent initiatives to train health workers on human rights and medical ethics have included: (1) training and sensitization workshops for health workers (i.e. curriculum development followed by extensive training reaching almost 14,000 health workers in over 50 districts in Nepal); and (2) routine monitoring of client satisfaction among people living with HIV seeking services in health facilities receiving training to address stigma, human rights and medical ethics.

To comprehensively address discrimination in health-care settings, these interventions should be refined as follows:

- Update existing NCASC stigma-reduction curriculum to include information on HIV, TB (including infection control for TB), non-discrimination, and violence, and to promote supportive, accepting, and responsive services. Roll out training-of-trainers of new curricula among key populations and NGOs and others (i.e. Ministry of Health) who will be involved in training for health workers.
- Incorporate stigma reduction, human rights and medical ethics training in pre-service curricula as a required course, mostly in medical colleges and CTEVT, so that the knowledge is shared from the institutional-level.
- Institutionalize routine (i.e. annual), in-service trainings on HIV, key population and TB-related stigma reduction, nondiscrimination and medical ethics for current health facility staff. Engage administrators and identify champions within the health sector/or facilities for sustainability and follow-up.

- Support routine assessments (i.e. every 1-2 years) of knowledge, attitudes and practices of health care towards people living with HIV and/or TB and other key populations to support health facility administrators to identify and address any issues. Healthcare setting-based surveys should be done among providers and exit interviews with key population clients throughout the country with the help of proper guidelines executed for this.

PA 3: Sensitization of law makers and law enforcement agents

Current and recent initiatives to sensitize lawmakers and law enforcement agents have included: trainings and orientation programs to promote HIV prevention and appropriate policing practices and sensitize police about the rights and services for people living with HIV and other key populations. No programs were identified to reach lawmakers, i.e. parliamentarians.

These interventions should be refined as follows:

- Update existing Nepali Police HIV curriculum to include information on HIV, TB (including infection control for TB), non-discrimination, and violence, and to promote supportive, accepting, and responsive services, in consultation with the Ministries of Education and Home Affairs, administrators of local police training colleges, and representatives of key and vulnerable populations. Once approved, this training-of-trainers should be rolled out to build capacity for facilitation.
- Develop curriculum for law students on stigma and discrimination, human rights and gender-based violence in the contexts of HIV and TB, based on the existing NCASC and Nepal Police curricula. This should be done through a consultative process with the Ministries of Education and Home Affairs, administrators of local police training colleges, and representatives of key and vulnerable populations. Once approved, this training-of-trainers should be rolled out to build capacity for facilitation.
- Institutionalize training in Police Academy and Law Schools on reducing stigma, discrimination and violence against key populations. Institutionalize the curricula for Armed Police force (involved in border security) and Police Academy at their own respective institutions all over the nation and require a minimum passing mark for certification.
- Support in-service trainings for police, judges, prison staff, and policy makers on HIV and TB policies and key populations, responsible and supportive policing in the context of HIV and TB, and reduction of illegal police practices using the new curricula. Planners and policy makers should also be included in their respective level and area: for national-level - MPs, ministries, NHRC, National Bar association, health workers, Nepal Medical Association; for local-level: metropolitan, sub-metropolitan, municipality, Village Development Committee, lawyers and media people; for state level: prison management, prison securities, state government and stakeholders. It was noted that new sources of funding for training will be needed with the reduction in USG support to the HIV response in Nepal.
- Support routine assessments of law enforcement agents' knowledge, attitudes and behaviors towards people living with HIV and/or with TB and other key populations and support police administrators to identify and address any issues. Monitoring and evaluation should be done in police academy and police headquarters so that these KAPB

can be monitored more effectively biannually or annually. The MERG-approved stigma assessment tool for health settings needs to be adapted for use with police.

- Support key population networks to engage with law enforcement to prevent harmful policing practices, such as arresting sex workers and peer educators for carrying condoms and arresting people who inject drugs on criminal drug charges instead of referring to harm reduction/OST. Different key population networks should be involved so that more is known about the KABP and advocacy is properly executed.

PA 4: Legal literacy (“know your rights”)

Current and recent initiatives to sensitize lawmakers and law enforcement agents have included: (1) legal counsel and support specific to trafficked and rescued girls; and (2) curricula for civil society organizations on legal matters relevant to women living with HIV.

Current efforts should be expanded throughout the country and additional efforts including people living with HIV and/or TB and key populations should be added as follows:

- Legal literacy and patient’s rights education should be supported through conducting awareness campaigns and workshops among people living with HIV and/or TB, women, migrants and other key populations in each state/district towards mobilizing around health rights, freedom from discrimination and violence and other relevant rights. The literacy package should be produced, updated and reviewed accordingly and disseminated widely through various community groups such as community networks, community-based organizations, and other interest groups for them to tailor these packages to reflect appropriate content to each key population and deliver this package through trainers from among the key populations.

PA 5: HIV-related legal services

No programs were identified to address lack of legal services in the context of HIV in Nepal. The following activities are suggested:

- Train and support peer paralegals to provide legal advice, awareness-raising and conduct “know your rights” campaigns in each state/district among key populations and/or in health care facilities. Key stakeholders noted that there should be legal services available at district-level network organizations, or the district-level networks should have good contact with lawyers situated at the central-level network organizations. Training and mobilization of paralegals should be for the district-level organizations or at community-level through networks and CBOs.
- These expanded services should be linked with a newly established help line for legal services with a toll free number. The help line should be managed at the central level by a single network organization or committee. The help line services can be used for both the components of TB and HIV. For legal support, there can be coordination with the 29 existing one-stop crisis management centers (OCMCs), which support services for women experiencing gender-based violence. OCMCs can be expanded or scaled-up and linked with HIV and TB services by making them key population- friendly and sensitive.
- Identify and support *pro bono* lawyers in universities and in the private bar to link to NGOs and community-based organizations and provide legal services, including legal representation. Establish a MOU between the service providers, including court and

Nepal Bar Association (in all districts), law faculties/schools, NGOs and individual lawyers throughout the country. In addition, NGOs could promote the use of existing government lawyers by promoting uptake of legal services among people.

- Establish rapid response units/systems that will help prevent arbitrary arrest, detention and other mistreatment of key populations (e.g. a hotline that sex workers, migrants or people who use drugs can call to seek urgent legal support, NGO support, etc.). This would address the immediate needs of abused/mistreated populations. A 24-hour service should be supported with a well-capacitated rapid response team placed in a convenient location to the community. The rapid response team should be empowered to advocate on behalf of clients, coordinate with high-level law enforcement personnel, and have linkages with networks in order to handle cases immediately.

PA 6: Monitoring and reforming laws, regulations and policies relating to HIV

There were no current programs identified to monitor and reform laws, regulations and policies relating to HIV in Nepal. A comprehensive program aimed at reducing human rights-related barriers to HIV will require the following activities:

- In order to coordinate the comprehensive response to remove human rights barriers to HIV and TB services, a human rights point person in the National Human Rights Institute or Ombudsman's office should be identified. This person could support the process to begin reforming the problematic laws and policies identified in the 2015 Legal Environment assessment in Nepal.
- In addition to supporting the legal reform process, s/he could support other key aspects of the comprehensive response, such as the national monitoring and redressal system for stigma, discrimination and rights violations, and the routine assessments of KAPB for police and health workers on stigma, discrimination and human rights in the contexts of HIV and TB.
- Funding for advocacy groups to support the legal reform process and advocate for and monitor the implementation of supportive policies and laws should be maintained.
- Funding for advocacy groups to support the development of a Memorandum of Understanding between India and Nepal would help to ensure health services for Nepalese migrants in India.

PA 7: Reducing discrimination against women in the context of HIV

Current and recent initiatives to reduce discrimination against women in the context of HIV have included: (1) community awareness campaigns to facilitate open communication around women's sexual and reproductive health, sexuality, stigma reduction and changing harmful gender norms; (2) training for advocate leaders to support advocacy efforts, create a platform for sharing, and empower women to provide information on HIV, rights and relevant laws; and (3) Prevention and mitigation of gender-based violence through comprehensive integration of multi-disciplinary reduction efforts in targeted districts.

As part of a comprehensive program aimed at reducing human rights-related barriers to HIV services, these interventions should be continued on a larger scale and refined and added to as follows:

- Support networks of women living with HIV, female sex workers, transgender people and women who inject drugs to advocate and organize against mistreatment by police and health care providers. Central-level networks should be advocated for to help/support community-level networks.
- Mobilize women's groups and support networks to combat violence and support survivors to seek redress and services from OCMCs. OCMC staff will need training and sensitization regarding how to support clients who seek services for experiences of stigma and discrimination in addition to gender-based violence.
- Continue mitigation and prevention of gender-based violence programming and expand to other regions in the country.
- Implement community and school-level campaigns (i.e. in addition to or as part of Comprehensive Sexuality Education) and dialogues to promote gender equality, shift harmful gender norms and reduce gender-based violence. Community dialogues should be organized to promote gender equality at every level, from the national to the grass-root level. Particular emphasis should be placed on implementing school-based programs for prevention of GBV.

2016 investments and what a comprehensive program will cost - HIV

In 2016 a total of around \$285,868 USD was invested in Nepal to reduce human rights-related barriers to HIV services. Major funders and allocated amounts for reduction of human rights barriers to HIV services in 2016 were as follows:

Funding source	2016 allocation*
FRI – Norwegian Organization for Sexual and Gender Diversity, Norway	USD 16,576
United Nations Educational, Scientific and Cultural Organization (UNESCO)	USD 12,108
GFATM	USD 48,088
USAID	USD 209,096
Total	USD \$285,868

* Many organizations were not comfortable providing financial information, so the cost estimate of existing programs is likely an underestimate.

Although several funders stated that they were unable to provide exact figures for the amounts allocated to each program area, the assessment team calculated the likely split between program areas by acquiring expenditure data from the funded organizations and matching these to activities under each program area. This gave the following split of funding across program areas to remove human rights-related barriers to services:

HIV Human Rights Barriers Program Area	2016*
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PA 1: Stigma and discrimination reduction for key populations	USD 100,648
PA 2: Training for health care workers on human rights and medical ethics related to HIV	USD 19,853
PA 3: Sensitization of law-makers and law enforcement agents	USD 0
PA 4: Legal literacy (“know your rights”)	USD 35,012
PA 5: HIV-related legal services	USD 0
PA 6: Monitoring and reforming laws, regulations and policies relating to HIV	USD 4,897
PA 7: Reducing discrimination against women in the context of HIV	USD 125,458
Total	USD \$285,868

* Many organizations were not comfortable providing financial information, so the cost estimate of existing programs is likely an underestimate.

A comprehensive program aimed at reducing human rights-related barriers to HIV services would require a substantially higher annual investment, as follows:

HIV Human Rights Barriers Program Area	Total
PA 1: Stigma and discrimination reduction for key populations*	USD 1,008,690
PA 2: Training for health care workers on human rights and medical ethics related to HIV*	USD 201,161
PA 3: Sensitization of law-makers and law enforcement agents*	USD 335,666
PA 4: Legal literacy (“know your rights”)*	USD 620,744
PA 5: HIV-related legal services*	USD 1,121,543
PA 6: Monitoring and reforming laws, regulations and policies relating to HIV*	USD 76,834
PA 7: Reducing discrimination against women in the context of HIV	USD 427,469
Total (programmatic costs)	USD \$3,792,108
Total (including program management, M&E and Research costs)^v	USD \$4,787,157

* Some activities within specific program areas involve both the HIV and TB responses. For these program activities, costs were split 60% for HIV and 40% for TB, based on the suggestion of key stakeholders involved in financing decisions for these grants in Nepal. ^vAs program management costs were difficult to estimate, given the hesitancy of

some implementers to share information on recurrent costs such as staffing and other indirect costs, we have added a percentage share of program management (20.0%), Monitoring and Evaluation (1.0%) and research (2.0%) costs to the prospective costing calculations to counteract such underestimation. This method is based on the approach the Global Fund has used for KPI 9b.

Some activities within this program area involve both the HIV and TB responses. For these program activities, costs were split 60% for HIV and 40% for TB, based on the suggestion of key stakeholders involved in financing decisions for these grants in Nepal.

Details of yearly costs are set out in the main report below and detailed costing information is available in Annexes 3, 4 and 5.

Summary of baseline assessment findings - TB

Key and vulnerable populations

In Nepal, tuberculosis joins HIV as a major public health problem. Opinions about the populations most at-risk of TB in Nepal varied. Key stakeholders reported that the key populations include people living with HIV, migrants (both internal and external), slum dwellers, and children. A 2016 WHO Bulletin on TB in Nepal also included people who use drugs and sex workers as experiencing a higher prevalence of TB. However, the Ministry of Health of Nepal uses a broader, global definition of people at high risk of TB, including people who come under direct contact with a sputum smear positive TB patient, people living with HIV, people living in slums and densely populated urban settings, people living in congregated settings like factories, prisons, refugee camps, and people with diabetes, children and malnourished populations (2016-2021 National Strategic Plan). The NTP has implemented TB control activities with these vulnerable groups in consideration and notes that appropriate program activities will be proposed so as to identify the high-risk groups at the local level itself for more effective and results-oriented interventions. The situation in prisons is not well understood, as little data is currently available on prisoners' access to healthcare, including TB services.

Barriers to TB services

The most significant human rights-related barriers are:

- I. Stigma and discrimination, based on TB status alone and additionally based on key population status. These occur within the community and in healthcare settings, as well take the form of self-stigma.
- II. Gender-related barriers along with cultural beliefs about health affect detection, early diagnosis, treatment initiation and adherence, particularly among women. While more TB cases are reported among men than women in Nepal, women usually do not have equal access to TB diagnostic and treatment services because of their workload at home, lack of decision-making power, and gendered preferences for where to seek health care, and thus have a significantly longer delay before diagnosis of TB. Men seem to face higher risk of becoming ill with TB due to social contacts and high-risk work and habits, yet women face higher stigma, delayed diagnosis, and limited access to treatment.
- III. Institutional barriers, such as the lack of standard universal precautions for occupational hazards (i.e. ventilation, appropriate masks, etc.) in health facilities support stigmatizing behavior from health providers. The lack of required reporting of TB cases to the National TB Program by private providers makes it difficult to estimate the prevalence of

- TB to inform the TB response. There is also limited capacity to utilize TB diagnostic equipment in health facilities, lengthening time for diagnosis.
- IV. Lack of information on TB in prison settings limits the implementation of appropriate programs to ensure the right to health of prisoners and access to TB services and TB control activities in such settings.
 - V. Poverty and geophysical barriers make it difficult for vulnerable populations in hilly areas to access TB services, as both time and financial resources are needed to reach health centers.

The ways that these barriers impact on the key and vulnerable populations are set out in detail in the findings section of this report.

Programs to address barriers to TB services – from existing programs to comprehensive programs

No past or existing programs to address human rights-related barriers to TB services in Nepal were identified. This section describes how a comprehensive program aimed at reducing human rights-related barriers to TB services in Nepal would look like.

Several activities in the comprehensive plan should be developed and implemented jointly by the HIV and TB sectors, and these activities should be cost-shared. The shared activities are italicized below.

PA 1: Reducing stigma and discrimination

A comprehensive program aimed at reducing TB-related stigma and discrimination should include:

- *Update existing NCASC stigma-reduction curriculum to include information on HIV, TB (including infection control for TB), non-discrimination, and violence, and to promote supportive, accepting, and gender-responsive services. Roll out training-of-trainers on new curricula among key populations and NGOs.*
- *Institutionalize training on reducing stigma, discrimination and violence related to HIV and TB in professional schools for duty bearers (i.e. teachers, doctors, nurses, social workers, lawyers, judges, etc.) using updated curricula. Continue in-service trainings and community leader/stakeholder trainings.*
- *Increase frequency of mass media campaigns, both audio and visual, to reduce stigma and discrimination based on HIV and TB status, increase awareness on laws and policies protecting the rights of people living with HIV and/or with TB, and reduce fear of infection and subsequent avoidance behavior. Social media should also be used in this context.*
- *Continue funding for support groups, but consider adding more structure by integrating curriculum-based sessions that address key areas of concern for people living with TB. Combining support group interventions with economic and income-generation skills development should also be considered.*
- *Support stigma-reduction programs that use cultural media delivered through large, public events, combined with advocacy and engagement led by key populations should*

be supported and scaled-up throughout the country. Consider linking these events or running concurrently with mass media campaigns.

- *Establish a national-level monitoring system to capture stigma, discrimination and rights violations experienced by people living with TB, people with HIV and other key populations and support redress.*

PA 2: Reducing gender-related barriers to TB services

There were no formal programs identified through the fieldwork to remove gender-related barriers to TB services. However, one NGO, Jantra, noted that they used mothers groups to reach out to the communities at large and used peers to encourage women with TB to come for care and treatment gender-specific services. A comprehensive program in this area should include:

- *Relevant information and strategies related to TB should be integrated into programs suggested in the HIV section to reduce gender-related disparities and inequalities in access to services in the context of HIV.*
- *Strategies to reduce gender-related risks and barriers, for women, girls, men and boys, should be fully developed, implemented and evaluated. Existing approaches, utilizing mothers groups and peers, should inform the development of these strategies. Community sensitization campaigns and information should be implemented to shift gender norms that place the household work burden on women and inhibit women's ability to make decisions about health-related spending. Sensitization of women in communities is also needed about recognizing TB symptoms and the importance of going to government health facilities for treatment are also recommended.*
- *Workplace policies regarding housing of male workers should be examined in industries where TB exposure in the occupational setting is more common. This could include improved ventilation in shared housing, preventive screening and early linkage to care and treatment for men living with TB.*

PA 3: TB-related legal services

A comprehensive program in this area should include:

- *Train and support peer paralegals for different communities to provide legal advice, awareness raising and conduct "know your rights" campaigns in each state/district among key populations and/or in health care facilities. Key stakeholders noted that there should be legal services available at district-level network organizations, or the district-level networks should have good contact with lawyers situated at the central-level network organizations. Training and mobilization of paralegals should be for the district-level organizations or at community-level through networks and CBOs.*
- *These expanded services should be linked with a newly established help line for legal services with a toll free number. The help line should be managed at the Central Level by a single network organization or committee. It was noted by key stakeholders that a large initial investment is required for training and mobilization at the district-level. The help line services can be used for both the components of TB and HIV. For legal support, there can be coordination with the 29 existing OCMCs, which support GBV*

services for women. OCMCs can be expanded or scaled-up and linked with HIV and TB services by making them KP friendly and sensitive.

PA 4: Monitoring and reforming policies, regulations and laws that impede TB services

A comprehensive program in this area should include:

- *Develop a protocol and guidelines on TB infection protection for health workers. These guidelines could be merged into the updated NCASC toolkit for health workers.*
- *In order to coordinate the comprehensive response to remove human rights barriers to HIV and TB services, a human rights point person in the National Human Rights Institute or Ombudsman's office should be identified. This person could support the process to begin replacing or updating the problematic laws and policies identified in the 2015 Legal Environment Assessment in Nepal.*
- *In addition to supporting the legal reform process, s/he could support other key aspects of the comprehensive response, such as the national monitoring and redressal system for stigma, discrimination and rights violations, and the routine assessments of KAPB for police and health workers on stigma, discrimination and human rights in the contexts of HIV and TB.*
- *Funding for advocacy groups to support the legal reform process and advocate for and monitor the implementation of supportive policies and laws should be maintained.*
- *Funding for advocacy groups to support the development of a Memorandum of Understanding between India and Nepal would help to ensure health services for Nepalese migrants in India.*

PA 5: Know your TB-related rights

A comprehensive program in this area should include:

- *Legal literacy and patient's rights education should be supported through conducting awareness campaigns and workshops among people living with HIV and/or TB, women, migrants and other key populations in each state/district towards mobilizing around health rights, freedom from discrimination and violence and other relevant rights. The literacy package should be produced, updated and reviewed accordingly and disseminated widely through various community groups such as community networks, community-based organizations, and other interest groups for them to tailor these packages to reflect appropriate content to each key population and deliver this package through trainers from among the key populations.*

PA 6: Sensitization of lawmakers and law enforcement agents

A comprehensive program in this area should include:

- *Update existing Nepali Police HIV curriculum to include information on HIV, TB (including infection control for TB), non-discrimination, and violence, and to promote supportive, accepting, and responsive services, in consultation with the Ministries of Education and Home Affairs, administrators of local police training colleges, and representatives of key and vulnerable populations. Once approved, this training-of-trainers should be rolled out to build capacity for facilitation.*

- *Develop curriculum for law students on stigma and discrimination, human rights and gender-based violence in the contexts of HIV and TB, based on the existing NCASC and Nepal Police curricula. This should be done through a consultative process with the Ministries of Education and Home Affairs, administrators of local police training colleges, and representatives of key and vulnerable populations. Once approved, this training-of-trainers should be rolled out to build capacity for facilitation.*
- *Institutionalize training in Police Academy and Law Schools on reducing stigma, discrimination and violence against key populations. Institutionalize the curricula for Armed Police force (involved in border security) and Police Academy at their own respective institutions all over the nation and require a minimum passing mark for certification.*
- *Support in-service trainings for police, judges, prison staff, and policy makers on HIV and TB policies and key populations, responsible and supportive policing in the context of HIV and TB, and reduction of illegal police practices using the new curricula. Planners and policy makers should also be included in their respective level and area: for national-level - MPs, ministries, NHRC, National Bar association, health workers, Nepal Medical Association; for local-level - metropolitan, sub-metropolitan, municipality, Village Development Committee, lawyers and media people; for state level - prison management, prison securities, state government and stakeholders. It was noted that a new source/s of funding for training will be needed with the reduction in USG investment in the HIV response in Nepal.*
- *Support routine assessments of law enforcement agents' knowledge, attitudes and behaviors towards people living with HIV and/or with TB and other key populations and support police administrators to identify and address any issues. Monitoring and evaluation should be done in police academy and police headquarters so that these KAPB can be monitored more effectively biannually or annually. The MERG-approved stigma assessment tool for health settings needs to be adapted for use with police.*

PA 7: Training of health care workers on human rights and ethics related to TB

A comprehensive program in this area should include:

- *Update existing NCASC stigma-reduction curriculum to include information on HIV, TB (including infection control for TB), non-discrimination, and violence, and to promote supportive, accepting, and gender-responsive services. Roll out training-of-trainers on new curricula among key populations and NGOs and other (i.e. Ministry of Health) who will be involved in training for health workers.*
- *Incorporate stigma reduction, human rights and medical ethics training in pre-service curricula as a required course, mostly in medical colleges and CTEVT, so that the knowledge is shared from the institutional-level.*
- *Institutionalize routine (i.e. annual), in-service trainings on HIV, key population and TB-related stigma reduction, nondiscrimination and medical ethics for current health facility staff. This will ensure that training reaches all staff working at the health facility (i.e. front desk staff, lab technicians, cleaners, etc.). As new medical staff join who have received pre-service training, the size of in-service trainings will likely reduce, but should still be held routinely. Shorter, refresher trainings may also be*

needed for medical with pre-service training to maintain their knowledge in this area. Engage administrators and identify champions within the health sector/or facilities for sustainability and follow-up.

- *Stigma, discrimination and human rights training sessions should also be provided to all TB-related agencies through National Tuberculosis Center.*
- *Support routine assessments (i.e. every 1-2 years) of knowledge, attitudes and practices of health care towards people living with HIV and/or TB and other key populations to support health facility administrators to identify and address any issues. Healthcare setting-based surveys should be done among providers and exit interviews with key population clients throughout the country with the help of proper guidelines executed for this.*

PA 8: Ensuring confidentiality and privacy

Key informants and focus group participants did not mention any concern over confidentiality and privacy when accessing TB services. In addition, privacy and confidentiality are included as topics in the medical ethics and human rights training described above under PA 7. Therefore, no programs are recommended under this program area.

PA 9: Mobilizing and empowering patient and community groups

A comprehensive program in this area should include:

- Support the formation of patient advocacy groups for TB and provide training to facilitate advocacy on patient rights related to TB. These include but are not limited to: gender-related barriers, including gender-norms and stereotypes, gender-inequalities that increase men's and women's vulnerability to TB, and workplace policies that support protections from TB exposure in occupational settings (e.g. for men working of staying in confined spaces with poor ventilation to health workers working in facilities without proper Universal Precaution protection supplies and processes). These groups could advocate for different strategies to support treatment access for vulnerable populations living in hilly or mountainous areas, as well as for government support to help with the catastrophic financial costs faced by many families of people living with TB. In addition, these groups could advocate for better workplace protections for men working in industries where ventilation is poor and risk of TB exposure is greater.

PA 10: Programs in prisons and other closed settings

There was alarming lack of data and information available relating to TB in Nepalese prisons. In order to determine what types of programs are needed in the prison setting, more information is needed. As such, the following activity is recommended:

- A national-level assessment of health care services, specific health risks, and protections provided to prisoners in terms of access to TB and HIV treatment should be conducted to fully elucidate the situation in prisons. This assessment should examine health risks from dangerous living conditions leading to TB, accessibility to TB screening, diagnosis and treatment services; sexual violence, and discrimination and arbitrary isolation; and make recommendations for reducing these risks and increasing protections for

prisoners, including access to TB and HIV health services. It should be noted that Save the Children is currently finalizing an analysis of the needs of prisoners for HIV, TB and malaria and the findings of this analysis can be used to define what program to address human rights-related barriers to these services should be prioritized.

What a comprehensive program will cost – TB

The total amount expended on the TB response in Nepal in 2016 was 17 million USD. No investments were identified in programs to reduce human rights-related barriers to TB services. Estimated costs for the recommended interventions for the five-year comprehensive program are set out in the table on the table below. Detailed intervention areas and costs are set out in Annex 3.

TB Human Rights Barriers Program Area	Total
PA 1: Stigma and discrimination reduction	USD 400,764
PA 2: Reducing gender-related barriers to TB services	USD 0
PA 3: TB-related legal services	USD 5,944
PA 4: Monitoring and reforming laws, regulations and policies relating to TB services	USD 5,190
PA 5: Knowing your TB-related rights	USD 346,932
PA 6: Sensitization of law-makers, judicial officials and law enforcement agents	USD 42,466
PA 7: Training of health care providers on human rights and medical ethics related to TB	USD 134,107
PA 8: Ensuring confidentiality and privacy*	USD 0
PA 9: Mobilizing and empowering patient and community groups	USD 48,654
PA 10: Programs in prisons and other closed settings*, ^v	USD 0
Total	USD \$984,056

*No programmes were recommended for these program areas, therefore no costs have been estimated. ^v There was not enough information on prisoners to make any programmatic recommendations. An assessment by Save the Children is currently underway to understand the barriers to HIV and TB services in prisons, which will inform future programming decision.

Priorities for scaling up towards comprehensive programs to reduce barriers to HIV and TB services

The full list of programs and activities in the comprehensive response are summarized in Annex 1 (for HIV) and Annex 2 (for TB). Given the nature of barriers in Nepal, it is recommended that the early focus be on activities to update or develop curricula on stigma and discrimination reduction and human rights for key duty bearers and the integration of these curricula into the

appropriate professional training schools and colleges. In addition, the establishment of various systems to capture experiences of stigma and discrimination and support redress should be prioritized, including a national monitoring system, with a linked hotline, as well as a rapid response unit for survivors of violence and other abuses that require immediate support. The appointment of a human rights point person in the National Human Rights Institute or Ombudsman's office should also be done early, so this person can support and help coordinate the comprehensive response, ensure consultations and collaboration across various stakeholder (i.e. key population networks, CBOs, government ministries, etc.) and support the process to begin replacing or updating the problematic laws and policies identified in the 2015 Legal Environment assessment in Nepal. The development/updating of advocacy and legal literacy tools and subsequent training for advocacy groups should also be prioritized, to ensure that networks and patient advocacy groups are able to actively support the comprehensive response throughout its 5-year implementation. Discussions with the Indian Government about migrant health towards the development of a Memorandum of Understanding should also begin early in the response.

Following the completion of these initial activities, the next stage in the response would focus on training-of-trainers and training of instructors/professors, followed by the rollout of routine training/re-training of key duty bearers both pre-service and in-service. Linked with the scale-up of training activities, mid-term efforts should focus on developing and implementing appropriate monitoring tools for the various duty-bearers (i.e. health workers, police, prison staff, teachers, lawyers, judges, etc.) with a feedback loop for institutional administrators to ensure appropriate action and support following the trainings. In addition, this phase of the response would also include outreach and engagement with *pro bono* lawyers and paralegals to support clients utilizing the new monitoring mechanism or the rapid response unit. The *PLHIV Stigma Index* should be implemented in year three or four, with additional funding support to PLHIV networks to conduct follow-on advocacy and awareness raising activities in the final year of the comprehensive response.

Next Steps

The Global Fund will utilize this baseline assessment to assist the government, other stakeholders, technical partners and donors in Nepal to develop a five-year, comprehensive program to remove human rights-related barriers to services. Data from the baseline assessment has been used to inform the matching fund application of Nepal and will inform its grant-making and implementation. Finally, the data will be used as a baseline for subsequent reviews at mid-term and end-term during the period of the Global Fund strategy to assess the impact of scaled up programs in reducing human rights-related barriers to services.

II. Introduction

This report comprises the baseline assessment conducted in Nepal to support scaling up of programs to remove human rights-related barriers to HIV and TB services. Since the adoption of its strategy, *Investing to End Epidemics*, 2017-2022, the Global Fund has joined with country stakeholders, technical partners and other donors in a major effort to expand investment in programs to remove human rights-related barriers in national responses to HIV, TB and malaria. This effort is grounded in Strategic Objective 3 which commits the Global Fund to: “*introduce and scale up programs that remove human rights barriers to accessing HIV, TB and malaria service*”; and, to “*scale-up programs to support women and girls, including programs to advance sexual and reproductive health and rights and investing to reduce health inequities, including gender-related disparities*.”⁶ The Global Fund recognizes that programs to remove human rights-related barriers are an essential means by which to increase the effectiveness of Global Fund grants as they help to ensure that health services reach those most affected by the three diseases. The Global Fund is working closely with countries, UNAIDS, WHO, UNDP, Stop TB, PEPFAR and other bilateral agencies and donors to operationalize this Strategic Objective.

Though the Global Fund will support all recipient countries to scale up programs to remove barriers to health services, it is providing intensive support in 20 countries in the context of corporate Key Performance Indicator (KPI) 9 – «Reduce human rights barriers to services: # of countries with comprehensive programs aimed at reducing human rights barriers to services in operation”. This KPI measures “the extent to which comprehensive programs are established to reduce human rights barriers to access with a focus on 15-20 priority countries”.⁷ Based on criteria that include needs, opportunities, capacities and partnerships in country, the Global Fund selected Nepal as one of the countries for intensive support to scale up programs to reduce barriers to services. This baseline assessment, focusing on HIV and TB, is the first component of the package of support the country will receive.

The outcomes of this assessment in Nepal are to: (a) establish a baseline of human rights-related barriers to HIV and TB services and existing programs to remove them; (b) set out a costed, comprehensive program aimed at reducing these barriers; and (c) recommend next steps in putting this comprehensive program in place.

The programs recognized by UNAIDS, STOP TB and other technical partners as effective in removing human rights-related barriers to HIV and TB services are: (a) stigma and discrimination reduction; (b) training for health care providers on human rights and medical ethics; (c) sensitization of law-makers and law enforcement agents; (d) reducing discrimination

⁶ *The Global Fund Strategy 2017-2022: Investing to End Epidemics*. GF/B35/02

⁷ 2017-2022 Strategic Key Performance Indicator Framework, The Global Fund 35th Board Meeting, GF/B35/07a - Revision 1, April 2016

against women in the context of HIV and TB; (e) legal literacy (“know your rights”); (f) legal services; and (g) monitoring and reforming laws, regulations and policies relating to HIV and TB. Three additional program areas are included for TB: (a) ensuring confidentiality and privacy related to TB diagnosis; (b) mobilizing and empowering TB patient and community groups; and (c) establishing programs in prisons and other closed settings.⁸

Programs to remove human rights-related barriers to services are *comprehensive* when the *right programs* are implemented *for the right people* in the *right combination* under each of the program areas set out above, at the *right level of investment* to remove human rights-related barriers and increase access to HIV, TB and malaria services.

The findings of this baseline assessment will be used by countries, the Global Fund, technical partners and other donors to develop a five-year plan by which to fund and implement a comprehensive set of these programs to remove human rights-related barriers to services in Nepal. Its data will also be used as the baseline against which will be measured the impact of the interventions put in place in subsequent reviews at approximately mid-term and end-term during the current Global Fund Strategy period.

⁸ See *Key Programmes to Reduce Stigma and Discrimination and Increase Access to Justice in National HIV Responses*, Guidance Note, UNAIDS/JC2339E (English original, May 2012); ISBN: 978-92-9173-962-2. See also *Technical Briefs HIV, Human Rights and Gender Equality* Global Fund to Fight AIDS, TB and Malaria (April 2017); *Tuberculosis, Gender and Human Rights* Global Fund to Fight AIDS, TB and Malaria (April 2017)

III. Methodology

Conceptual Framework

The conceptual framework for the baseline assessments (and Global Fund Strategic Objective 3) is the following: (a) Depending on the country and local contexts, there exist human rights-related barriers to the full access to, uptake of and retention on HIV, TB and malaria services. (b) These human rights-related barriers are experienced by certain key and vulnerable populations who are most vulnerable to and affected by HIV, TB and malaria. (c) There are human rights-related program areas comprising several interventions and activities that are effective in removing these barriers, (d) If these interventions and activities are funded, implemented and taken to sufficient scale in country, they will remove or at least significantly reduce these barriers. (e) The removal of these barriers will increase access to, uptake of and retention in health services and thereby make the health services more effective in addressing the epidemics of HIV, TB and the malaria. (f) These programs to remove barriers also protect and enhance Global Fund investments, strengthen health systems and strengthen community systems.

Under this conceptual framework, the assessment in Nepal has identified:

- a) Human rights-related barriers to HIV and TB services
- b) Key and vulnerable populations most affected by these barriers
- c) Existing programs to address these barriers; and
- d) A comprehensive set of programs to address these barriers most effectively.

Human rights-related barriers to HIV and TB services were grouped under the following general categories: stigma and discrimination; punitive laws, policies, and practices; gender inequality and gender-based violence; and poverty and economic and social inequality.

Key populations have been defined as follows by the Global Fund:

- a) Epidemiologically, the group faces increased risk, vulnerability and/or burden with respect to at least one of the two diseases due to a combination of biological, socioeconomic and structural factors.
- b) Access to relevant services is significantly lower for the group than for the rest of the population – meaning that dedicated efforts and strategic investments are required to expand coverage, equity and accessibility for such a group; and
- c) The group faces frequent human rights violations, systematic disenfranchisement, social and economic marginalization and/or criminalization – which increase vulnerability and risk and reduces access to essential services.⁹

⁹ The Global Fund to Fight AIDS, Tuberculosis and Malaria. *Key Populations Action Plan 2014-17*. Geneva

Vulnerable populations are people who do not fit into the definition of key populations, but nevertheless are more vulnerable to HIV and TB and their impact.¹⁰

The assessment analyzed the key and vulnerable populations and the nature of the human rights related barriers experienced by them, as well as the design, outcomes and costs of existing programs to reduce these barriers. Based on these findings, the assessment describes a set of intervention that would comprise a comprehensive response to the human rights-related barriers.

Steps in the baseline assessment process

Desk review

We conducted a search to assess human rights-related barriers to HIV and TB services in Nepal, key and vulnerable populations affected by these barriers and programs to address them using PubMed, Embase, and Web of Science to identify peer-reviewed literature. Thirty-eight relevant articles were identified for HIV, and 13 were identified for TB. The publications section of local NGOs and CBOs working in Nepal in the HIV and TB sector were also searched for relevant publications. In addition, searches were made in Nepali, with a total of three publications found. Emails seeking additional information on programs were sent to several non-government organizations (NGOs) working on HIV and/or TB in Nepal to achieve a greater understanding of issues faced by their clients. Lastly, five phone interviews were conducted with key stakeholders at NANGAN, KNCV, Blue Diamond Society, Recovery Network, and NCASC, and the legal and policy environment in Nepal was reviewed in the context of HIV and TB.

Preparation for in-country research

From the Desk Review, a list of key informants and types of focus groups was developed to guide data collection in country. Instruments developed for these forms of data collection were adapted to the circumstances of Nepal. Researchers (nationals of Nepal and India) were trained in the use of these instruments and were assigned tasks. The Ministry of Health of Nepal was contacted about the need for ethics approval, and the research team was informed by the relevant officer that ethical approval was not required for this assessment.

In country research

At an inception meeting, the research team introduced the project to national stakeholders, explained the role of the baseline assessment and data collection procedures, and summarized and discussed the findings of the Desk Review. This meeting was followed by key informant interviews and focus group discussions with members of key and vulnerable populations in Kathmandu, Kailali and Parsa. A total of 22 face-to-face and 4 phone interviews were carried out with 28 key and vulnerable population informants; and 26 key and vulnerable population members participated in 6 focus groups. Data were collected on the following areas:

- Human rights-related barriers to HIV and TB services

¹⁰ Greenall M, Kunii O, Thomson K, Bangert R and Nathan O (2017). Reaching vulnerable populations: lessons from the Global Fund to Fight AIDS, Tuberculosis and Malaria. *Bulletin of the World Health Organization* 2017;95:159-161.

- Key and vulnerable populations most affected by these barriers
- Programs carried out presently or in the recent past that have been found through evaluation or through agreement by many key informants to be effective in reducing these barriers
- Stated needs regarding comprehensive programs to address the most significant barriers for all groups most affected by these barriers
- Funding of all such programs (for 2016 financial year); and
- Costing of effective¹¹ programs carried out presently or in the past.

Data analysis

The in-country data were analyzed to explore agreement with or divergence from the Desk Review findings and to add data on barriers and affected populations missing from the Desk Review. This information, together with data on funding in 2016, was used to develop the Baseline Data Summary. Data on effective projects and on stated needs were combined to suggest the comprehensive programs to reduce human rights barriers to HIV and TB services in Nepal.

Prioritization meeting

Following the fieldwork and initial data analysis, a meeting was held with the same key stakeholders who participated in the inception meeting to capture feedback on the proposed activities in the comprehensive response, including prioritization and implementation suggestions. Based on the outcomes of this meeting, the comprehensive response was updated, costed and draft indicators to measure the impact of the comprehensive programs were developed.

Finalization and next steps

This assessment will be used as background in preparation of an in-country multi-stakeholder meeting to consider how to best scale up programs to reduce human rights barriers to HIV and TB services in Nepal.

Costing methodology

Three sets of costing processes were undertaken for this assessment:

First, all donors and funders who were discovered to have financed any activities in the program areas for HIV or TB were asked to supply details of the amount of funding provided and the program areas in which funding was provided; and, if possible, to state the type of activities and reach or coverage of funded activities. This approach was largely successful in overall terms for HIV, in that most donors were able to state what program areas the funds were directed to, but did not provide details of the funded activities or their reach. For TB, no existing programs were identified so cost data was not collected.

¹¹ Effectiveness is determined either by evaluation or by broad agreement among key informants that a program is/was effective.

Second, specific implementers were approached and information was gathered on costs involved in carrying out specific interventions. This process followed the Retrospective Costing Guidelines (available from Global Fund on request). The expenditure lists and donors for HIV are summarized in Annex 3. Individual costing sheets for services provided by each of the organizations were prepared.

Third, a Prospective Costing of the comprehensive program was carried out. The results of this process are provided in Annex 4. For each type of intervention, an intervention-level cost was assembled.

The unit costs for activities included in the prospective costing of the 5-year comprehensive response were premised on the unit cost of the budgetary sheet of the main HIV country proposal submitted to GFATM (under allocation), with the envisioned grant starting from 16 March 2018 and ending on 15 March 2021. This costing was based on the standard unit costs for activities of the Principal Recipients (i.e. for activities like training, counseling etc.). Preparation of budget for the main HIV country proposal was done through a wide, participatory process, in which all representatives of key populations in the CCM consensually agreed on unit costs and scale of each of the activities in the budget. This approach was taken to encourage use of the same unit costs for other prospective costing activities, which was also consensually agreed by CCM members.

These costs were used to construct calculation tables (see HIV and TB calculation tables in Annex 4). In these calculations, the number of services to be provided/people to be reached/trained were multiplied by the intervention-level cost to provide an annual cost for each activity. Annual costs are required because some activities only take place every few years, such as the PLHIV Stigma Index, and others require capacity-building or other activities in the first year that are not needed in later years. Comment boxes to the right of each activity in these calculation tables show where the data came from to construct the calculation. These calculation tables were used to provide overall Program Area and Activity sub-activity budgets (tabs labeled 'HIV Budget' and 'TB Budget' in Annex 3), for each of five years as well as a five-year total. These are the budgets that are used to construct the five-year totals provided at the end of the HIV and TB sections of this report.

For most activities, a 10% increment is considered to counter inflation. For quarterly meeting with key population groups, a 15% increment in unit cost was applied instead, after a round of consultations with representatives of key population networks, and based upon of their request, to counter yearly inflation and taking note of the financial difficulties of these groups. As program management costs were difficult to estimate, given the hesitancy of some implementers to share information on recurrent costs such as staffing and other indirect costs, we have added a percentage share of program management (20.0%), Monitoring and Evaluation (1.0%) and research (2.0%) costs to the prospective costing calculations to counteract such underestimation. This method is based on the approach the Global Fund has used for KPI 9b. Some activities within specific program areas involve both the HIV and TB responses. For these program activities, costs were split 60% for HIV and 40% for TB, based on the suggestion of key stakeholders involved in financing decisions for these grants in Nepal.

Limitations

With regards to the retrospective costing, it should be noted that the tool for data collection was sent to a wide range of organizations, including key population networks, UN agencies, notably WHO, UNFPA UNAIDS, and INGOs involved in the response to HIV. This often involved visiting these organizations repeatedly for orientations on the tool and follow-up as well as telephone conversations. Many organizations were not comfortable providing financial information, so the cost estimate of existing programs is likely an underestimate. Though unit costs for many outputs have been calculated, it was not possible for a number of activities. This was because it was extremely difficult to separate out the expenditures incurred for each of these activities due to the fact that many headings, including salary, utilities, transportations and communications, were shared by other interventions also. Moreover, many interventions also have multiple outputs at the same time. Further costing considerations are described in detail in Annex 5.

IV. Baseline findings: HIV

Overview of epidemiological context and key and vulnerable populations

According to UNAIDS, an estimated 32,000 adults and children were living with HIV in Nepal in 2016. HIV prevalence among adults aged 15-49 is estimated at 0.2%, with a slightly higher prevalence among adult men (0.2% compared to adult women 0.1%). (UNAIDS, 2016a)¹² Approximately 56% of people living with HIV in Nepal know their status (N=18,000), 40% of which are taking antiretroviral therapy. It is estimated that 36% of people living with HIV taking ART are virally suppressed (UNAIDS, 2016b)¹³.

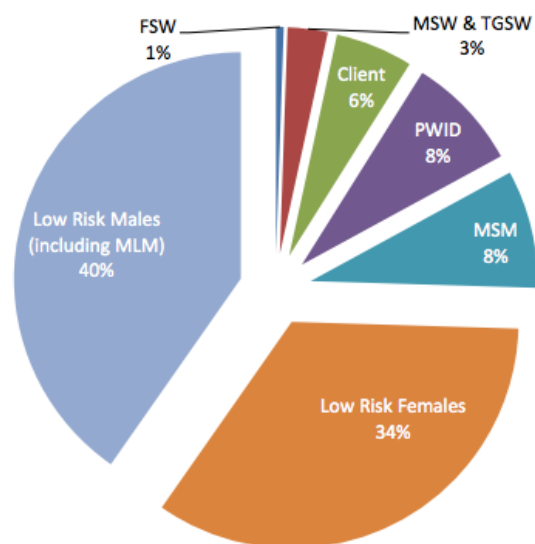
The HIV epidemic in Nepal is concentrated among the following key and vulnerable populations: people living with HIV, men who have sex with men, transgender people, and people who inject drugs. Male labor migrants and their female spouses are considered vulnerable populations. These populations are reflected in the Nepal HIVision 2020, which also includes female sex workers, transgender sex workers, male sex workers, clients of sex workers, incarcerated people, mobile, migrant and displaced populations, young people, uniformed services and all pregnant women. Adolescents are not included as a priority 'vulnerable' population in this assessment, as HIV prevalence is less than 0.1% among adolescents in Nepal¹⁴. Although the National HIV program identifies incarcerated people as a key population for HIV, there are currently no estimates of HIV prevalence among prisoners, and key informants expressed some concerns about the conditions in prison that could increase susceptibility of prisoners to HIV.

2014 estimates indicate that 26% of total infections are distributed as follows: (a) among people who inject drugs (8%), male sex workers and transgender sex workers (3%), clients of sex workers (6%), men who have sex with men (8%), and female sex workers (1%). The remainder of infections occurs among male labor migrants (40%) and their female partners (34%).

¹² UNAIDS. (2016). HIV Epidemic Update 2016.

¹³ UNAIDS. Nepal Country Fact Sheet 2016. <http://www.unaids.org/en/regionscountries/countries/nepal>

¹⁴ Ibid.



Source: HIV Estimates 2014, as reported in Country Progress Report Nepal 2015

The IBBS 2017 surveillance data estimates prevalence for these populations as follows: 2.2% for female sex workers,¹⁵ 0.4% for male labor migrants,¹⁶ 1.4% for women who inject drugs,¹⁷ and 3.3% and 5.3% among people who inject drugs in the Eastern and Western Terai Highway Districts, respectively (IBBS 2017c).^{18,19}

While the prevalence among male labor migrants is only slightly higher than the prevalence among the general population, it still translates to a large number of people living with HIV, as there are an estimated 505,728 male labor migrants in Nepal. Male labor migrants come from western, mid and far-western regions and migrate to areas in India with a high HIV burden. Due to their mobility and frequent return visits to family in Nepal, their spouses are also at a higher risk of HIV transmission (Ministry of Health Nepal. Country Progress Report 2015). The lack of a memorandum of understanding with the Indian Government makes it challenging to protect the health of Nepali migrants while in India, where they often are not able to access basic health care services. The Global Fund has recognized the lack of focus on spouses (normally female) of

¹⁵ National Centre for AIDS and STD Control Ministry of Health and Population. (2017). Integrated Biological and Behavioral Surveillance (IBBS) Survey among Female Sex Workers in Kathmandu Valley Round VI, 2017.

¹⁶ National Centre for AIDS and STD Control Ministry of Health and Population. (2017). Integrated Biological and Behavioral Surveillance (IBBS) Survey among Male Labour Migrants in Western and Mid to Far Western Region of Nepal Round VI – 2017.

¹⁷ National Centre for AIDS and STD Control Ministry of Health and Population. (2017). Integrated Biological and Behavioral Surveillance (IBBS) Survey among Women Injecting Drug Users (WIDUs) in Pokhara Valley.

¹⁸ National Centre for AIDS and STD Control Ministry of Health and Population. (2017). Integrated Biological and Behavioral Surveillance (IBBS) Survey among People Who Inject Drugs (PWIDs) in Eastern Terai Highway Districts of Nepal, 2017 (Round VII).

¹⁹ National Centre for AIDS and STD Control Ministry of Health and Population. (2017). Integrated Biological and Behavioral Surveillance (IBBS) Survey among People Who Inject Drugs (PWIDs) in Western Terai Highway Districts of Nepal, 2017 (Round VI).

key and vulnerable populations in Nepal and their potential to be the first point of transmission, and has therefore put in place a grant management action to address this gap over the next three years.

Overview of the policy, political and social context relevant to human rights-related barriers to HIV services

Protective laws (with challenges of enforcement)

Nepal is a signatory to 21 human rights-related international conventions and treaties, including the *International Covenant on Civil and Political Rights* (1966), the *International convention on Economic, Social and Cultural Rights* (1966), and the *Convention on the Rights of the Child* (1989), and the convention on the *Elimination of Forms of Discrimination against Women* (1979). Nepal's involvement in these conventions and treaties signifies the government's commitment to ensuring the rights and protections of Nepal's citizens. In addition, Nepal also made commitments in the United Nations General Assembly Special Session of HIV/AIDS *Declaration of Commitment on HIV/AIDS* (UNGASS).

The National Human Rights Commission (NHRC) was established in 2000 with the intention of rights protection and effective enforcement of human rights legislation. The Collective Rights Division of this commission identified HIV and AIDS as a priority issue in the context of human rights in the country.

The *National Constitution*, ratified in 2015, contains a specific "Right to Health", which states that: "every citizen shall have the right to free basic health services from the State and no one shall be deprived of emergency health services; every person shall have the right to information about his or her medical treatment; every citizen shall have equal access to health services".²⁰ The *National Health Policy*, 2071 BS (2014 AD), issued by the Ministry of Health and Population, ensures the rights of every citizen to quality health services. Other important provisions laid out in the Nepali Constitution include the right to live with dignity, the right to freedom, the right to equality, the right against preventive detention, the right to privacy, the right against exploitation, the rights of women, the rights of the child, the right to social justice, and the right to social security. These rights protect citizens from discrimination based on religion, race, sex, health, economic status, and other similar grounds.

In 2007, a group of LGBTI rights NGOs led by Sunil Babu Pant of the Blue Diamond Society successfully petitioned the Supreme Court to decriminalize homosexuality and recognize a third gender identity. The Supreme Court also provided protective and anti-discriminatory provisions for PLHIV and people with diverse sexual orientation and gender identity.²¹ *The Sunil Babu Pant and Others Vs. Government of Nepal and Others* (writ no 917 of Year 2007) case was groundbreaking, and although implementation of the third gender category has been slow,

²⁰ Government of Nepal, Constituent Assembly Secretariat. (Unofficial Translation). (2015). Constitution of Nepal.

²¹Bochenek, Michael and Kyle Knight. "Establishing a Third Gender Category in Nepal: Process and Prognosis." *Emory International Law Review*. Emory University School of Law, 2012. Web. <http://law.emory.edu/eilr/content/volume-26/issue-1/recent-development/establishing-a-third-gender-in-nepal.html>.

several important changes have followed since the ruling. As a result of wide advocacy efforts, Article 18(3) of the Constitution identifies the existence of ‘gender and sexual minorities’, the first Constitution in Asia to do so, and makes special provisions for the protection, empowerment and development of those who identify with this group. Additionally, Article 42(1), under the rights to social justice, guarantees gender and sexual minorities, along with several other groups, the right to participate in state bodies on the basis of the principle of inclusivity.

A legal environment assessment, supported by UNDP, was conducted in 2014 and published by the National Centre for AIDS and STD Control of the Ministry of Health and Population in 2015. The assessment identified gaps between international obligations and national practices as evidence showed the need for reform to protect the rights of people living with or affected by HIV and AIDS (Government of Nepal, Legal Environment Assessment, 2015). Key stakeholders noted that this process was successful at identifying laws that need to be updated or removed in alignment with the Constitution and felt they were in a good position to advocate for and begin the process of law reform. Problematic laws will be discussed in the section on human rights-related barriers to HIV services. An HIV Bill to protect the rights of people living with HIV and key populations remains in draft form with the Ministry of Health and Population.

In addition to laws, a number of supportive policies have been enacted over the last decade to support prevention, care and treatment efforts among people living with HIV and other key and vulnerable populations, including the:

- *Nepal Narcotic Drugs Control Policy and Strategy, 2006*: This policy has adopted various strategies like supply control, demand reduction, treatment and rehabilitation, harm reduction, research and development and collaboration, partnership and resource mobilization, etc. It was amended in 2010 to include programs to control and reduce the transmission of HIV among people who use drugs and their families/communities.
- *National Policy on HIV/AIDS in the Workplace, 2064 BS (2007 AD)*: the Business Coalition on AIDS in Nepal (BCAN) was established to expand workplace programs to protect the workforce from HIV infection and to create a supportive environment for the care and treatment of infected and affected people as a part of the corporate social responsibility of the business sector.
- *National Policy on HIV and STI, 2011*: The revised policy of 2011 established linkages among the National AIDS Council (NAC), the HIV/AIDS and STI Control Board (HSCB), the private sector, and civil society including people living with HIV, to respond to the HIV epidemic through enhanced coordination for a strengthened HIV response.
- *National Blood Transfusion Policy, 2014*: This policy contains provisions for Transfusion Transmissible Infections (TTI) screening that covers testing for HIV. The policy has a clear bio-safety guideline to minimize injuries, infections and harmful toxins and a flow chart for PEP in the case of needle stick injuries.
- *Nepal HIV Investment Plan 2014-2016*: Based on the principles of UNAIDS’ Investment Framework, this strategy advocated for strategic investments in the

country's response to HIV, such as public-private partnerships, evidence-based policies or the rapid scale up of HIV testing and ART.

- *National Health Sector Strategy (2015-2020)*: This strategy establishes HIV and AIDS services as one of the elements of the basic health service package.
- *National HIV Strategic Plan 2016-2021*: This plan outlines a set of evidence-informed strategies focused on building one consolidate, unified, rights-based and decentralized HIV programme with services that are integrated in the general health services of the country. A key theme among these strategies is their focus on reaching key populations with HIV prevention, care and treatment services and retaining people living with HIV on treatment, resulting in undetectable viral load. The strategy is aligned with the global Fast-Tracking approach to achieve the 90-90-90 treatment targets by 2020.
- *National HIV Testing and Treatment Guideline 2017*: The revised guidelines are in alignment with the latest global evidence on HIV testing and treatment practices, and provide comprehensive evidence-based recommendations for HIV testing services, including community-based testing by lay providers, with a view to moving towards the first 90 of 90-90-90 in the country. They also provide guidance on use of pre-exposure prophylaxis (PrEP) as an additional prevention choice for people at substantial risk of acquiring HIV; and guidance on various operational issues like retention in care, adherence, differentiated care model and cascade monitoring with a view to achieving 90-90- 90 by 2020.

Challenges of enforcement and other gaps

The findings from the 2015 *Legal Environment Assessment* revealed:

“Many supportive efforts initiated from both state and non-state sectors which has resulted in gradual improvements in the lives of PLHIV and key populations. Family and social acceptance towards PLHIV has been improving. Social media also seems supportive in producing enabling news. Advocacy conducted at national, regional, and local levels have been eye openers for local leaders, government authorities, law enforcement, and political leaders. Nepal has a commendable history where legal and justice systems have played constructive roles in responding to HIV, by respecting, protecting and fulfilling human rights, in the absence of appropriate laws and acts. Policies and programs for the mobilization of these groups for the effective prevention and treatment interventions are in place though the implementation is not optimum. (Page 23)”

Several recommendations that were included in the LEA related to the formulation of supportive laws and improving policies and programmes related to HIV (see pages 23 through 25).²²

²² National Centre for AIDS and STD Control Ministry of Health and Population. An Assessment of the Legal and Policy Environment in Response to HIV in Nepal. Teku, Kathmandu, Nepal: 2015.

In terms of risk reduction, the *National Guideline on Universal precautions, Waste Disposal and Post Exposure Management* was developed in 2007 to standardize procedures among health service providers and minimize risks of infections for health service providers and their patients. However, it was found that in practice, the mandatory universal precaution procedures were often compromised, depending on the setting of the service sites. In addition, the guideline does not include the new approaches of preventing HIV transmission with pre- and post-exposure prophylaxis.

With regard to the *National Policy on HIV/AIDS in the Workplace*, 2064 BS (2007 AD)—BCAN's work is limited to awareness-raising programs in only a few workplaces/industries in Kathmandu Valley. Additionally, uniformed services and foreign employment agencies have been found to exclude candidates for employment after a positive HIV result. Other countries (e.g. in the Gulf area) also demand HIV tests within a week following entry and return people living with HIV to their home country.

The *National Blood Transfusion Policy* is silent about the rights of patients, in case of HIV infection, HBsAg, HCV or other blood-borne diseases from a blood transfusion. The *National HIV Strategic Plan 2016-2021* outlines three main challenges and priority action areas, including: (1) foreign aid dependency – about 90% of funding for HIV is currently coming from external donors. With expected reductions in external funding, the Government of Nepal needs to increase its investments in HIV, yet, as of 2016, the pooled fund health sector-wide approach, no longer has an earmark for HIV; (2) systemic issues – HIV services are not always delivered in the most effective, efficient and integrated way. There is a lack of integration, especially with TB services, and logistics and procurement services for HIV and general health must be harmonized. Strategic information for programme planning and monitoring is inadequate, and there is a lack of effective dialogue between the public sector, private sector and communities which hinders prevention services for key populations; and (3) service delivery issues – public health services and NGOs need to work to increase demand for services, especially among key and vulnerable populations. Testing levels among key populations are too low, and the distribution of clean needles to people who inject drugs is also well below the recommended 200 syringes per person per year.

Other challenges include mainstreaming HIV issues into sectoral ministries, creating an enabling environment for needle syringe exchange programs and providing for the distribution of condoms.

Political environment

Though there are many protective and supportive laws and policies, many key informants referred to a problem of lack of accountability at multiple levels throughout the Government's response to HIV. Laws are in place under a well-developed Constitution that guarantees key populations' access to health services without interference from police. However, several key population representatives noted that police behavior is one of the biggest barriers they face in accessing services, as described more fully below.

Human rights barriers to access, uptake and retention in HIV services

The major human rights-related barriers identified in the desk review and confirmed in discussions with key stakeholders and members of key populations, included:

- a) Stigma and discrimination based on HIV status and/or based on key population status experienced in the community and at health facilities (i.e. inefficient and discriminatory practices in healthcare facilities, which is heightened for members of key and vulnerable populations)
- b) Gender inequality, including gender-based violence, lack of decision-making power, which influences gender-related vulnerabilities to HIV
- c) Outdated laws that hinder key population access to HIV services – the 2015 Legal Environment Assessment identified some problematic laws that should be updated or removed to reduce rights-related barriers to health services access
- d) Illegal police practices against key populations - specifically men who have sex with men and transgender individuals and female sex workers; and
- e) Poverty and geophysical barriers that make it difficult for vulnerable populations in hilly areas to access HIV services, as both time and financial resources are needed to reach health centers.

Stigma and discrimination

Stigma and discrimination were the most commonly cited barriers in the literature review, and applied to all key populations. Despite the inclusion of stigma and discrimination reduction in policies, the *National Commitments and Policies Instrument* states that they remain one of the major barriers to treatment in Nepal.^{23,24} In Nepal, societal discrimination and stigma are prevalent, with demographic information indicating that 30.7% of women and 24.9% of men reported discriminatory attitudes towards people living with HIV.²⁵ Stigma manifests itself in multiple areas of an individual's life, including in the family, the community and in healthcare facilities.

Many people living with HIV experience stigma and discrimination in the context of their families, which may lead them to isolate themselves from loved ones to protect themselves or their families from discrimination. Lack of family support can interfere with a person's ability to access and adhere to ART. The higher the level of emotional distance and the more experienced physical harm from family, the higher the risk of non-adherence.²⁶ Participants of a focus group with the Federation of Women Living with HIV/AIDS noted that stigma has become subtler, but persists. While women living with HIV are no longer kicked out of their homes, they are often

²³ UNAIDS (2013). National Commitments and Policies Instrument.

²⁴ NCASC. (2015). Integrated Biological and Behavioral Surveillance (IBBS) Survey among People Who Inject Drugs (PWID) in Kathmandu Valley, Round 6, 2015.

²⁵ United States State Department. (2016). Nepal 2016 Human Rights Report.

²⁶ Poudel K, Buchanan D, Amiya M, Poudel-Tandukar K. (2015). Perceived family support and antiretroviral adherence in HIV-positive individuals: results from a community-based positive living with HIV study. *International Quarterly of Community Health Education* 36(1), 71-91.

made to do more housework than other members of the family not living with HIV. In addition, they are often given less access to family resources, including money and food.

In Nepal, discrimination in health facilities appears to be a strong impediment to care, treatment and support. People living with HIV have reported experiencing discrimination in health facilities, and some avoided treatment due to fear of mistreatment and prejudice, or violations of confidentiality. Some clients have reported being ignored and judged by medical staff after sharing their HIV status.^{27,28}

Discussions and interviews with key informants and community representatives clarified the instances of stigma faced by people accessing HIV services. Key informants agreed that stigma and discrimination in health facilities still persists. However, what emerged from the data is that over a period of time, manifestations of stigma and discriminatory behaviors have changed. According to several key informants and community representatives, with increased sensitization of health providers, outright refusals of health services are no longer commonplace. There are, however, newer manifestations of discriminatory behavior on the part of the health providers that were noted, such as delay in initiation of treatment, referrals to other providers, and quoting higher fees for procedures. An experience of a community representative highlights the process of these manifestations:

“I wanted to get a rod put in my thumb, first they kept postponing until 2:00 AM, hoping that I would go away, then finally they did the surgery, they made me buy a HAZMAT suit for a thumb surgery and I was charged 24,000 Rupees instead of 8,000 rupees”.

Another key informant from the Network of Women Living with HIV noted a similar experience:

“Providers don’t refuse treatment outright. For example, a dentist may triple the cost of extracting a tooth, hoping that the person living with HIV will seek treatment somewhere else.”

Some people living with HIV experience self-stigma, which can include feelings of shame or guilt, lowered self-esteem, or suicidal thoughts. Self-stigma can increase chances of self-isolation and a lower adherence or willingness to seek treatment.²⁹

Stigma and discrimination based on key population status

Individuals living with HIV may face increased stigmatization when combined with another marginalized identity. Though most key populations are likely to face more stigma and discrimination than members of the general population, transgender people and women who inject drugs appear to be especially likely to experience stigma and discrimination.³⁰ In the context of healthcare, many health workers not only perpetuate social stigmas by participating

²⁷ Neupane D, Khanal V, Sharma S, Aro A. (2012). Perceived discrimination among people living with HIV in Nepal. *Journal of Nepal Health Research Council*,10(21), 136-140.

²⁸ Jha C and Madison J (2009). Disparity in health care: HIV, stigma, and marginalization in Nepal. *Journal of the International AIDS Society* 12(26). <http://doi.org/10.1186/1758-2652-12-16>.

²⁹ Family Planning Association of Nepal. (2011). *The People Living with HIV Stigma Index Nepal 2011*.

³⁰ Ibid.

in discrimination against people living with HIV, but also tend to discriminate against other key populations who are more likely to be infected with HIV.³¹ According to the NAP+N report 'Human Rights Count 2015', a majority of the discrimination faced by key populations living with HIV occurred within rehabilitation and healthcare centers by staff at non-governmental organization-led centers.³²

Female sex workers in Nepal experience significant stigma due to their profession. Additionally, female sex workers often report experiencing stigma and discrimination in healthcare facilities. Respondents to one study in Nepal reported sexual harassment by male service providers, as well as violations of confidentiality, judgment and neglect by staff at healthcare facilities.³³ These findings from the desk review were also validated in the various interviews and discussions held with representatives for the community of sex workers and the key informants. Stigmatizing attitudes towards members of key populations, and women within the key populations in particular, were observed. Experiences shared by community members from within the sex worker community revealed the discreet and not-so-discreet ways in which they experience stigma at the hands of health providers. For example, several female sex worker representatives shared the trauma that these women face in HIV testing and pre-test counseling, when the counselors ask them several questions that seem unwarranted for getting an HIV test. To illustrate, a peer leader shared the following: *"While going for HIV test, several of our members have been asked, 'where do you meet your clients? How much do you charge per client? Do you charge on an hourly basis or nightly basis?' Most of us fail to understand how these questions are related to getting an HIV test."*

The range of experiences in health care reported by female sex workers also brought to light disturbing evidence of sexual harassment by providers. One member notes: *"In Sunsari district, one doctor asked a female sex worker: 'Why are you feeling ashamed for getting a check-up while you do not feel ashamed to sleep with 10 people?'"*. Another key informant shared that while getting services at the government level, some staff ask for sexual favors from sex workers and ask them to bring in or contact other sex workers to provide payment for service at the health facility.

These rights violations in healthcare setting fueled by the moral attitudes towards female sex workers were not limited to HIV services, but also could be found in other health services, where women reported being humiliated and being sexually abused while seeking an abortion, as well as for other general health care services. Consequently, several representatives of the sex worker networks reported that women do not willingly disclose being engaged in sex work for the fear of being violated in the healthcare setting. This fear of ramifications for disclosing their occupation, along with the existing criminalization of sex work in Nepal, is identified as a major hindrance to the collectivization of the sex work community and their fight for their rights.

³¹ Jha C and Madison J (2009).

³² NAP+N. (2015). Human Rights Count 2015.

³³ Ghmire L, Smith W, van Teijlingen E. (2011). Utilisation of sexual health services by female sex workers in Nepal. BMC Health Services Research 11(79). <http://www.biomedcentral.com/1472-6963/11/79>

Men who have sex with men often face discrimination by family, society and health workers. Denial of examinations and lack of confidentiality regarding sexual orientation status are noted as common problems in health facilities for men who have sex with men in Nepal. Discrimination from the family remains a problem, specifically for men who identify as feminine or women (Metis).³⁴

While discussing the reach of HIV programs, key informants also spoke about inaccessible key populations whom the current programs are unable to reach within the lesbian, gay, bi-sexual, transgender and intersex community and among people who inject drugs. For example, among people who inject drugs, women who use drugs are a hidden population who face more stigma than men, according to a key informant from Recovery Nepal: *“Women users face stigma more than their male counterparts, this impacts their service utilization and they also face greater discrimination.”*

Gender inequality and discrimination against women

For women, the risk of contracting HIV during unprotected sex is estimated at two to four times that for men. Paired with the cultural sexual subordination of women and increased risk of sexual violence, gender becomes a highly relevant topic to address in the discussion of human rights and HIV. Women’s vulnerabilities in the context of HIV go beyond the increased biological and sociocultural risk of contracting HIV, and include the physical and psychological gender-specific consequences that occur when a woman is infected with HIV. Stigma among women living with HIV is associated with societal rejection, low self-esteem, fear, anxiety, depression, and suicidal ideation.³⁵

Women face a high degree of exclusion, and the prevalence of violence against women and girls, in Nepal remains high despite significant efforts to combat it.³⁶ The UNFPA reports that 48% of Nepali women have experienced violence in their lives.³⁷ Gender-based violence and intimate partner violence greatly increases a woman’s chance of acquiring HIV in comparison to women who do not experience violence. UNAIDS reports that women who experience violence are 50% more likely to become infected with HIV.³⁸

Several key informants concurred with the literature and noted that the status of women in Nepal is lower than the status of men. Key informants also expressed disappointment that while gender constraints were significant barriers in HIV service seeking for women, HIV programs did not address issues of violence faced by women. For example, a key informant representing spouses of male migrants highlighted how violence and the lack of support to address issues of violence made wives of migrants vulnerable to HIV infection. As expressed by this key informant:

³⁴ Oli N and Onta S. (2012). Self-perception of stigma and discrimination among men having sex with men. *Journal of Nepal Health Research Council* 10(22), 197-200.

³⁵ Poudel V, Baral K. (2015). Women living with HIV/AIDS (WLHA), battling stigma, discrimination and denial and the role of support groups as a coping strategy: a review of literature. *Reproductive Health* 12:53.

³⁶ National Strategy and Plan of Action related to Gender Empowerment and Ending Gender Based Violence 2012-2017

³⁷ United Nations Population Fund. (2016). *Gender-based Violence in Nepal*.

³⁸ UNAIDS. (2013). *Global Report: UNAIDS report on the global AIDS epidemic 2013*.

“Wives of migrants need more services, as they are quite vulnerable to violence of all kinds from the community, as she is alone by herself when her husband is in India. She can get into a relationship and sometimes face violence from other men in the community. But she has no place she can talk about this and no services for addressing these issues...”

In addition to lack of services that address issues of violence faced by women, further unmet needs in services were reported by representatives of networks of women living with HIV and female sex workers. The unaddressed needs of the women were the lack of availability of reproductive health services, such as availability of safe abortions and family planning methods. As discussed above, key informants highlighted that female sex workers faced discrimination while accessing reproductive health services in general hospitals. A sex worker network member noted that:

“One of our members became pregnant. She went to seek a medical abortion in Ayurveda hospital where the doctor made her wait for three hours and in the process of the check-up, he sexually assaulted her. Luckily she could escape from the situation.”

Key informant interviews with a representative of females injecting drugs also highlighted barriers to OST treatment. According to this key informant, women who use drugs are not comfortable accessing OST services at a community-based OST center as these centers typically cater to men who inject drugs, and such centers do not respond to the specific needs of women who inject drugs.

Punitive laws, policies, and practices

According to the *Infectious Diseases Control Act 2020* (1963), the government can give power to an entity in charge of limiting the spread of infection, which may include keeping people with infectious diseases in isolation or otherwise limiting their mobility. This is more likely to apply to people living with tuberculosis in Nepal, as HIV is not as infectious. However, the provision does not differentiate between different types of infectious disease and still provides a risk for both diseases. It does not appear that this act is implemented.

One of the biggest motivators of ART adherence for people living with HIV is the support and trust of healthcare practitioners.³⁹ Female sex workers in Nepal often report inefficient and/or unethical healthcare practices on numerous levels that lead to lack of trust of health care workers. These concerns include: lack of confidentiality lack of professionalism, discrimination, neglect, and sexual harassment.⁴⁰ The network members observed that even female health providers discriminated against them, noting: *“the female doctors tell female sex workers that they are a disgrace and they shouldn’t be considered as women of the community.”* The nature

³⁹ Wasti S, Simkhada P, Randall J, Freeman J, van Teijlingen E. (2012). Factors influencing adherence to antiretroviral treatment in Nepal: a mixed methods study. PLOS ONE 7(5): e35547. <https://doi.org/10.1371/journal.pone.0035547>.

⁴⁰ Ghmire L, et al. (2011).

of laws and the illegal status of sex work and drug use in Nepal often provide room for violation of rights.⁴¹

Further, for other key populations, like people who inject drugs, a large amount of discrimination occurs in detoxification centers and rehabilitation centers that are led by non-governmental organizations. This often is a result of the high commercialization and lack of regulatory mechanisms in the country's rehabilitation centers. Limited availability of skilled and trained staff and lack of resources result in human rights violations for people who inject drugs and people living with HIV.⁴²

The proposed draft of the *Penal Code* under Article 103, Chapter 5, Offense against Public Interest, Health and Safety, Convenience and Morals, criminalizes people who “purposefully or knowingly commit acts that would transmit Hepatitis B or HIV, give blood or coerce to give blood or come into sexual contact without precautionary measures in place, or cause entry of blood, semen, saliva, or other bodily fluids into the body of another. Charged with attempt to murder, this could result in imprisonment and a fine.⁴³ While it does not appear that this law has ever been enforced, this kind of counterproductive law has the potential to create a barrier for people living with HIV accessing care, and might further stigmatize people living with HIV.

Illegal police practices

While key informants of all key populations reported being harassed by the police, it appears that sex workers, both female and transgender, seemed to be most affected by police harassment. Interviews and discussions with various community representatives and key stakeholders suggested that sex workers are arrested and prosecuted by police and Chief District Offices under laws or regulations regarding disturbing the peace or demonstrating obscenity under the Some Public (Offence and Punishment) Act. Reported cases include possession of condoms being taken as evidence of sex work; and peer educators and outreach workers being harassed/arrested by police on the basis of carrying condoms.⁴⁴ This type of mistreatment by the police appears to be common, according to key population representatives. While human rights training for law enforcement has been happening regularly in Kathmandu, mistreatment continues. Female and transgender sex workers have very little power to prevent such abuses and advocate for their rights. The negative attitudes and discriminatory actions of law enforcement towards sex workers create a barrier to accessing healthcare for HIV testing and treatment.

Discussion with representatives from the sex workers' network revealed several instances of other illegal practices at the hands of law enforcement, including extortion of money from female sex workers. One key informant noted an instance in which the police took a female sex worker from a restaurant and asked for money, threatening that she would be arrested. She is now facing lifetime imprisonment in the Central jail. Human rights violations at the hands of

⁴¹ Godwin, J (2012). Sex work and the law in Asia and the Pacific: Law, HIV and Human Rights in the context of sex work. Bangkok; UNDP

⁴² NAP+N. (2015). Human Rights Count 2015.

⁴³ The Draft Penal Code, Criminal procedure Code and the Sentencing Act and Report 2010, Government of Nepal, Ministry of Law and Justice.

⁴⁴ The Rights Evidence: Sex work, Violence and HIV in Asia 2015; A multi-country qualitative study; UNDP, UNFPA, APNSW, SANGRAM

law enforcement personnel sometimes took the form of sexual abuse. The following experience was shared by a participant in a group discussion: *“In Sunsari, a female sex worker was arrested from the local restaurant where she was having lunch. The policeman brought her to the jail where she was sexually assaulted.”* The members of the JMMS organization asked for help from the Deputy Superintendent of Police (DSP); however, the members too faced sexual harassment, as the DSP asked for sexual favors.

Despite homosexuality and transgenderism not being criminalized in Nepal, men who have sex with men and transgender people (Metis) experience stigma and discrimination from the police and the army, as well as harassment and physical violence from law enforcement.⁴⁵ Numerous cases of police abuse against men who have sex with men and transgender people have been recorded. These include harassment, beatings, torture and arbitrary arrests without hearings under the public nuisance law.⁴⁶ Some research has documented how Metis, who migrated to cities as a result of stigma in the family, face harassment and violence, including rape at the hands of police which influence their risk of HIV, among other vulnerabilities, such as, inconsistent condom use and high reported numbers of sexual partners.⁴⁷ A key informant from the Blue Diamond Society reflected that despite the favorable legal environment, transgender women involved in sex work still face violence at the hands of police.⁴⁸ Although the Constitution grants rights to sexual and gender minorities, it does not include a specific prohibition against discrimination on the grounds of gender and sexual orientation.

Poverty and geophysical barriers

As Nepal has hilly and mountainous terrain, services are difficult to reach for many people living with HIV who do not have the time and financial resources to travel regularly across these regions. The most challenging adherence issues for people living with HIV in accessing care in Nepal appear to be distance to health facility, traveling methods to reach the health facility, and costs for services provided. This is particularly true outside of Kathmandu⁴⁹. For patients who should travel long distances to access treatment, expenses are high due to the financial burden of transportation, lab services, and possibly staying overnight and having to take off of work, despite the HIV treatment being free⁵⁰. Accessibility is also an issue for the urban poor, who face the same financial challenges as the rural poor when accessing care and treatment for HIV.⁵¹

In addition, sociocultural barriers like likelihood of family support, age, religious tradition, and personal habits, can become barriers to accessible care. Within the context of key populations, informants also noted that being a sex worker or a transgender woman often meant expulsion from the family, forcing them to fend for themselves and face discrimination based on their

⁴⁵ Oli N et al. (2012).

⁴⁶ APCOM, UNDP; Legal environments, human rights and HIV responses among men who have sex with men and transgender people in Asia and the Pacific. An agenda for action, July 2010

⁴⁷ Wilson, E., Pant, S. B., Comfort, M., & Ekstrand, M. (2011). Stigma and HIV risk among Metis in Nepal. *Culture, health & sexuality*, 13(03), 253-266.

⁴⁸ Key informant interview with Ms. Manisha Dhakal, Executive President Blue Diamond Society

⁴⁹ Wasti S, Simkhada P, Randall J, Freeman J, van Teijlingen E. (2012). Barriers to and facilitators of antiretroviral therapy adherence in Nepal: a qualitative study. *Journal of Health, Population, and Nutrition* 30(4), 410-419.

⁵⁰ Key informant interview with Dr Usha Jha

⁵¹ Key informant interview with Tushar Ray of KNCV.

profession or gender. A key informant from the Blue Diamond Society made an observation regarding the financial status of transgender women and the inability to get regular jobs: “If you look around, how many trans people do you see working in proper jobs? The only ones you see are here in this place- the rest have no other option but to do sex work or do menial work in hotels where they are exploited.”

Programs to address barriers to HIV services – from existing programs to comprehensive programs

Overview – challenges and opportunities

This section describes existing or recent programs in Nepal to reduce human rights-related barriers to services organized under the seven key program areas set out in the Global Fund Technical Brief, as well as the comprehensive programs that, if put in place at scale, would help to minimize these barriers to service access. Several non-government and community-based organizations, as well as government entities, have been working to address human rights-related barriers to HIV. However, these activities do not fully cover each program area and most are being implemented at a scale that is unlikely to bring about major change. Nepal has institutions, protective laws and civil society organizations that can all be strengthened and engaged to significantly reduce these barriers. However, this will require increased and sustained investment in interventions and activities that provide important human rights-related knowledge, skills and resources to officials and to the populations of those affected by HIV.

There have been many pilot projects comprising activities to reduce human rights-related barriers to services, but few of them have been evaluated and taken to scale. Institutionalization of some activities – such as training of practicing doctors in stigma reduction – is underway, but for many other effective or promising interventions there is little likelihood that they will survive the departure of external funders. Programs to reduce stigma and discrimination among health workers have yet to be institutionalized in medical education more broadly, and medical ethics is not a major component of pre- or in-service education for doctors, nurses or health administrators. Nor has stigma reduction and human rights training been institutionalized in other key sectors, such as law enforcement.

The funding for HIV programming in Nepal comes from two main sources. The US Government, through USAID, PEPFAR and FHI 360, funds HIV-related prevention, care and treatment activities for sex workers and men who have sex with men. The Global Fund, through a prime award to Save the Children, supports HIV-related programming for people who inject drugs, transgender individuals and migrants. A high degree of coordination between USAID, FHI 360, Save the Children and UNAIDS ensures that there is no duplication in programming. Despite some overlap of districts, there is no overlap with the populations served. Some CBOs receive additional funding support from other bilateral donors or foundations (i.e. UNESCO and FRI, - a Norwegian Organization for Sexual and Gender Diversity).

The key funding agencies for HIV in Nepal have a high level of engagement and work to minimize any redundancies in funding. In the past, USAID through FHI360 has supported most of the activities and programs to reduce HIV-related stigma and discrimination, including trainings with health workers, police, key stakeholders and the general population. However, USG funding for HIV is decreasing, which means that additional support will be needed from other sources to continue these stigma-reduction activities. Matching funding through the Global Fund for programs to remove human rights-related barriers has the potential to bridge this gap and ensure both continued efforts to remove a range of human rights-related barriers, and also an opportunity to expand programs and update existing curricula to address these barriers more comprehensively (i.e. including stigma-reduction in a human rights-focused curriculum that also addresses key population stigma, gender-based violence and legal literacy about supportive laws and policies, etc.). The programmes implemented by FHI 360, Save the Children and their partner organizations over the past decade are described in more detail in the following sections.

There is an opportunity to enhance both the quality of and participation in trainings offered by key populations networks. For example, several networks are providing similar stigma-reduction and sensitivity trainings to police that could be streamlined to increase participation and consistency of messaging.

There is also an opportunity to remove the siloes of HIV and TB programming and to support an integrated national response to addressing the human rights barriers affecting both HIV and TB services. Key informants were supportive of an integrated approach to both service provision for HIV and TB and strategies to remove human rights barriers.

Many key informants referred to the important role that NGOs have played in working with key populations, especially in advocacy for the reduction of human rights barriers to services. Many of the interventions described empower and engage key population representatives to be strong advocates for increased access to services and support among law enforcement and health care providers for this access. A summary description of existing or recent interventions to address human rights-related barriers to HIV services for each program area is presented below.

PA 1: Stigma and discrimination reduction for key populations

The table below provides an overview of current programmatic efforts on stigma and discrimination reduction as well as recommendations for scale-up. The content of the table is then further elaborated upon in the text that follows the table.

Stigma and discrimination reduction for people living with HIV and other key and vulnerable populations						
Program	Description					Limitations
Curricula for civil societies on trainings for stigma and discrimination reduction	Toolkit for trainings on stigma and discrimination to be used by civil society organizations and government agencies to promote a safer community for people living with HIV and people vulnerable to HIV.					Does not currently include information on human rights or TB.
Implementer	Population targeted	# trained	Region(s)	Timeframe	Recommended scale-up	
NCASC/FHI 360 Stigma-reduction Toolkit	General population	Several CBOs trained (i.e. BDS, FSGMN, NAPN, NFWLHA, JMMS) who then trained their networks	Country-wide	Initially developed in 2004/2005; updated in 2010.	Update existing curricula to include information on HIV, TB, non-discrimination, violence, (including infection control for TB) and promote supportive, accepting, and responsive services. Roll out training of trainers on new curricula among key populations and NGOs.	
Program	Description					Limitations
Stigma-reduction training	Training for a variety of populations to increase awareness on stigma and discrimination and promote a safe and healthy environment for people living with HIV and other key and vulnerable populations. The trainings are based on standardized toolkit and can be adapted to fit the needs of a variety of populations. Sessions are participatory in nature. People living with HIV and representatives of key populations are typically involved in the training sessions as co-facilitators.					Current curricula do not include content on human rights or the policy/legal environment; focus is on HIV mainly and also key populations. TB is not included. Trainings are typically one-time or in-service.
Implementer	Population targeted	# trained	Clients reached	Region(s)	Timeframe	Recommended scale-up
Himalayan Association against STI-AIDS and New Diyalo Samai (Acham)	General population, people living with HIV, migrants and their families, health workers, students, journalists, volunteers, opinion leaders	37 peer educators	Not identified	Acham, Seti Zone, Far Western Region	June – November 2009	Institutionalize training on reducing stigma, discrimination and violence related to HIV and TB in professional schools for duty bearers (i.e. teachers, doctors, nurses, social workers, lawyers, judges, etc.) using updated curricula. Course curricula can be adapted from the standardized NCASC curriculum. Continue in-service
FHI 360/Linkages Project	People living with HIV, sex workers, men	n/a	2000	16 southern districts	October 2016– March 2018	

	who have sex with men, transgender individuals, clients of sex workers					trainings and community leader/stakeholder trainings.
FHI 360 and partners/Saath-Saath project	People living with HIV, female sex workers, migrants, health workers, general population	n/a	48,139 (60% women)	33 of 75 districts	October 2011 – June 2016	
FHI 360 and partners/ASHA project	People living with HIV, female sex workers, migrants, health workers, general population	n/a	50,000	38 districts	2007-2011	
Program	Description					Limitations
Mass media campaigns	The campaigns are meant to address community-based stigma and create a more supportive health environment for people living with HIV. Supportive and educational media programming, including scripted radio programs, has been utilized to change problematic behaviors and attitudes toward people living with HIV, including key populations affected by HIV.					Mass media campaigns have not been mounted in past decade. Limited evaluation data, difficult to gauge impact of campaigns.
Implementer	Population targeted	Clients reached	Region(s)	Timeframe	Recommended scale-up	
NCASC/FHI 360/Impact Project “Let’s start to talk about AIDS today” & “Ek Aapas ka Kura”	General population, youth, policy makers	In first 3 months: • More than 3 million through TV • 2.5 million through print • 3 million through radio	Country-wide	2002	Increase frequency of mass media campaigns to reduce stigma and discrimination based on HIV and TB status and increase awareness on laws and policies protecting the rights of people living with HIV and/or with TB, and to reduce misconceptions regarding fear of infection and subsequent avoidance behavior and attitude.	
FHI 360/NAP+N/ Impact Project <i>Ek Aapas ka Kura</i> Radio Program on	General population	Not measured	Country-wide	2005-2006		

national radio and FM stations nationwide					
Program	Description				Limitations
Group-based support for PLHIV and other key populations to overcome stigma and discrimination	Group-based interventions and programmes typically support PLHIV and other key populations by providing a safe-space for people to come together, discuss challenges, seek support and build community. These interventions range from unstructured sessions on a drop-in basis to structured sessions. For example, a 6-week empowerment intervention on social self-value was piloted to improve the quality of life (QoL) of people living with HIV receiving antiretroviral treatment. The empowerment intervention mainly focused on autonomy and community activism, self-esteem/self-efficacy, self-care, optimism and control over the future, family and social relationships, power-powerlessness, management of stress and righteous anger, stigma and discrimination issues, legal provisions, and human and health rights.				Lack of standardization in the type of support provided across different NGOs; minimal structure to sessions, not necessarily based on a curriculum.
Implementer	Population targeted	Clients reached	Region(s)	Timeframe	Recommended scale-up
Prince of Songkla University, Thailand; Bhatta et al. 2017	PLHIV	132	Kathmandu	2014-2015	Good model ready for scaling to reduce internalized stigma and increase self-esteem among PLHIV. Successful intervention; significantly reduced stigma and increased quality of life, social support and empowerment.
Multiple NGOs/CBOs	PLHIV, key populations	Not identified	Country-wide	2011-2018	Funding for support groups should continue. Support groups are valuable tools for reaching and engaging PLHIV and other key and vulnerable populations in prevention, care and treatment service, fostering resilience and improving quality of life. Integrating tested sessions/curricula and also combining support group interventions with skills development should be considered.
Program	Description				Limitations
Advocacy and awareness raising	Women leaders, transgender women and men who have sex with men trained to lead advocacy, awareness-raising, and platforms for information sharing and community dialogues. In support of local advocacy efforts, trainings have included empowerment				Limited funds available to support advocacy events linked to beauty pageant project.

	workshops, encouraging a positive environment to engage members to reduce stigma and discrimination in communities, and beauty pageants.				
Implementer	Population targeted	Clients reached	Region(s)	Timeframe	Recommended scale-up
Right to Health Women's Group	Girls/Women	Not identified	Kathmandu; Country-wide	2012-2013	These types of interventions, that use cultural mediums delivered through large, public events, combined with advocacy and engagement led by key populations should be supported and scaled-up throughout the country.
Federation of Sexual and Gender Minorities Nepal "Beauty and Brains in Action to Tackle HIV/AIDS Stigma and Discrimination"	General population, men who have sex with men, transgender communities	1,500 attended pageants; 228 advocacy events; a broader reach was estimated given national coverage of the programme.	Narayangadh, Pokhara, Biratnagar, Dhangadi, Nepalguni	2009	
Program	Description				Limitations
PLHIV Stigma Index	A process led by and for PLHIV to gather data on the experiences of PLHIV in Nepal, including stigma and discrimination in the community and health care settings. The data generated are used to inform advocacy efforts by civil society.				Only one survey has been conducted.
Implementer	Population targeted	Clients reached	Region(s)	Timeframe	Recommended scale-up
Family Planning Association of Nepal, UNAIDS, NAP+N	PLHIV	848 (402 men; 419 women and 27 transgender individuals)	Country-wide	May-June 2011	Repeat national PLHIV stigma index on a 3-5 year basis to provide updated data for assessing impact of programs to remove human rights barriers to HIV services. Provide resources for follow up including targeted advocacy, mobilization and utilization of the PLHIV trained for the process.

Current Programs

Stigma-reduction training

Efforts to improve understanding of stigma and its harmful consequences on PLHIV and key populations through participatory training methods have been underway in Nepal since 2006. In 2010, the NCASC adapted and standardized a toolkit that has been used ever since by the NGO community to inform stigma-reduction training throughout the country. The USAID-funded ASHA and Saath-Saath projects trained 50,000 and 48,139 people living with HIV, female sex workers, migrants, health workers, and members of the general population throughout the country between 2007-2016, respectively, and the follow-on LINKAGES project has trained 2000 PLHIV and key population members since 2017. Support for stigma-reduction training through USAID will come to end in March 2018, with the end of the LINKAGES project. There have also been other, smaller scale projects involving stigma-reduction training, such as the Himalayan Association against STI-AIDS and New Diyalo Samai (Achim). This yearlong project combined stigma-reduction training for health care workers with exit interviews with people living with HIV to assess client satisfaction. Evaluation findings suggested that client satisfaction improved among people living with HIV seeking services at 3 health facilities that participated in the intervention.

Limitations/Challenges:

The main focus of the NASAC curriculum is HIV-related stigma among people living with HIV and other key populations. The curriculum does not include content on human rights, the current policy and legal environment, or information on TB stigma. As the stakeholders interviewed overwhelmingly thought that these issues should all be covered together in one curriculum that can be standardized and used across NGOs in Nepal, it will be important to update the curriculum to ensure that these areas are covered. Key informants in several interviews noted some implementation challenges that can lead to resistance from duty-bearers being trained. For example, several NGOs have support to provide training to the police, which can result in overlap and redundancy. There is a need for better coordination around stigma-reduction and human rights training. In addition, there is a need to institutionalize training on stigma and human rights within professional colleges for key duty-bearers (i.e. nurses, doctors, social workers, lawyers, judges, police,) to make the trainings more sustainable over time. Currently, trainings are in-service, and it is often difficult to reach all police or health workers in a facility, for example. In addition, regular re-assignment of staff in government health facilities and police stations requires regular re-training of staff.

Media Campaigns

The National Centre for AIDS and STD Control, together with FHI 360, implemented two mass media campaigns with support from USAID through the Impact Project.⁵² The first campaign, called “Let’s talk about AIDS today,” was implemented in 2002 and mainly focused on general sensitization about HIV and prevention messages. The campaign had a broad reach across the country, reaching more than 3 million through TV, 2.5 million through print, and 3 million

⁵² Rai B. (2008) HIV and AIDS: related stigma and discrimination in Nepal. *International Course in Health Development, KIT*. <http://www.bibalex.org/search4dev/files/353724/193923.pdf>

through radio. Following this in 2005-2006, a campaign specifically designed to reduce HIV-related stigma and discrimination called “Ek Aapas ka Kura” was implemented. This campaign utilized supportive and educational media programming in order to reduce stigmatizing attitudes and behaviors toward people living with HIV, including towards key populations affected by HIV.⁵³ The reach of this campaign was not assessed.

Limitations/Challenges:

Key informants noted that mass media campaigns are helpful in reaching large numbers of people throughout the country and should be a key part of the response to reduce HIV-related stigma and discrimination. The main limitation with mass media campaigns is that there have only been two campaigns in Nepal, and they took place over 10 years ago. New campaigns are needed to ensure that the latest information, about pre-exposure prophylaxis, post-exposure prophylaxis and treatment as prevention, are widely disseminated to the general public. Another limitation of mass media campaigns is that it is difficult to evaluate their direct impact on knowledge, attitudes and behaviors.

Group-based support to people living with HIV and other key populations to overcome stigma and discrimination

Group-based interventions and programmes have been a key component of the HIV response, with local NGOs and key population networks supported to provide such services through USAID and Global Fund funding via FHI 360 and Save the Children, respectively. Support groups provide a safe-space for people living with HIV and other key populations to come together, discuss challenges, seek support and build community. These interventions range from unstructured sessions on a drop-in basis to structured sessions. For example, a 6-week empowerment intervention on social self-value improved the quality of life (QoL) of people living with HIV receiving anti-retroviral treatment in a recent study.⁵⁴ The empowerment intervention mainly focused on autonomy and community activism, self-esteem/self-efficacy, self-care, optimism and control over the future, family and social relationships, powerlessness, management of stress and righteous anger, stigma and discrimination issues, legal provisions, and human and health rights. Key stakeholders reiterated the importance of group-based support programmes during both key informant interviews and at the prioritization meeting, and recommend continued funding for these efforts.

Limitations/Challenges:

The lack of structure with many of the current support groups makes it difficult to assess their effect on people living with HIV and key populations and demonstrate their importance, which may make it difficult to secure continued funding for these activities. While support groups have been found to successfully combat the multidimensional effects of stigma and discrimination in previous research, additional support services could be offered, particularly to women living

⁵³ NCASC, USAID, FHI. “Let’s start talking about AIDS today.” “Ek Aapas ka Kura.”

⁵⁴ Bhatta D, Liabsuetrakul T. (2017). Efficacy of a social self-value empowerment intervention to improve quality of life of HIV infected people receiving antiretroviral treatment in Nepal: a randomized controlled trial. *AIDS Behavior* 21(6), 1620-1631.

with HIV and their children, including economic and income-generation skill development, educational programs, transitional economic and housing support, and counseling and referral services⁵⁵.

Advocacy and raising awareness

One innovative approach to reducing stigma and discrimination is the combination of public events, using relevant cultural mediums, and advocacy. In Nepal, NANGAN, with support from the World Bank through the South Asia Regional Development Marketplace, held a beauty pageant in Kathmandu in 2009 for transgender women to raise awareness about the stigma and discrimination faced by the transgender community and how this stigma heightens their risk of HIV. Following the pageant, the winners were trained as community ambassadors and travelled around the country holding advocacy events, culminating in a national level event with Parliamentarians. The reach of this project was estimated to be fairly wide, with 1500 people attending the pageant, 228 advocacy events held and media stories that were aired on radio and TV surrounding the pageant. While the project was not formally evaluated, NANGAN linked the project with a number of positive outcomes, including expanded coverage of LGBTI issues in mass media, including: (1) the establishment of a weekly, 30-minute *Third Sex* programme on the national TV station designed to promote LGBTI human rights; (2) inclusion of LGBTI human rights in political party manifestos and constitutional concept notes; (3) first-time allocation by the Nepalese government of more than Nr 3 million in the 2009/10 fiscal budget for promotion of LGBTI rights; (4) expanded interest in LGBTI issues among researchers, students, activists, journalists and others; and (5) boosted self-esteem, increased HIV knowledge, more acceptance from families, and less teasing and harassment from the public among the HIV ambassadors (Stangl et al. 2010).

The Right to Health Women's Group has also been engaged in advocacy training with women in Nepal to create a platform for information sharing and community dialogues. These trainings have included empowerment workshops to encourage a positive environment to engage members to reduce stigma and discrimination in communities.

Limitations/Challenges:

The combination of public awareness events and advocacy is a model with great potential for reaching a large number of people with key stigma and discrimination-reduction messages and shifting harmful social and cultural norms. However, funding for these approaches has been limited to date, and only one national program has been implemented. As research suggests that reducing stigma requires multiple strategies with multiple audiences/levels of society (Stangl, et al. 2013), more focus should be placed on innovative strategies that engage the broader community and foster critical dialogue that can facilitate broader social change.

PLHIV Stigma Index

The PLHIV Stigma Index is a process that was developed by and for people living with HIV to generate data for advocacy and empower communities to advocate for their rights using the

⁵⁵ Poudel V et al. (2015). Women living with HIV/AIDS (WLHA), battling stigma, discrimination and denial and the role of support groups as a coping strategy: a review of literature.

data. With support from UKaid, the Family Planning Association of Nepal and UNAIDS, NAP+N conducted the PLHIV Stigma Index in Nepal in 2011. The study, carried out among 848 people living with HIV throughout the country (402 men, 419 women, and 27 transgender individuals), found that half of respondents reported experiencing at least one form of stigma, with gossip being the most common. A greater percentage of people living with HIV who were people who inject drugs (60%) and female sex workers (68%) had experienced stigma and discrimination than had those who were migrants (50%), men who have sex with men (53%) and others (refugees/indigenous people) (50%). The most commonly cited reasons for HIV-related stigma were: “people are afraid of acquiring HIV infection from me” (53%) followed by “ignorance about HIV transmission” (49%). The majority of participants (87%) reported internalized stigma. Fourteen percent (N=114) reported experiences of human rights violations, but only 17 people attempted to seek legal redress.⁵⁶

Limitations/Challenges:

Data on stigma, discrimination and rights violations is not being collected routinely from people living with HIV and other key populations, which makes it difficult to assess the impact of the stigma and discrimination reduction efforts that have been implemented over the last 15 years. Investments in routine data collection efforts, like conducting the PLHIV Stigma Index every 3-5 years are needed to support national goals to achieve the 90-90-90 targets by 2022. Outside of the Index, there is currently no mechanism to capture experiences of stigma and discrimination and facilitate redress.

Moving to comprehensive programming on stigma and discrimination

The following describes what should be done to comprehensively address stigma and discrimination :

- Update existing NCASC stigma-reduction curriculum to include information on HIV, TB (including infection control for TB), non-discrimination, and violence, and to promote supportive, accepting, and responsive services. Roll out training-of-trainers on new curricula among key populations and NGOs.
- Institutionalize training on reducing stigma, discrimination and violence related to HIV and TB in professional schools for duty-bearers (i.e. teachers, doctors, nurses, social workers, lawyers, judges, traditional and religious leaders, etc.) using updated curricula. Course curricula can be adapted from the standardized NCASC curriculum. Continue in-service trainings and community leader/stakeholder trainings.
- Increase frequency of mass media campaigns, both audio and visual, to reduce stigma and discrimination based on HIV and TB status, increase awareness on laws and policies protecting the rights of people living with HIV and/or with TB, and reduce fear of infection and subsequent avoidance behavior. Social medias should also be used in this context. The coordination of National Health Education, Information and Communication Center (NHEICC) and NHRC is important for this intervention.

⁵⁶ PLHIV Stigma Index Nepal. 2011.

<http://www.stigmaindex.org/sites/default/files/reports/Nepal%20People%20Living%20with%20HIV%20Stigma%20Index%20Report%202011.pdf>

- Funding for support groups should continue. Support groups are valuable tools for reaching and engaging people living with HIV and other key and vulnerable populations in prevention, care and treatment service, fostering resilience and improving quality of life. Integrating curriculum-based sessions and also combining support group interventions with economic and income-generation skills development should be considered. There should be various innovative approaches to reach migrants, since they are the most mobile groups and are harder to engage in group-based community mobilization approaches. The local groups and community groups can help in reaching migrants and/or their spouses (i.e. women's saving and credit groups, mothers groups).
- Support and scale up throughout the country stigma-reduction programmes that use cultural mediums delivered through large, public events, combined with advocacy and engagement led by key populations. Consider linking these events or running concurrently with mass media campaigns.
- Repeat the national PLHIV Stigma Index on a 3-5 year basis to provide updated data for assessing impact of programs to remove human rights barriers to HIV services.
- Key stakeholders prioritized the establishment of a monitoring system at the national-level to capture stigma, discrimination and rights violations experienced by people living with HIV, other key populations and people with TB and to support redress. There are several monitoring systems being piloted that have the potential for scale-up on a national level, including by the Blue Diamond Society, the Federation of Women Living with HIV, and an SMS system that FHI 360 has implemented in India and is considering adopting for Nepal. These systems capture experiences of violence, stigma and harassment among the various key populations served by the NGOs. At this point, there are no systems currently in place to capture human rights barriers or challenges experienced by people with TB. Given this, a monitoring system would need to be developed, based on the existing ones, to capture these experiences for both HIV and TB. Stakeholders noted that all key populations should be involved, and community-based organizations and outreach workers should be involved in supporting the stigma and discrimination cases in their related areas. Information should be collected through these networks at the central level, followed up by rapid response through grass roots organizations. It was suggested that monitoring and review be done at the national level, as a national monitoring system with proper strategies and guidelines. The human right count from NAP+N and stigma count from UNAIDS were methods that were proposed, with complete data recorded and kept properly, so that there is evidence to show the national body and law enforcement that there is stigma, discrimination and violence occurring in the context of health, HIV and social status. It was recommended that a joint committee of NHRC, NGOs, MoHA and other national bodies should meet every four months to review the monitoring data and appropriate action should be taken by NHRC.

PA 2: Training of health care providers on human rights and medical ethics related to HIV

The table below provides an overview of current programmatic efforts on stigma and discrimination reduction as well as recommendations for scale-up. The content of the table is then further elaborated upon in the text that follows the table.

Training for health care providers on human rights and medical ethics						
Program	Description					Limitations
Curricula for civil society organizations and the government of Nepal for capacity-building on HIV-related stigma	Development of IEC materials and training package to improve the hospital environment for people living with HIV. The training materials are designed for health facilities. Materials are meant to deliver education on HIV/AIDS stigma, appropriate and sufficient care, and enhanced knowledge about HIV/AIDS. Master trainers are first trained in a 'training-of-trainers' format, and then these master trainers go on to implement stigma-reduction trainings at health facilities.					Current curriculum lacking information on human rights more broadly and the legal and policy environment relevant to HIV, and TB.
Implementer	Population targeted	# trained	Clients reached	Region(s)	Timeframe	Recommended scale-up
NANGAN	Health workers (TOT)	66	n/a	3 hospitals in Kathmandu, Kaski, and Banke	2009	Update curricula; offer training on an annual basis in health facilities for new staff, and incorporate pre-service curricula mostly in medical colleges and CTEVT so that the knowledge is shared from an institutional level.
NCASC (Reducing Stigma and Discrimination Toolkit)	Health workers	Not identified	n/a	Country-wide	2010	
Program	Description					Limitations
Training and sensitization workshops for health workers	Widespread training in procedures, confidentiality, and stigma reduction to improve treatment and care for people living with HIV in Nepal's healthcare facilities. Some trainings are HIV-specific, and others include an HIV-specific component. Training included counseling and other sensitization techniques to limit stigma faced by patients in routine healthcare. The objectives include addressing patient rights as well as the rights and needs of health workers, ensuring government healthcare systems to provide quality confidential and non-discriminatory care. For women living with HIV, mother-to-child prevention strategies and safe delivery training for health workers.					In-services trainings are not implemented routinely; different NGO facilitators leads to some overlap/redundancy, and fidelity to training curriculum is uncertain. Limited evaluation data on attitudes and behaviors of health workers is available to assess impact/change over time.

Implementer	Population targeted	# trained	Clients reached	Region(s)	Timeframe	Recommended scale-up
NANGAN	Health workers	339	n/a	3 hospitals in Kathmandu, Kaski, and Banke	2009	Support routine in-service trainings on HIV, key population and TB-related stigma reduction, non-discrimination and medical ethics for current health facility staff; engage administrators and identify champions within the health sector and/or facilities for the sustainability and follow-up/
FHI 360/Saath-Saath Project	Health workers	13,420	n/a	33 of 75 districts in Nepal	2011-2016	
FHI 360 (with 24 implementing partners)/LINKAGES Project Nepal	Health workers	Not identified	Not identified	16 southern districts	October 2016 – March 2018	
Program	Description					Limitations
Routine monitoring of PLHIV client satisfaction to encourage PLHIV friendly health facilities	A 10-question client satisfaction survey was implemented three times over the course of two years in health facilities where a stigma-reduction training program was being implemented. Workshops were held with health workers to share the findings of the surveys to encourage discussion and changes in practices and attitudes as needed.					Limited time-frame and reach of the program.
Implementer	Population targeted	Clients reached	Region(s)	Timeframe	Recommended scale-up	
NANGAN	PLHIV and health workers	204 PLHIV surveyed; 1 day regional workshop held in each region/hospital	3 hospitals in Kathmandu, Kaski, and Banke	2009	Expand this effort throughout the country, linked with stigma-reduction training in health facilities. Client satisfaction improved over the course of the one-year program. This type of data is very helpful to share with hospital administrators to provide a snapshot of how health workers are doing to meet the needs of PLHIV clients.	

Current Programs

Stigma-reduction training for health workers

The National Response on STI Case Management from the National STI Control Programme implemented widespread training of health workers in procedures, confidentiality, and stigma reduction in order to improve STI treatment, including HIV/AIDS care in 2004.⁵⁷ Since then, a number of in-service training efforts have been undertaken in Nepal to reduce HIV-related stigma and discrimination among health workers.

In 2009 to 2010, the National NGOs Network Group Against AIDS-Nepal (NANGAN) implemented a program with the support of the World Bank's South Asia Regional Development Market Place to improve the hospital environment for people living with HIV in regional Nepalese hospitals. The goal of the project was to help the health system provide adequate and professional care to people living with HIV, and also enhance the working environment for health workers. Evaluation findings suggested that hospitals were more effective when staff were friendly, considerate, and compassionate to their clients. Additionally, clients felt more comfortable and satisfied with appropriate and professional care.⁵⁸

The improvement of quality of care, as well as the accessibility and reliability of care was addressed in the Saath-Saath Project in Nepal, implemented by FHI 360 between 2011 and 2016. The program worked to improve health for key populations including female sex workers and their clients, transgender sex workers, migrant workers and their spouses, and people living with HIV. The addition of drop-in health centers and expansion of clinics allowed for improved accessibility and availability, while HIV-specific training and counseling for health workers positively influenced their ability to work with and treat people living with HIV and limit the stigma these patients faced in their routine healthcare.⁵⁹ Overall, the project trained a total of 13,420 health workers in 33 districts throughout Nepal. The follow-on LINKAGES project, is continuing stigma-reduction training on a smaller scale in 16 southern districts.

Limitations/Challenges:

As reported above, the 2010 NCASC stigma-reduction curriculum does not include information on HIV and TB-related human rights, the policy and legal environment, or TB and thus needs to be updated. In-services trainings are not implemented routinely, and multiple NGO implementers have led to some overlap/redundancy in trainings and also to some uncertainty about fidelity to the training curriculum. Coordination of training efforts across NGOs is also needed to reduce overlap in training implementation within health facilities and enhance the consistency and quality of training content. In addition, limited evaluation data on attitudes and behaviors of health workers is available to assess impact and change over time. It was noted by one key informant that the USG funding for the HIV response will soon be reduced in Nepal,

⁵⁷ National Centre for AIDS and STD Control Ministry of Health and Population. (2014). National Guidelines: Case Management of Sexually Transmitted Infections.

⁵⁸ National NGOs Network Group Against AIDS-Nepal (NANGAN). Creating PLHAs Friendly Hospital. <http://www.nangan.org.np/project.php>

⁵⁹ USAID. (2016). Saath-Saath Project End of Project Report.

and stigma-reduction training efforts will need to be funded through other channels after the LINKAGES project ends in March 2018.

Routine monitoring of PLHIV client satisfaction to encourage PLHIV-friendly health facilities

As part of the NANGAN project to foster PLHIV-friendly health facilities, a 10-question client satisfaction survey was implemented three times over the course of the two-year project in three health facilities that received the stigma-reduction training program. The findings showed that client satisfaction improved overtime in all of the facilities, reflecting less stigmatizing and more supportive care and treatment received. Workshops were held with health workers to share the findings of the surveys to encourage discussion and changes in practices and attitudes as needed.

Limitations/Challenges:

This activity was only completed in three health facilities linked to one project. In addition, the survey was only completed with clients living with HIV. This model should be considered for replication and scale-up, as a part of the routine monitoring of the experiences of people living with HIV, as well as for other key and vulnerable populations in health facilities in Nepal.

Comprehensive programming: Training for health-care providers

- Update existing NCASC stigma-reduction curriculum to include information on HIV, TB (including infection control for TB), non-discrimination, and violence, and to promote supportive, accepting, and responsive services. Roll out training-of-trainers on new curricula among key populations and NGOs and others (i.e. Ministry of Health) who will be involved in training for health workers.
- Incorporate stigma reduction, human rights and medical ethics training in pre-service curricula as a required course, mostly in medical colleges and CTEVT, so that the knowledge is shared at the institutional-level.
- Institutionalize routine (i.e. annual), in-service trainings on HIV, key/vulnerable population and TB-related stigma reduction, nondiscrimination and medical ethics for current health facility staff. This will ensure that training reaches all staff working at the health facility (i.e. front desk staff, lab technicians, cleaners, etc.). As new medical staff join who have received pre-service training, the size of in-service trainings will likely reduce, but should still be held routinely. Shorter, refresher trainings may also be needed for medical staff with pre-service training to maintain their knowledge/commitment in this area. Engage administrators and identify champions within the health sector/or facilities for sustainability and follow-up.
- Stigma, discrimination and human rights training sessions should also be provided to all TB-related agencies through National Tuberculosis Center.
- Support routine assessments (i.e. every 1-2 years) of knowledge, attitudes and practices of health care towards people living with HIV and/or TB and other key populations to support health facility administrators to identify and address any issues. Healthcare setting-based surveys should be done among providers and exit interviews with key and vulnerable population clients throughout the country with the help of proper guidelines

executed for this. The brief, facility-based tool for health facilities, developed by the Health Policy Project with USAID and PEPFAR support, and tested in six countries, is recommended as several indicators from this tool are now approved by the UNAIDS MERG (Nyblade, L. et al. 2013). Questions related to TB stigma need to be incorporated into this tool, and well as questions on human rights and the legal environment. It was noted that there are no strong networks for TB, so it will be best to incorporate TB stigma alongside HIV stigma in monitoring efforts. Proper data collection should be done and monitored. An SMS system can also be included in this intervention because it measures stigma and discrimination for both KPs and health care workers.

PA 3: Sensitization of law-makers and law enforcement agents

The table below provides an overview of current programmatic efforts on stigma and discrimination reduction as well as recommendations for scale-up. The content of the table is then further elaborated upon in the text that follows the table.

Sensitization of law-makers and law enforcement agents					
Program	Description				Limitations
Trainings and orientation programs	Promotes HIV prevention among officers and their families and educates officers on appropriate policing practices when engaging with people living with HIV and members of key and vulnerable populations while on duty. Sensitizes police to rights and services for people living with HIV and other vulnerable groups in Nepal. Ensures that police practices do not diminish or counteract impact of national and programmatic efforts to ensure access to HIV prevention, testing, treatment, care and support services for all. Covers common complaints against police system by sex workers, people who inject drugs, and men who have sex with men: stigma and discrimination, abuse, arbitrary arrest, torture, and other rights violations. Employs positive response initiatives through education on rights and support channels for vulnerable groups. The methodology typically includes lectures, group work, and interactions with representatives of key and vulnerable groups.				Challenges to full implementation include limited resource allocation, lack of commitment from high-level officials, and difficulty in pursuing an integrated approach for all key and vulnerable populations.
Implementer	Population targeted	# trained	Region(s)	Timeframe	Recommended scale-up
Nepali Police/HIV/AIDS curriculum	Law Enforcement	n/a	Kathmandu	2004/2005	Continue and expand training and orientation programs and include policymakers and other important players in Nepal's justice system. Expanded programs should include routine monitoring of attitudes and behaviors to inform the need for re-training/refreshers training. Partnerships between sensitized police and key/vulnerable population advocacy groups to reduce stigma and discrimination could enhance the long-term impact of these programs.
Blue Diamond Society/Nepali Police	Law Enforcement	~1,000 recruits and officers	Kathmandu	2004-2005	
Blue Diamond Society/Nepali Police/DIVA project	Law Enforcement	Not identified	Kathmandu and some additional districts outside Kathmandu	2012-present	

Current Programs

Trainings and orientation programs

The Nepali Police developed a training curriculum and partnered with BDS to implement a program in 2005 that not only addressed sensitivity to people living with HIV by law enforcement, but also the concerns of law enforcement agents living with HIV. The curriculum included training activities which aimed to help Nepali police better respond to HIV-related situations, and provided officers with the most up-to-date knowledge on how to effectively fight HIV transmission and stigma. This program was implemented in Kathmandu only and was not evaluated.⁶⁰ Since 2012, BDS has been receiving support from the GFATM to continue sensitization trainings with police. This training is occurring in and around Kathmandu⁶¹.

Limitations/Challenges:

A major challenge in sustaining the impact brought about by sensitization trainings relates to the constant transfers of police on the ground. Several key informants reported that at the top levels there is a fair amount of understanding within the Ministries of Home Affairs, Health & Population and Ministry of Law & Justice regarding issues faced by key populations with respect to HIV and their vulnerabilities in terms of using drugs or soliciting sex for survival. However, this understanding is not found among the police who patrol the streets who continue to perpetrate rights violations against key populations. Key informants from BDS reported that:

“Every time we have a function, we call police, they come give a nice supportive speech, and then next day, most act insensitive... we really don’t know how to change this. We keep sensitizing, training, and some change, but then they are transferred somewhere else... there are still many who need to understand.”

A majority of the interviewed key informants agreed that incorporating “*training of all police while in the police training academy needs to be institutionalized to ensure that all the training is reaching everyone for sure.*”

It was noted by key informants that follow-up mechanisms are very weak, so monitoring mechanisms should be strengthened. There was general agreement among stakeholders at the prioritization meeting that the existing curriculum needs to be updated. There is an HIV strategy in the existing police curricula and also information is given about HIV during their orientations, but trainings are not implemented properly as per the manual. There are ‘human rights cells’ for human rights issues in the police. But these cells are not a priority and those in them are not motivated enough for proper execution. So, strategies should be strengthened. The way of training should be changed and innovative ideas should be used in a holistic approach so that deliverance of knowledge and information can be effective. Lastly, the training programs have been focused mainly in and around Kathmandu, and need to be expanded throughout the country.

⁶⁰ Nepali Police. (2005). HIV/AIDS Curriculum for the Senior-Level Officer.

⁶¹ Adhikari, B, Nepal Police. (2011) Arresting HIV: Programs that work with police to reduce HIV vulnerability in sex workers, IDU, and MSM in Nepal. http://66.147.244.77/~leahnorg/wp-content/uploads/2013/08/Bishwa_ICAAP.pdf

Comprehensive programming: Sensitization of law-makers and law enforcement agents

- Update existing Nepali Police HIV curriculum to include information on HIV, TB (including infection control for TB), non-discrimination, and violence, including gender based violence, and to promote supportive, accepting, and responsive services, in consultation with the Ministries of Education and Home Affairs, administrators of local police training colleges, and representatives of key and vulnerable populations. Updates should include sessions on recognizing and mitigating gender-based violence, as well as sessions to highlight the latest developments in protective laws for key and vulnerable population passed in Nepal and how to implement them effectively. The NCASC stigma-reduction tool should also be reviewed during this process to pull relevant information into the updated curriculum for police. Once approved, this training-of-trainers should be rolled out to build capacity for facilitation.
- Develop curriculum for law students on stigma and discrimination, human rights and GBV in the contexts of HIV and TB, based on the existing NCASC and Nepal Police curricula. This should be done through a consultative process with the Ministries of Education and Home Affairs, administrators of local police training colleges, and representatives of key and vulnerable populations. Once approved, this training-of-trainers should be rolled out to build capacity for facilitation.
- Institutionalize training in Police Academy and Law Schools on reducing stigma, discrimination and violence against key populations. Institutionalize the curricula for Armed Police force (involved in border security) and Police Academy at their own respective institutions all over the nation and require a minimum passing mark for certification. These trainings should be conducted through MoHA with the budget derived from government funds, in part because NGOs should not have this responsibility alone.
- Support in-service trainings for police, judges, prison staff, and policy-makers on HIV and TB policies and key and vulnerable populations, responsible and supportive policing in the context of HIV and TB, and reduction of illegal police practices using the new curricula. Policy-makers and supervisors should also be included in their respective level and area: for national-level: Members of Parliament, relevant ministries, NHRC, National Bar Association, health workers, Nepal Medical Association. For local-level: metropolitan, sub-metropolitan, municipality, Village Development Committees, lawyers and media people; for state level: prison management and securities, state government and stakeholders. It was noted that new sources of funding for training will be needed with the reduction in USG investment in the HIV response in Nepal.
- Support routine assessments of law enforcement agents' knowledge, attitudes and behaviors towards people living with HIV and/or with TB and other key and vulnerable populations and support police administrators to identify and address any issues. Monitoring and evaluation should be done in the police academy and police headquarters so that these KAPB can be monitored more effectively biannually or

annually. The MERG-approved stigma assessment tool for health settings needs to be adapted for use with police.

- Support networks of key and vulnerable populations to engage with law enforcement to prevent harmful policing practices, such as arresting sex workers and peer educators for carrying condoms and arresting people who inject drugs on criminal drug charges instead of referring to harm reduction/OST. Different networks of key and vulnerable populations should be involved so that more is known about the KABP and the advocacy is properly executed.

PA 4: Legal literacy (“know your rights”)

The table below provides an overview of current programmatic efforts on legal literacy as well as recommendations for scale-up. The content of the table is then further elaborated upon in the text that follows the table.

Legal Literacy (“know your rights”)						
<i>Program</i>	<i>Description</i>					<i>Limitations</i>
Curricula for civil society organizations on legal matters for women living with HIV	Provides tools to empower women on their rights and opportunities to seek justice; creates avenues for community organizations to interact with the legal system in regard to HIV; develops mechanisms for organizations to monitor Nepal legal environment; and details plans of action to address human rights violations in healthcare facilities.					Only disseminated through non-profit organizations.
<i>Implementer</i>	<i>Population targeted</i>	<i># trained</i>	<i>Clients reached</i>	<i>Region(s)</i>	<i>Timeframe</i>	<i>Recommended scale-up</i>
NAPN+/UNDP/UNAIDS	Girls/Women	Not identified	Not identified	Country-wide	Not identified	Training curricula should be circulated via various channels to create social consciousness around legal literacy, especially within key populations.

Current Programs

Curricula for civil society organizations on legal matters for women living with HIV

NAPN+, UNAIDS and UNDP developed a curriculum that provides tools to empower women about their rights and opportunities to seek justice. The tool also creates an avenue for community organizations to interact with the legal system in regard to HIV, develops mechanisms for organizations to monitor the legal environment in Nepal, and details plans of action to address human rights violations in healthcare facilities.

Limitations/Challenges:

Key stakeholders noted that this curriculum was only disseminated through non-profit organizations.

Comprehensive programming: Legal Literacy

- Current efforts should be continued and expanded throughout the country. Legal literacy and patient's rights education should be supported through conducting awareness campaigns and workshops among people living with HIV and/or TB, women, migrants and other key and vulnerable populations in each state/district towards mobilizing around health rights, freedom from discrimination and violence and other relevant rights. The literacy package should be produced, updated and reviewed accordingly and disseminated widely through various community groups such as community networks, community based organizations, and other interest groups for them to tailor these packages to reflect appropriate content for each key and vulnerable population and deliver this package through trainers from among the key populations.

PA 5: HIV-related legal services

The table below provides an overview of current programmatic efforts on legal literacy as well as recommendations for scale-up. The content of the table is then further elaborated upon in the text that follows the table.

<i>Program</i>	<i>Description</i>				<i>Limitations</i>
Legal counsel and support	Provides information, aid and support for women and girls vulnerable to abuse and exploitation, including girls and women with HIV. Assistance in finding shelter or psychosocial counseling, as well as other supplementary supports. Monitored negotiations, filing of cases, and court representation.				No explicit focus on women and girls with HIV; works out of only office in Kathmandu.
<i>Implementer</i>	<i>Population targeted</i>	<i>Clients reached</i>	<i>Region(s)</i>	<i>Timeframe</i>	<i>Recommended scale-up</i>
Maiti Nepal	Girls/Women	Trafficked and rescued girls	Kathmandu	Not identified	Work within each state or district to mobilize and create awareness around health rights and needs.

Current programs

Legal counsel and support

Maiti Nepal, an NGO that works with girls who have been trafficked in sexual exploitation, provides legal and prosecution counseling and support, also supports women and girls living with HIV and advocates for ART access.⁶² During the fieldwork, it was revealed that a number of CBOs and networks working with key populations have been educating community members about their rights and have provided legal support, but this support has been *ad hoc* and no monitoring data was available on the number of clients reached or type of legal support provided. Key informants consistently reported that these initiatives of education and legal support provision do result in the uptake of legal services, but these initiatives need to be strengthened and available consistently, not just over small periods of time.

Limitations/Challenges:

Limited services are currently available and are narrowly focused in Kathmandu and for specific populations only. It was noted by key informants that professional legal aid was provided in relatively rare cases to go to court and/or in strategic litigation. Community-based legal support services are needed at community-based organizations and networks of key populations to facilitate greater awareness of rights and access to redress. In addition, the draft HIV Bill is still under discussion, so the laws surrounding HIV specifically are still somewhat unclear.

Comprehensive programming: HIV-related legal services

- Train and support peer paralegals to provide legal advice, awareness raising and conduct “know your rights” campaigns in each state/district among key and vulnerable populations and/or in health care facilities. Key stakeholders noted that there should be legal services available at district-level network organizations, or the district-level networks should have good contact with lawyers situated at the central-level network organizations. Training and mobilization of paralegals should be for the district-level organizations or at community-level through networks and community-based organizations.
- These expanded services should be linked with a newly established help-line for legal services with a toll free number. The help-line should be managed at the central level by a single network organization or committee. It was noted by key stakeholders that a large initial investment is required for training and mobilization at the district-level. The help-line services can be used for both the components of TB and HIV. For legal support, there can be coordination with the 29 existing OCMCs, which support services for women experiencing gender-based violence. OCMCs can be expanded or scaled-up and linked with HIV and TB services by making them key-population friendly and sensitive.
- Identify and support *pro bono* lawyers in universities and in the private bar to link to NGOs and community-based organizations and provide legal services, including legal representation. It was suggested by key stakeholders at the prioritization meeting that a

⁶² Maiti Nepal.

MOU between the service providers, including Court and Nepal Bar Association (in all districts), law universities/colleges, NGOs and individual lawyers be established throughout the country. It was also suggested that NGOs could promote the use of existing government lawyers by promoting uptake of legal services among people.

- Establish rapid response units/systems that will help prevent arbitrary arrest, detention and other mistreatment of key populations (i.e. hotline that sex workers, migrants or people who use drugs can call to seek urgent legal support, NGO support, etc.). This would address the immediate needs of abused/mistreated populations. A 24-hour service should be supported with a well-capacitated rapid response team placed in a convenient location for the community. The rapid response team should be empowered to advocate on behalf of clients, coordinate with high-level law enforcement personnel, and have linkages with all networks in order to handle cases immediately. The rapid response unit should cover all districts. There are rapid response systems for children's health care, so the example of this system could be used for effectiveness of the 24-hour rapid response team proposed.

PA 6: Monitoring and reforming laws, regulations and policies relating to HIV

Current Programs

No current or recent programs were identified on monitoring and reforming laws, regulation and policies related to HIV.

Comprehensive programming

- In order to coordinate the comprehensive response to remove human rights barriers to HIV and TB services, a human rights point person in the National Human Rights Institute or Ombudsman's office should be identified. This person could support the process to begin replacing or updating the problematic laws and policies identified in the 2015 Legal Environment Assessment in Nepal. Several respondents noted the importance of ensuring that supportive laws and policies are implemented and that old, harmful laws are identified and updated in line with the 2015 Constitution to reduce confusion among duty-bearers and improve the engagement of key populations with law enforcement and health workers. There was a general sense from stakeholders at the inception meeting, that it would be a relatively simple exercise to review the old laws that have not been updated since the ratification of the new Constitution and begin advocating and working to update or replace them.
- In addition to supporting the legal reform process, s/he could support other key aspects of the comprehensive response, such as the national monitoring and redressal system for stigma, discrimination and rights violations, and the routine assessments of KAPB for police and health workers on stigma, discrimination and human rights in the contexts of HIV and TB.
- Funding for advocacy groups to support the legal reform process and advocate for and monitor the implementation of supportive policies and laws should be maintained.

- Funding for advocacy groups to support the development of a Memorandum of Understanding between India and Nepal would help to ensure health services for Nepalese migrants in India.

PA 7: Reducing discrimination against women in the context of HIV

The table below provides an overview of current programmatic efforts on reducing discrimination against women in the context of HIV as well as recommendations for scale-up. The content of the table is then further elaborated upon in the text below the table.

Reducing Discrimination Against Women					
Program	Description				Limitations
Community awareness campaigns	This campaign used a variety of methods to facilitate culturally sensitive discussions about safe sex, women's sexuality, and changing gender norms, including small group discussions and community dialogues. Stigma-reduction components promoted women's empowerment and encourage HIV disclosure in health care facilities.				It may be challenging to maintain gains in HIV knowledge over a longer time period following discussions/dialogues. Current efforts are only focused on adult women.
Implementer	Population targeted	Clients reached	Region(s)	Timeframe	Recommended scale-up
Harman, Kaufman, Shrestha 2014, "Let's Talk" Intervention	Women	88 women	Kathmandu	2008	These types of programs should be expanded and scaled-up across the country to increase comfort among women to communicate about SRH issues, decrease shame around sexuality and improve gender norms around sexuality. The larger awareness campaigns should be expanded and implemented at both the community-level as well as in schools. There are existing models from neighboring countries of successful school-level campaigns and dialogues to promote gender equality, shift harmful gender norms and reduce gender-based violence. Focused support for networks of women living with HIV and women vulnerable to HIV should be continue, as well as efforts to increase awareness of the mistreatment faced by female sex workers and transgender individuals from police and health workers.
Program	Description				Limitations
Training for advocate leaders	Women's empowerment program trains local leaders, including from key populations, to recognize gender-based violence and address discrimination against women, especially among populations of female sex workers, females who inject drugs, women living with HIV, and transgender women. Activities include, training, raising community awareness, creating a platform for				Efforts are all focused on adolescent girls and women, including women for key populations.

	information sharing and support networks, and encouraging advocacy efforts. Empowerment and sensitization trainings for women also provide information about HIV, rights and legal information.					
Implementer	Population targeted	# trained	Clients reached	Region(s)	Timeframe	Recommended scale-up
Right to Health/UNAIDS/ UNFPA/ UNDP	Girls/Women	Not identified	Not identified	Kathmandu, Country-wide	Not identified	Continue and expand efforts to mobilize women's groups and support networks to combat violence and support survivors to seek redress and services from OCMCs. OCMC staff will need training and sensitization about support. Support networks of women living with HIV and women vulnerable to HIV. Expand trainings to bring on male champions as well.
Positive Protection	Girls/Women	Not identified	Not identified	Country-wide	Not identified	
Program	Description					Limitations
Prevention and mitigation of gender-based violence	The goal of the project was to decrease the vulnerability of female and transgender sex workers to HIV through comprehensive integration of multi-disciplinary GBV reduction efforts in targeted districts. Specifically, the program sought to improve access to evidence-based clinical intervention and quality health services for GBV, enhance awareness of violence prevention strategies and legal resources for female and transgender sex workers, and to strengthen Government of Nepal's policy and law enforcement environment for combating GBV against female and transgender sex workers.					Women were often not comfortable disclosing their experiences of violence.
Implementer	Population targeted	# trained	Clients reached	Region(s)	Timeframe	Recommended scale-up
FHI360/JMMS/FSG MN/Saath-Saath Project/GBV prevention and mitigation program	Female sex workers, transgender sex workers	For GBV recognition & prevention: 6000 FSWs, 1500 TGSWs; For stigma-reduction:	6807 FSWs; 587 TGSWs	Bhaktapur, Kailali, Kaski, Kathmandu, Lalitpur and Sunsari	October 2014-June 2016	Continue GBV mitigation and prevention programming and expand to other regions in the country.

		122 FSWs and TGSWs				
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Current Programs

Community awareness campaigns

Prevailing gender norms and power imbalances within relationships make communication about sexuality and health problematic for many women, particularly in rural and traditional parts of the country. The inability or discomfort of many women related to discussing sexual and reproductive health issues with health workers makes it difficult for women to claim their right to health and access available prevention, care and treatment services. The *Let's Talk* intervention for Nepali women was designed to increase communication about sexual health with other women and in mother-daughter relationships, as well as with the men in their lives. The intervention also contained an education element in order to target myths and inform participants about HIV and STIs. The intervention targeted women in Kathmandu and spanned three 2-hour group sessions in which open discussion about sexual communication was facilitated along with role-playing activities to prepare women to discuss with their sexual partner. Results showed that the *Let's Talk* intervention was effective at promoting communication between women and men about sex, decreasing shame about sex and sexuality for women, improving attitudes about being knowledgeable about sex, and changing gender norms around sexual health. The intervention was also culturally sensitive to the way communication about sexual health happens in Nepal. Overall, women reported greater comfort discussing sex after the intervention.⁶³

Limitations/Challenges:

The evaluation of the *Let's Talk* intervention suggested that it might be challenging to maintain gains in HIV knowledge over a longer time period following discussions/dialogues, suggesting the need for follow-on activities or refresher sessions. In addition, the campaign only focused on adult women and did not include adolescent girls. There is a need to expand the reach of communication campaigns and interventions to reduce discrimination against women and adolescent girls and to men and boys as well, in order to shift harmful gender norms and behaviors.

Training for advocate leaders

With the help of UNAIDS, UNWomen, UNFPA, and UNDP, the Right to Health group implemented a women's empowerment program in Nepal to address discrimination against women in healthcare settings, especially those in vulnerable populations. Women leaders were trained to lead advocacy among populations of female sex workers, females who inject drugs, women living with HIV, and transgender women. Goals of the program were to raise awareness, create a platform for information sharing, support advocacy efforts, and encourage a positive environment for members.⁶⁴ Similarly, a UNDP program known as *Positive Protection* worked to empower and educate women affected by HIV by training local facilitators to provide information about HIV, as well as rights in a legal and healthcare setting.⁶⁵

⁶³ Harman J et al. (2014).

⁶⁴ Right to Health Women's Group Terms of Reference (TOR)

⁶⁵ United Nations Development Programme. (2016). *Positive Protection: Empowering Women Affected by HIV to Protect their Rights at Health Care Settings*.

Limitations/Challenges:

It may be challenging to maintain gains in HIV knowledge over a longer time period following discussions/dialogues. Current efforts to enhance communication around sexual and reproductive health are only focused on adult women, and there is a need to expand these types of interventions to adolescent girls as well. Efforts are also needed to raise awareness among men about gender-based violence and discrimination against women and involve them in shifting harmful gender norms.

Prevention and mitigation of gender-based violence

As a part of the Saath-Saath project, FHI 360 implemented a two-year program in six districts to prevent and mitigate gender-based violence. The goal of the project was to decrease the vulnerability of female and transgender sex workers to HIV through comprehensive integration of multi-disciplinary gender-based violence reduction efforts in targeted districts. Specifically, the program sought to improve access to evidence-based clinical intervention and quality health services for gender-based violence, enhance awareness of violence prevention strategies and legal resources for female and transgender sex workers, and to strengthen Government of Nepal's policy and law enforcement environment for combating gender-based violence against female and transgender sex workers. The program reached 2,727 female and transgender sex workers.

Limitations/Challenges:

Women were often not comfortable disclosing their experiences of violence and multiple engagements with them may be needed to foster trust and support disclosure in order to link women with appropriate psychosocial services.

Comprehensive programming: Reducing discrimination against women

- Support networks of women living with HIV, female sex workers, transgender people and women who inject drugs to advocate and organize against mistreatment by police and health care providers, e.g. the Right to Health women's group. Central-level networks should be advocated for, so that they can help/support the community-level networks.
- Mobilize women's groups and support networks to combat violence and support survivors to seek redress and services from one-stop crisis management centers (OCMCs). OCMC staff will need training and sensitization regarding how to support clients who seek services for experiences of stigma and discrimination in addition to gender-based violence. OCMCs are not being fully utilized at present. OCMC staff wait for clients to come for services and do not include outreach or community dialogues as part of their work.
- Continue gender-based violence mitigation and prevention programming and expand to other regions in the country.
- Implement community and school-level campaigns and dialogues to promote gender equality, shift harmful gender norms and reduce gender-based violence. Community dialogues should be organized to promote gender equality at every level, from the

national to the grass-root level. Particular emphasis should be placed on implementing school-based programs for prevention of gender-based violence.

Investments to date and costs for comprehensive programming

In 2016, a total of around USD 295,869 was invested in Nepal to reduce human rights-related barriers to HIV services.

Major funders and allocated amounts for reduction of human rights barriers to HIV services in 2016 were as follows:

Funding source	2016 allocation*
FRI – Norwegian Organization for Sexual and Gender Diversity, Norway	USD 16,576
United Nations Educational, Scientific and Cultural Organization (UNESCO)	USD 12,108
GFATM	USD 48,088
USAID	USD 209,096
Total	USD \$285,868

* Many organizations were not comfortable providing financial information, so the cost estimate of existing programs is likely an underestimate.

Although several funders stated that they were unable to provide exact figures for the amounts allocated to each program area, the assessment team calculated the likely split between program areas by acquiring expenditure data from the funded organizations and matching these to activities under each program area. This gave the following split of funding across program areas to remove human rights-related barriers to services:

HIV Human Rights Barriers Program Area	2016*
PA 1: Stigma and discrimination reduction for key populations	USD 100,648
PA 2: Training for health care workers on human rights and medical ethics related to HIV	USD 19,853
PA 3: Sensitization of law-makers and law enforcement agents	USD 0
PA 4: Legal literacy (“know your rights”)	USD 35,012
PA 5: HIV-related legal services	USD 0
PA 6: Monitoring and reforming laws, regulations and policies relating to HIV	USD 4,897

PA 7: Reducing discrimination against women in the context of HIV	USD 125,458
Total	USD \$285,868

* Many organizations were not comfortable providing financial information, so the cost estimate of existing programs is likely an underestimate.

Estimated costs for the recommended interventions for the five-year comprehensive program set out are set out in the table on the following page. Detailed intervention areas and costs are set out in Appendix 3.

Costing for 5-year comprehensive program – HIV

HIV Human Rights Barriers Program Area	Year 1	Year 2	Year 3	Year 4	Year 5	Total
PA 1: Stigma and discrimination reduction for key populations*	211,012	239,395	143,063	160,130	225,090	852,310
PA 2: Training for health care workers on human rights and medical ethics related to HIV*	47,623	36,556	36,556	40,212	40,212	201,161
PA 3: Sensitization of law-makers and law enforcement agents*	78,420	61,490	61,147	67,304	67,304	335,666
PA 4: Legal literacy (“know your rights”)*	154,564	90,964	153,364	75,046	146,806	620,744
PA 5: HIV-related legal services*	262,416	151,510	258,236	166,541	282,840	1,121,543
PA 6: Monitoring and reforming laws, regulations and policies relating to HIV*	25,866	13,090	13,090	12,394	12,394	76,834
PA 7: Reducing discrimination against women in the context of HIV	104,545	44,700	104,545	53,925	119,754	427,469
Total (programmatic)	884,448	637,707	770,002	575,552	924,400	3,635,724
Programme management Cost (20.0%)	195,198	140,742	169,939	127,024	204,015	8,36,918
Monitoring and Evaluation (1.0%)	10,702	7,716	9,317	6,964	11,185	45,885
Research (2.0%)	26,180	18,876	22,792	17,036	27,362	112,246
Total^v	1,116,527	805,041	972,050	726,577	1,166,963	4,787,157

* Some activities within these program areas involve both the HIV and TB responses. For these program activities, costs were split 60% for HIV and 40% for TB, based on the suggestion of key stakeholders involved in financing decisions for these grants in Nepal. ^vAs program management costs were difficult to estimate, given the hesitancy of some implementers to share information on recurrent costs such as staffing and other indirect costs, we have added a percentage share of program management (20.0%), Monitoring and Evaluation (1.0%) and research (2.0%) costs to the prospective costing calculations to counteract such underestimation. This method is based on the approach the Global Fund has used for KPI 9b.

Other interventions

The table below provides an overview of other interventions that are addressing broader right-to-health issues in the context of HIV such as accessibility, acceptability, availability and quality of services. These programs do not fall under the seven human rights program areas being assessed through this effort. However, they are critical to a successful and rights-based response to barriers to HIV services. Continued funding for these programs from sources other than that provided for human rights activities is recommended. The content of the table is then further elaborated upon.

Other Programs: HIV					
Program	Description				Limitations
Increasing accessibility, acceptability, availability, and quality of services	Reducing risk of transmission in geographically marginalized and low socioeconomic areas where healthcare may not be readily available through community-based HIV testing and care, preventive services, increased capacity and advocacy, and enhancing of the HIV care continuum. KP-led outreach activities for key populations were also utilized.				
Implementer	Population targeted	Clients reached	Region(s)	Timeframe	Recommended scale-up
FHI 360/ASHA Project	People living with HIV	13,589 PLHIV reached	38 districts	Not identified	Continue support for one-stop crisis management centers that are currently situated in health centers to support survivors of violence, including women and transgender individuals, and link them to health and legal services. Integrate health services for HIV, TB, OST, and violence with general health services.
FHI 360/LINKAGES Project Nepal	People living with HIV, sex workers, men who have sex with men, transgender individuals, clients of sex workers	Not identified	16 southern districts	October 2016-March 2018	
UNICEF	Women living with HIV (linked with PMTCT and MNCH services)	Not identified	6 districts	Ongoing technical support	

Current Programs

Increasing accessibility, acceptability, availability, and quality of services

Increasing availability and accessibility has become a key strategy and necessary requisite to improve quality care and reduce risk of transmission in geographically marginalized or low socioeconomic areas, where healthcare is not easily accessible. The implementation of community-based HIV testing and care (CBHTC) can fall under this key strategy, including stand-alone HIV services, outreach testing, and home-based services.⁶⁶

The LINKAGES program is currently being implemented in Nepal, with support from USAID and PEPFAR. This program aims to expand access to HIV services for key populations using a combination of activities, including a peer-to-peer outreach model and training of health workers and providers to improve the quality of care on the continuum of HIV prevention, care, support, and treatment. Thus far, the program has expanded access and availability of care for many people living with HIV, including for key populations such as people who inject drugs, female sex workers and their clients, migrant workers and their spouses, men who have sex with men, male sex workers, and transgender people.⁶⁷ The aspects of the LINKAGES program that involve efforts to reduce stigma and discrimination in the healthcare setting have been included above in the section on training for health workers. The National HIV Strategic Plan states that identifying and reaching key populations is critical for the elimination of HIV. This level of accessibility requires scaling-up testing and treatment, making services efficient and effective, promoting social protection and cohesion, and eliminating discrimination and punitive laws.⁶⁸

USAID's program, Advancing Surveillance, Policies, Prevention, Care, and Support to Fight HIV/AIDS (ASHA), while mainly focusing on reduced transmission, data collection, and other prevention objectives, also had a goal to increase access to quality care, support, and treatment services through various avenues: public, private, and non-governmental. Because ASHA's implementing partners were directly involved in care work to meet these objectives, much of the support was specified to specific vulnerable groups. Although the service quality was high, the services were underutilized.⁶⁹

Vertical transmission of HIV from mother-to-child is a risk for women living with HIV who become pregnant. Stigma and discrimination can be major deterrents for pregnant women to disclosing their status and seeking help for themselves and their fetus. Intervention in maternal services can be critical in preventing mother-to-child transmission. UNICEF estimates that as many as 45% of children born to HIV-positive mothers will acquire HIV without any intervention. However, this requires women to acknowledge their status, and to have the necessary access to health services before and after birth.⁷⁰ One study showed that integrating

⁶⁶ National Center for AIDS and STD Control, Ministry of Health and Population. (2014). National Consolidated Guideline for Treating and Preventing HIV in Nepal.

⁶⁷ LINKAGES, USAID, PEPFAR. Linkages Project Nepal.

⁶⁸ National Centre for AIDS and STD Control Ministry of Health and Population. (2016). National HIV Strategic Plan 2016-2021.

⁶⁹ United States Agency for International Development. (2010). Evaluation of "Advancing Surveillance, Policies, Prevention, Care, and Support to Fight HIV/AIDS in Nepal (ASHA) Project."

⁷⁰ UNICEF. Preventing mother to child transmission of HIV (PMTCT) in Nepal.

Prevention of Vertical Transmission (PVT) services into existing maternal and child health care could reduce perinatal transmission from mother to child.⁷¹

Some organizations, such as UNICEF, have delivered technical support on the integration of PVT services at maternal, newborn, and child health clinics, and have undertaken other community-based prevention programs throughout the country to encourage greater access to healthcare for geographically marginalized groups. In order to reach marginalized women, there have also been efforts to advocate for stigma reduction in addressing mother-to-child transmission as part of the national HIV agenda.^{72,73}

Comprehensive programming

- **Address gender inequalities and sexual orientation discrimination** by supporting local leaders and training teachers to implement comprehensive sexuality education curriculum and routinely monitor quality of CSE classes. Update CSE curriculum to include lessons on gender norms, violence and stigma.
- **Support universal precautions to support health care workers and reduce fear of infection** by ensuring universal precaution supplies are available in health facilities to reduce fear of infection and stigma (avoidance behavior) from public servants. Incorporate into training of health care workers their rights to protection and to advocate for better protection.
- **Enhance the counseling skills of HCT, TB and OCMC counselors.** Update counseling curriculum and re-train HCT, TB, and OCMC counselors to enable the provision of enhanced counseling services to address HIV, TB and violence in an integrated manner and also address the psychosocial needs of people living with HIV and/or TB and other key populations.
- **Increase availability, accessibility and quality of health services for key and vulnerable populations.** Integrate health services for HIV, TB, OST, and violence into general health services, etc. *Female-only centers needed for women who inject drugs and female sex workers to prevent abuse and mistreatment.*
- **Implement prescription guidelines for ART.** Ensure that ART guidelines, which specify 3 months of ART can be prescribed for clients living with HIV who are in stable condition, are implemented.
- **Initiate a cross-border initiative to protect Nepali migrants health while in India.** Provide avenues for local leaders to scale-up successful cross-border pilot program to support migrants to access services for HIV and TB.

⁷¹ Shrestha M, Chaudhary P, Tumbhahangphe M, Poudel J. (2012). *Prevention of Mother to Child Transmission (PMTCT) Program at Paropakar Maternity and Women's Hospital: A Review*. Nepal Journal of Obstetrics and Gynaecology, 7(2), 25-28.

⁷² UNICEF. Preventing mother to child transmission of HIV (PMTCT) in Nepal.

⁷³ National Centre for AIDS and STD Control Ministry of Health and Population. (2011). National Guidelines: Prevention of Mother-to Child Transmission of HIV in Nepal. Fourth Edition, March 2011.

- **National evaluation/assessment of health care in the prison setting and protections provided to prisoners.** Conduct national assessment in prisons to understand health care in terms of access to HIV and TB treatment, protection from dangerous living conditions leading to TB, protection from sexual violence, protection from discrimination and arbitrary isolation.
- **Conduct evaluations to assess the effectiveness of new/scaled approaches to remove human rights barriers to HIV and TB services.** Evaluate selected approaches (e.g. integrated, one-stop shop services, training/transport costs for FCHVs to increase TB case identification and referral, etc.) to determine efficacy/effectiveness at removing HR barriers to HIV and TB.

V. Summary of baseline findings: TB

Overview of epidemiological context and key and vulnerable populations

In Nepal, tuberculosis joins HIV as a major public health problem. According to an annual report published by the National Tuberculosis Programme (NTP) in Nepal in 2015/16, 32,065 cases of TB were notified and registered. Among TB cases, 1.8 as many men were diagnosed as women. Childhood TB was estimated to be at 6%. The TB-HIV co-infection rate in Nepal was 1.1% (HIV among TB) and 8.5% (TB among HIV) based on the 2016 sentinel survey, prompting interventions aimed at testing for TB among people living with HIV. Sixty-one percent of all cases were reported and managed under regular TB services operated by the government. About 18% of cases were referred from the private sector, whereas 21% were referred from community health care workers⁷⁴.

Opinions about the populations most at-risk of TB in Nepal varied. Key stakeholders reported that the key populations included people living with HIV, migrants (both internal and external), slum dwellers, and children (KII, KNCV; KII, prison NGO). A 2016 WHO Bulletin on TB in Nepal also included people who use drugs and sex workers as experiencing a higher prevalence of TB. However, the Ministry of Health of Nepal uses a broader, global definition of people at high risk of TB, including people who come under direct contact with a sputum smear positive TB patient, people living with HIV, people living in slums and densely populated urban settings, people living in congregated settings like factories, prisons, refugee camps, and people with diabetes, children and malnourished populations (2016-2021 National Strategic Plan). The NTP has implemented TB control activities with these vulnerable groups in consideration and notes that appropriate program activities will be proposed so as to identify the high-risk groups at the local level itself for more effective and result-oriented interventions. The situation in prisons is not well understood, as little data is currently available on prisoners' access to healthcare, including TB services.

Early detection and diagnosis of TB is essential for effective treatment. The assessment identified several human right-related barriers to service access for TB. These barriers result in delays in care seeking, which can lead to more serious symptoms before entry into care, complicating and reducing adherence to treatment, and increasing the likelihood of TB transmission to others.

Overview of the policy, political and social context relevant to human rights-related barriers to TB services

Protective laws and regulations

In the section on HIV above, the assessment presents the range of protective laws relating to health that should also benefit people living with TB. Nepal does not have any laws specific to

⁷⁴ Government of Nepal, Ministry of Health and Population. (2016). National Tuberculosis Program, Annual Report.

TB. However, the Ministry of Health has published two strategies documents outlining priorities for the TB response, including:

- The *Global TB strategy 2015/16*: Protection and promotion of human rights, ethics, and equity; and the
- *National Strategic Plan for Tuberculosis prevention, care and control*: 2016-2021

According to key informants from the TB sector, an act was proposed to the government over a year ago that would require compulsory notification of TB cases to the national TB program from private sector clinics, but this act has not been passed yet. The impetus for this act is to increase case identification and treatment initiation among people living with TB, many of whom choose to seek care in the private sector.

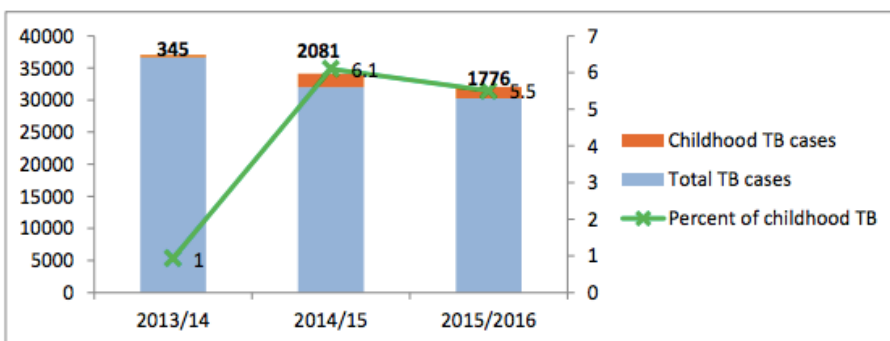
With regards to migration and TB, Nepal does not have restrictions for entry based on TB status, nor does Nepal require migrants to have chest x-rays. Where these types of restrictions come into play is when organizations, like the International Organization of Migration in Nepal, help to repatriate refugees (i.e. from Bhutan) to developed countries, such as the U.S. or Canada, that have very strict requirements surrounding TB. In these cases, refugees must be treated according to CDC guidelines, cured and given a certificate of good health before they are able to migrate to these and other developed countries.

Punitive laws, policies, and practices

Unlike with HIV, experiences with law enforcement did not emerge as a barrier to access and uptake of TB services. None of the key informants or focus group participants mentioned mandatory detention for TB treatment or discriminatory behavior with regards to employment for people with TB.

Political and social environment/political and funding support for the TB response

Nepal has a *National Strategic Plan for TB* for 2016-2021, and programming support for TB from the Global Fund has been based on this strategy. Approximately 17 million USD was spent on TB in 2016, 59% from domestic and 41% from international sources, namely the Global Fund. The Government of Nepal is committed to a TB-free Nepal and is working towards increasing the case identification rate and the case notification rate to reach this goal. In 2016, the Ministry of Health released the *National Childhood TB Management Guideline* to facilitate the achievement of the objectives outlined in the *National Strategy*, including: to increase case detection rate of childhood TB from 6% of 2015 to 10% by 2021 and a cumulative increase of 20,000 of total TB during the same period. The figure below shows the current situation of childhood TB in Nepal.



Human rights-related barriers to TB services

Overview

The major barriers set out below were found to be prominent in discussions with key informants and with members of key populations in focus groups, including:

- a) Stigma and discrimination, based on TB status alone, or in addition to stigma and discrimination based on key population status, occurs within the community, from health worker, and in the form of self-stigma.
- b) Gender-related barriers along with cultural beliefs about health affect detection, early diagnosis, treatment initiation and adherence, particularly among women. While more TB cases are reported among men than women in Nepal, women usually do not have equal access to TB diagnostic and treatment services because of their workload at home, lack of decision-making power, and gendered preferences for where to seek health care, and thus have a significantly longer delay before diagnosis of TB. Men seem to face higher risk of becoming ill with TB due to social contacts and high-risk work and habits, yet women face higher stigma, delayed diagnosis, and limited access to treatment.
- c) Institutional barriers, such as the lack of standard universal precautions for occupational hazards (i.e. ventilation, appropriate masks, etc.) in health facilities support stigmatizing behavior from health providers. The lack of required reporting of TB cases to the National program by private providers makes it difficult to estimate the prevalence of TB to inform the TB response. There is also a limited capacity to utilize TB diagnostic equipment in health facilities, lengthening diagnostic time.
- d) Lack of information on TB in prison settings limits the implementation of appropriate programs to ensure the right to health of prisoners and access to TB services and TB control activities in the prison setting.
- e) Poverty and geophysical barriers make it difficult for vulnerable populations in hilly areas to access TB services, as both time and financial resources are needed to reach health centers.

Stigma and discrimination

Community and self-stigma

In general, stigma and discrimination associated with a TB diagnosis are present, but appear to be less of an issue for people living with TB in Nepal than for people living with HIV, with the exception of MDR-TB and self-stigma. Self-stigma was reported namely as an issue for the middle and upper class, who appear to be more afraid of their TB diagnosis becoming known among their peers. Stigma related to TB still has negative consequences for people's health. One study noted that experiences of stigma may affect access and adherence to TB treatment⁷⁵, and another noted that a TB diagnosis could lead to stigma and discrimination at home, in the workplace, in healthcare institutions, and in the general community.⁷⁶ Some key stakeholders reported experiences of stigma within the family and at health facilities related to TB diagnosis. Stigma seems to be more common with regards to MDR-TB, though. One key informant observed that, *"stigma and discrimination are probably experienced by MDR-TB patients due to fear of infection among others"*. Another key informant shared the following incident of discrimination in the community:

"After the earthquake, when we went the Bhaktapur for a visit, a woman came to me and began crying because the camp volunteers were not allowing her husband to take shelter. A man was staying on the periphery of the village in a small hut and upon examining her husband it was found that he had TB. The refusal of entry in the relief camp was due to his TB status."

Anticipated stigma

Key informants also noted that anticipated stigma is also an issue for many people living with TB, causing them to isolate themselves from loved ones⁷⁷. In addition, family members may hide the TB status of a family member from others, as exemplified by this key informant:

"Very often, I can see on the prescription that a girl has TB, but if you ask her family, 'what problem does she have?' Her parents will still not say TB. They will say she has fever, or something else... that is the extent of [anticipated]-stigma."

Other key informants have noted that anticipated stigma occurs as a result of the fear of stigma and discrimination from the community or the family. They feel that if they are exposed as having TB, then society may look at them differently.⁷⁸ Interestingly, several key informants, as

⁷⁵ Baral S, Aryal Y, Bhattarai R, King R, Newell J. (2014). The importance of providing counselling and financial support to patients receiving treatment for multi-drug resistant TB: mixed method qualitative and pilot intervention studies. BMC Public Health 14(46), <http://doi.org/10.1186/1471-2458-14-46>.

⁷⁶ Health and Development Networks: HIV-related stigma and discrimination in the workplace and institutions, The correspondence dialogues. 2006, Chiang Mai: Health and Development Networks.

⁷⁷ Aryal S, Badhu A, Pandey S, Bhandari A, Khatiwoda P, Khatiwada P, & Giri A. (2012) Stigma related to tuberculosis among patients attending DOTS clinics of Dharan municipality. *Kathmandu University Medical Journal (KUMJ)* 10(37), 48-52.

⁷⁸ TB focal person, Tikapur Hospital. 25 July 2017.

well as group interview participants, consistently noted that TB-related stigma was most commonly observed among the elite groups like the Brahmins or the Chhetri communities.

Stigma from health workers

From a provider perspective, fear of being infected by TB and in particular, MDR-TB, emerged as a driver of discriminatory practices among health care providers. Key informants alluded to both environmental factors, such as poorly ventilated examination rooms, and infrastructure issues, like an insufficient supply of N-95 masks that are needed for effective prevention against transmission of TB as drivers of stigma. At the ground level, interactions with the staff from health centers also echoed similar concerns about their own risk of occupational hazards for contracting TB, and noted that they needed incinerators for proper waste disposal.

Similar to the stigma in health facilities in the context of HIV, people with TB may also experience stigma and discrimination in health facilities as they seek treatment. The experience of stigma in health facilities was particularly noted in the context of MDR-TB where according to a key informant, *“one of our MDR-TB patients needed a surgery, but no hospital in Nepal would admit him for a surgery because he was MDR-TB patient. We ultimately had to send him to India for the surgery.”* Another key informant explained that some service providers participate in indirect discrimination by avoiding TB clients or rushing through their procedures. They do not use polite language with them, and may be rude or harsh to people with TB, especially to MDR-TB patients.⁷⁹

Key informants alluded to misconceptions among communities about TB that could keep people away from seeking government services. The assessment revealed that in some communities, TB is thought to be a ‘divine’ punishment and consequently leads to less frequent disclosure of TB status.⁸⁰ Importantly, the Ministry of Health has prioritized addressing TB-related stigma and discrimination in the 2016-2021 *National Strategic Plan for Tuberculosis Prevention, Care and Control*, which notes that stigma reduction efforts will be emphasized alongside community-based DOTS services.

Gender inequalities and discrimination

While UNAIDS estimates that 60% of tuberculosis infections are in men,⁸¹ according to key informants, the path of transmission shows that it is often the case that men become infected first and transmit the disease to female family members, who usually do not have equal access to TB diagnostic and treatment services because of their workload at home.⁸² Gender-specific risks become prevalent in the context of TB. Gender-related barriers along with cultural beliefs about health affect detection, early diagnosis, treatment initiation and adherence, particularly among women. Studies have documented that women have a significantly longer delay before diagnosis

⁷⁹ Health post in-charge, Pratapur Health Post. 25 July 2017.

⁸⁰ Baral S, Karki D, Newell J. (2007) Causes of stigma and discrimination associated with tuberculosis in Nepal: a qualitative study. *BMC Public Health* 7(211), <http://doi.org/10.1186/1471-2458-7-211>.

⁸¹ UNAIDS. (2016). Gender assessment tool for national HIV and TB responses.

⁸² Health post in-charge, Pratapur Health Post. 25 July 2017.

of TB.⁸³ Whereas men seem to face higher risk of becoming ill with TB due to social contacts and high-risk work and habits, women face higher stigma, delayed diagnosis, and limited access to treatment.^{84 85} Key informants explained a few reasons for women's delay in initiating TB treatment, including health-related decisions being made by other members of the family, the lower priority accorded women's health needs than men's, and lack of time to access healthcare due to the burden of household work. Consequently, it was noted that many women prefer taking treatment for TB symptoms from a local traditional healer first, as they are the nearest most provider for most women and often garner greater trust from the community.

Institutional barriers

Institutional factors, such as lack of trust in health care providers and fear of TB infection among health care providers appear to drive discriminatory behavior towards people living with TB, which poses a barrier to accessing TB services. For example, one study documented that patients' enrolment in TB treatment was delayed due to waning trust in public health care, lack of peer support for self-referral, economic and knowledge factors, non-availability of services, and lack of trust in the health provider (Asbroek, A. et al., 2008).⁸⁶

Another related factor that emerged from the fieldwork was that, although people did not readily access the government health facilities, they did seek treatment from private practitioners in various forms, such as over the counter medications from pharmacists or treatment from qualified private practitioners. As private providers are not required to report TB cases to the National TB Program, it is difficult to get an accurate estimate of the number of people living with TB who are on treatment. Several key informants stated that there is an urgent need to enforce a law to mandate notification of TB cases identified in private health services. This would help the national program gain a more realistic understanding of the number of people on treatment and think of ways to work with the private sector. In addition, the findings that many people experiencing symptoms of TB first seek guidance and care at the pharmacy (NTP Annual Report 2016), point to the need for additional training for pharmacists, in terms of identifying and referring TB clients, as well as the potential for involving pharmacists in activities to reduce the stigma and discrimination associated with TB.

TB in prisons

It was challenging to access information on TB and HIV in the prison setting in Nepal. There is a dearth of published reports on the topic, and it was difficult to elicit information from key stakeholders within the prison system during the fieldwork. As a result, the situation in prisons regarding TB, including access to treatment services and involuntary isolation or detention, is not clear. However, one key informant working for an NGO that supports programs in prisons expressed concern regarding human rights violations occurring in prisons, ranging from lack of safe, adequate places for women to sleep to overcrowding of prisons to mistreatment by prison

⁸³ Yamasaki-Nakagawa M, Ozasa K, Yamada N, Osuga K, Ishikawa N, Bam D, & Mori T. (2001) Gender difference in delays to diagnosis and health care seeking behaviour in a rural area of Nepal. *International Journal of Tuberculosis and Lung Disease* 5(1), 24-31.

⁸⁴ Ibid.

⁸⁵ UNAIDS. (2016). Gender assessment tool for national HIV and TB responses.

⁸⁶ Asbroek, et al. (2008).

guards and family members. With regards to HIV and TB services, problems were reported with both access to services and treatment. These problems appear to stem from a combination of women not wanting to disclose their HIV status to prison staff and a lack of cooperation among prison guards who do not prioritize calling in doctors for sick inmates. According to the informant:

“Most women do not disclose their HIV status while in prison, as they fear being discriminated, due to this we cannot arrange for health services in situations like delivery of children and unfortunately such women die without proper treatment.”

Another aspect that hinders health services for inmates is the lack of willingness of health providers to provide services to inmates, particularly those living with TB and HIV, due to fear of infection.

“Very few doctors and nurses are willing to provide services to the HIV and TB infected populations. The health personnel are scared to go near them in the fear of getting the disease since the hygiene and sanitation of the prison is at worse condition.”

This fear is further reinforced by the lack of hygienic conditions of the prisons and the fact that people living with TB do not have a sick room for recovery. Although this particular NGO conducts awareness programs on HIV and TB with the prison authorities, these programs are small in number and need to be expanded. Sensitization training for prison guards on TB, HIV, gender, and human rights issues is also needed.

Poverty and geophysical barriers

A number of key informants and focus group participants noted the challenges to care access posed by the physical geography of Nepal. People living with TB who live in the hilly or mountainous regions of Nepal have difficulty getting to TB treatment centers, as both time and financial resources are needed to reach health centers. The formation of advocacy groups for people living with TB to advocate with the government for different strategies to reach remote communities would help to remove these barriers.

Programs to address barriers to TB services – from existing programs to comprehensive programs

Overview

The baseline assessment did not uncover any past or current programming in Nepal designed to remove human rights-related barriers to TB services. To date, the focus of TB programming has been on improving the reach of TB-DOTS programs and case identification and referral only.

The lack of interventions may be due to the fact that people living with TB are not well represented by patient advocacy networks, and therefore the full extent of human rights barriers to TB services may not be known. A number of programs to address the human rights barriers to TB services were suggested by key informants. It should be noted that many of the suggestions involved integrating TB into the proposed activities for HIV. The local stakeholders who participated in the inception, prioritization and validation meetings conducted as part of the

assessment also supported this integration. Given the dearth of existing programs, this section focuses on the comprehensive programs.

PA1: Stigma and Discrimination Reduction

Key informants working with people living with TB suggested that there should be awareness programs at the grass-roots level to combat stigma and discrimination. Community-level programs, suggested one key informant, should be focused on reducing the stigma and discrimination burden for people living with TB^{87,88}. The following activities are also described in the HIV section and should be cost-shared with the HIV program.

- Update existing NCASC stigma-reduction curriculum to include information on HIV, TB (including infection control for TB), non-discrimination, and violence, and to promote supportive, accepting, and responsive services. Roll out training-of-trainers on new curricula among key populations and NGOs.
- Institutionalize training on reducing stigma, discrimination and violence related to HIV and TB in professional schools for duty-bearers (i.e. teachers, doctors, nurses, social workers, lawyers, judges, etc.) using updated curricula. Course curricula can be adapted from the standardized NCASC curriculum. Continue in-service trainings and community leader/stakeholder trainings.
- Increase frequency of mass media campaigns, both audio and visual, to reduce stigma and discrimination based on HIV and TB status, increase awareness on laws and policies protecting the rights of people living with HIV and/or with TB, and reduce fear of infection and subsequent avoidance behavior. Social medias should also be used in this context. The coordination of National Health Education, Information and Communication Center (NHEICC) and NHRC is important for this intervention.
- Funding for support groups should continue. Support groups are valuable tools for reaching and engaging people living with HIV and/or TB and other key and vulnerable populations in prevention, care and treatment service, fostering resilience and improving quality of life. Integrating curriculum-based sessions and also combining support group interventions with economic and income-generation skills development should be considered. There should be various innovative approaches to reach migrants, since they are the most mobile group and are harder to engage in group-based community mobilization approaches. The local groups and community groups can help in reaching migrants and/or their spouses (i.e. women's saving and credit groups, mothers groups).
- Support stigma-reduction programmes that use cultural media delivered through large, public events, combined with advocacy and engagement led by key populations should be supported and scaled-up throughout the country. Consider linking these events or running concurrently with mass media campaigns.

⁸⁷ TB focal person, Tikapur Hospital. 25 July 2017.

⁸⁸ Health post in-charge, Pratapur Health Post. 25 July 2017.

PA 2: Reducing gender-related barriers to TB services

There were no formal programs uncovered through the fieldwork to remove gender-related barriers to TB services. However, one NGO, Jantra, noted that they used mothers groups to reach out to the communities at large and used peers to encourage women with TB to come for care and treatment gender-specific services.

- Relevant information and strategies related to TB should be integrated into programs suggested in the HIV section to reduce discrimination against women in the context of HIV
- Strategies to reduce gender-related risks and barriers, for women, girls, men and boys, should be fully developed, implemented and evaluated. Existing approaches, utilizing mothers groups and peers, should inform the development of these strategies. Community sensitization campaigns and information should be implemented to shift gender norms that place the household work burden on women and inhibit women's ability to make decisions about health-related spending. Sensitization of women in communities is also needed about recognizing TB symptoms and the importance of going to government health facilities for treatment are also recommended.
- Workplace policies regarding housing of male workers should be examined in industries where TB exposure in the occupational setting is more common. This could include improved ventilation in shared housing, preventive screening and early linkage to care and treatment for men living with TB.

PA 3: TB-related legal services

The following recommendations are also listed in the HIV section and should be cost-shared with the HIV program.

- Train and support peer paralegals to provide legal advice, awareness raising and conduct "know your rights" campaigns that includes TB information and strategies in each state/district among key populations and/or in health care facilities. Key stakeholders noted that there should be legal services available at district-level network organizations, or the district-level networks should have good contact with lawyers situated at the central-level network organizations. Training and mobilization of paralegals should be for the district-level organizations or at community-level through networks and community-based organizations.
- These expanded services should be linked with a newly established help-line for legal services with a toll free number. The help-line should be managed at the central level by a single network organization or committee. It was noted by key stakeholders that a large initial investment is required for training and mobilization at the district-level. The help-line services can be used for both the components of TB and HIV. For legal support, there can be coordination with the 29 existing OCMCs, which support gender-based violence services for women. OCMCs can be expanded or scaled-up and linked with HIV and TB services by making them key population friendly and sensitive.

PA 4: Monitoring and reforming laws, regulations and policies relating to TB services

- Suggestions from key informants contained recommendations for a proper protocol and guideline for TB service providers. These guidelines could be merged into the updated NCASC toolkit for health workers.
- In addition, the following recommendations are also listed in the HIV section and should be cost-shared with the HIV program:
 - In order to coordinate the comprehensive response to remove human rights barriers to HIV and TB services, a human rights point person in the National Human Rights Institute or Ombudsman's office should be identified. This person could support the process to begin replacing or updating the problematic laws and policies identified in the 2015 Legal Environment assessment in Nepal.
 - In addition to supporting the legal reform process, s/he could support other key aspects of the comprehensive response, such as the national monitoring and redressal system for stigma, discrimination and rights violations, and the routine assessments of KAPB for police and health workers on stigma, discrimination and human rights in the contexts of HIV and TB.
 - Funding for advocacy groups to support the legal reform process and advocate for and monitor the implementation of supportive policies and laws should be maintained.
 - Funding for advocacy groups to support the development of a Memorandum of Understanding between India and Nepal would help to ensure health services for Nepalese migrants in India.

PA 5: Knowing your TB-related rights

The following recommendations are also listed in the HIV section and should be cost-shared with the HIV program:

- Legal literacy and patient's rights education should be supported through conducting awareness campaigns and workshops among people living with HIV and/or TB, women, migrants and other key populations in each state/district towards mobilizing around health rights, freedom from discrimination and violence and other relevant rights. The literacy package should be produced, updated and reviewed accordingly and disseminated widely through various community groups such as community networks, community-based organizations, and other interest groups for them to tailor these packages to reflect appropriate content to each key population and deliver this package through trainers from among the key populations.
- An awareness/raising "know our rights" campaign should be targeted towards young migrants from high out-migration areas to ensure safe migration to India and facilitate access to TB and HIV services while in India.

PA 6: Sensitization of law-makers, judicial officials and law enforcement agents

The following recommendations are also listed in the HIV section and should be cost-shared with the HIV program:

- Update existing Nepali Police HIV curriculum to include information on HIV, TB (including infection control for TB), non-discrimination, and violence, and to promote supportive, accepting, and responsive services, in consultation with the Ministries of Education and Home Affairs, administrators of local police training colleges, and representatives of key and vulnerable populations. Updates should include sessions on recognizing and mitigating gender-based violence, as well as sessions to highlight the latest developments in protective laws for key and vulnerable population passed in Nepal and how to implement them effectively. The NCASC stigma-reduction tool should also be reviewed during this process to pull relevant information into the updated curriculum for police. Once approved, this training-of-trainers should be rolled out to build capacity for facilitation.
- Develop curriculum for law students on stigma and discrimination, human rights and GBV in the contexts of HIV and TB, based on the existing NCASC and Nepal Police curricula. This should be done through a consultative process with the Ministries of Education and Home Affairs, administrators of local police training colleges, and representatives of key and vulnerable populations. Once approved, this training-of-trainers should be rolled out to build capacity for facilitation.
- Institutionalize training in Police Academy and Law Schools on reducing stigma, discrimination and violence against key populations. Institutionalize the curricula for Armed Police force (involved in border security) and Police Academy at their own respective institutions all over the nation and require a minimum passing mark for certification. These trainings should be conducted through MoHA and funded by government rather than NGOs..
- Support in-service trainings for police, judges, prison staff, and policy makers on HIV and TB policies and key populations, responsible and supportive policing in the context

of HIV and TB, and reduction of illegal police practices using the new curricula. Planners and policy makers should also be included in their respective level and area: for national-level: MPs, ministries, NHRC, National Bar Association, health workers, Nepal Medical Association. For local-level: metropolitan, sub-metropolitan, municipality, Village Development Committee, lawyers and media people; for state level: prison management and security, state government and stakeholders. It was noted that a new source/s of funding for training will be needed with the reduction in USG investment in the HIV response in Nepal.

- Support routine assessments of law enforcement agents' knowledge, attitudes and behaviors towards people living with HIV and/or with TB and other key populations and support police administrators to identify and address any issues. Monitoring and evaluation should be done in police academy and police headquarters so that these KAPB can be monitored more effectively biannually or annually. The MERG-approved stigma assessment tool for health settings needs to be adapted for use with police.

PA 7: Training of health care providers on human rights and medical ethics related to TB

The following recommendations are also listed in the HIV section and should be cost-shared with the HIV program:

- Update existing NCASC stigma-reduction curriculum to include information on HIV, TB (including infection control for TB), non-discrimination, and violence, and to promote supportive, accepting, and responsive services. Roll out training-of-trainers on new curricula among key populations and NGOs and other (i.e. Ministry of Health) who will be involved in training for health workers.
- Incorporate stigma reduction, human rights and medical ethics training in pre-service curricula as a required course, mostly in medical colleges and CTEVT, so that the knowledge is shared from the institutional-level.
- Institutionalize routine (i.e. annual), in-service trainings on HIV, key population and HIV/TB-related stigma reduction, nondiscrimination and medical ethics for current health facility staff. This will ensure that training reaches all staff working at the health facility (i.e. front desk staff, lab technicians, cleaners, etc.). As new medical staff join who have received pre-service training, the size of in-service trainings will likely reduce, but should still be held routinely. Shorter, refresher trainings may also be needed for medical with pre-service training to maintain their knowledge in this area. Engage administrators and identify champions within the health sector/or facilities for sustainability and follow-up.
- Stigma, discrimination and human rights training sessions should also be provided to all TB-related agencies through the National Tuberculosis Center.
- Support routine assessments (i.e. every 1-2 years) of knowledge, attitudes and practices of health care towards people living with HIV and/or TB and other key populations to support health facility administrators to identify and address any issues. Healthcare setting-based surveys should be done among providers and exit interviews with key

population clients throughout the country with the help of proper guidelines executed for this. The brief, facility-based tool for health facilities, developed by the Health Policy Project with USAID and PEPFAR support, and tested in six countries, is recommended as several indicators from this tool are now approved by the UNAIDS MERG (Nyblade, L. et al. 2013). Questions related to TB stigma need to be incorporated into this tool and well as questions on human rights and the legal environment. It was noted that there are no strong networks for TB, so it will be best to incorporate TB stigma alongside HIV stigma in monitoring efforts. Proper data-collection should be done and monitored. An SMS system can also be included in this intervention, because it measures stigma and discrimination for both key populations and health care workers.

PA 8: Ensuring confidentiality and privacy

Key informants and focus group participants did not mention any concern over confidentiality and privacy when accessing TB services. Once clients were aware of their TB status and enrolled in care, they typically went to the clinic for treatment and were not afraid of being seen at the clinic or identified as living with TB. As noted above, the stigma reported was mainly self-stigma, as well as some anticipated stigma of experiencing stigma from family or community members, as opposed to health care workers. In addition, privacy and confidentiality is included as a topic in the medical ethics and human rights training described above under PA 7. Therefore, no programs are recommended under this program area.

PA 9: Mobilizing and empowering patient and community groups

There are currently no patient advocacy groups for people living with TB. It is recommended that support be provided to form patient advocacy groups for TB and provide training to facilitate advocacy on patient rights related to TB. These include but are not limited to: gender-related barriers, including gender-norms and stereotypes, gender-inequalities that increase men's and women's vulnerability to TB, and workplace policies that support protections from TB exposure in occupational settings (e.g. for men working of staying in confined spaces with poor ventilation to health workers working in facilities without proper Universal Precaution protection supplies and processes).. These groups could advocate for different strategies to support treatment access for vulnerable populations living in hilly or mountainous areas, as well as for government support to help with the catastrophic financial costs faced by many families of people living with TB. In addition, these groups could advocate for better workplace protections for men working in industries where ventilation is poor and risk of TB exposure is greater.

PA 10: Programs in prisons and other closed settings

There was general lack of data and information available relating to TB in Nepalese prisons. A national-level assessment of health care services and protections provided to prisoners in terms of access to TB and HIV treatment should be conducted to fully elucidate the situation in prisons. This assessment should examine protection from dangerous living conditions leading to TB, protection from sexual violence, and protection from discrimination and arbitrary isolation and access to TB and HIV health services. It should be noted that Save the Children is currently finalizing an analysis of the needs of prisoners for HIV, TB and malaria and the findings of this

analysis can be used to define what program to address human rights-related barriers to these services should be prioritized.

Other interventions

The table below provides an overview of other interventions that address broader right-to-health related issues such as accessibility, acceptability, availability and quality of services. They cannot be funded by monies allocated to programs to reduce human rights-related programs but are nevertheless important to support a rights-based response to TB. The content of the table is then further elaborated upon.

Other Programs: TB					
Program	Description				Limitations
Increasing accessibility, acceptability, availability, and quality of services	These interventions sought to increase case-detection of TB and/or MDR-TB in vulnerable, hard-to-reach populations across the country using a range of methods including, in-school, mobile van screening and home-based testing.				Programs not accompanied by any stigma-reduction activities at the community-level.
Implementer	Population targeted	Clients reached	Region(s)	Timeframe	Recommended scale-up
FAITH: Friends affected and Infected Together/TB REACH; Joshi B, et al., 2015	Children aged 0-14 (intensified case-finding strategies)	16,740 children screened; 185 cases detected.	7 intervention districts: Chi-tawan, Makawanput, Bara, Rautahat, Mahottari, Dhanusha	March 2012 – March 2014	Continue and expand efforts to reach vulnerable populations in remote areas across the country to increase TB case detection and linkage to care and treatment, through methods such as routine mobile testing. Home-based testing for TB should also be expanded, as it increases accessibility and availability of services. Counseling and financial support for people living with TB can be linked with home-based testing visits. Support the offer of routine mobile testing for TB to increase case identification among hard-to-reach populations.
COMDIS/UKaid; Baral et al., 2014	People living with TB	49 with MDR-TB reached	7 control districts (DOTS-Plus centers in Kathmandu valley)	January – December 2008	
SORT IT; Khanal S, et al., 2016	Urban poor, workers, prisoners, refugees, monks, nuns, people living with HIV	145,679 screened, 1,195 initiated treatment	29 municipalities in 22 districts	July 2013 – November 2015	

Current Programs

Key informants suggested a training program for family members taking care of TB patients in order to limit transmission rates and improve adherence to TB treatment.⁸⁹ Similarly, another key informant suggested an updated training program for service providers, as well as appointing a community focal person to ensure effective implementation of community DOTS programs.

Research has documented that patients who are older and needed to travel to seek treatment were often delayed in seeking services and were less likely to be adherent to treatment regimens.⁹⁰ Similarly, other studies found that people who had to relocate to receive treatment lost the support of their family and community and felt isolated.⁹¹ However, even within urban areas in Nepal, accessibility is difficult for poor communities.⁹² A key informant at a DOTS center stated that most of the people with TB that come to the center are from economically disadvantaged groups. Poor living conditions, poor nutrition, and a heavy workload are strong predictors for TB infection. A majority of the clients are labor migrants, who struggle to keep up with the extensive treatment schedule. Most of them drop out within a month, as they should continue working. For this reason, relapse cases are very high. Geographical and topographical barriers are also a challenge. People living with TB who live in rural areas face difficulty travelling to treatment facilities due to the lack of financial resources.^{93,94}

For people who have difficulty accessing health services due to socioeconomic or physical barriers, one key informant in charge of a health post suggested that there be a provision for providing transportation money to get to health facilities that will treat them. She suggested that families with children who may be infected with TB should have priority in this provision. Similarly, she suggested that a successful strategy has been to refer patients with TB to their nearest health facility instead of large government and private hospitals to improve compliance. For this, however, health workers should be adequately trained on TB.⁹⁵

In an interview with a worker in a health post, the key informant pointed out that it was difficult to diagnose TB among children due to lack of proper facilities and equipment, a general lack of awareness in the community and family, as well as accessibility issues.⁹⁶ In an intensive case-finding intervention in which the studied districts were determined based on geographic and economic characteristics, one study of the TB treatment non-governmental organization, TB REACH, found that there was an increase in TB case registrations for children ages 0-4 in comparison to control districts. The intervention consisted of household screening, testing at school, and community home-based care for children living with HIV. The study's results

⁸⁹ TB focal person, Tikapur Hospital. 25 July 2017.

⁹⁰ Choudhari M, Jha N, Yadav D, Chaudhary D. (2012) Factors associated with patient delay in diagnosis of pulmonary tuberculosis in a district. *Journal of Nepal Research Council* 10(22), 234-238.

⁹¹ Baral S, et al. (2014). The importance of providing counselling and financial support to patients receiving treatment for multi-drug resistant TB: mixed method qualitative and pilot intervention studies.

⁹² KII interview with Tushar Ray

⁹³ TB focal person, Tikapur Hospital. 25 July 2017.

⁹⁴ Health post in-charge, Pratapur Health Post. 25 July 2017.

⁹⁵ Ibid.

⁹⁶ Ibid.

further discussed the utilization of community home-based care in the contexts of HIV and TB, considering this strategy to be not particularly useful for them in identifying significant numbers of children with TB because health facility-based services of this nature already exist in many of these communities (Joshi et al. 2015).⁹⁷

Adding to the findings of the desk review, a key informant from WHO noted that even though TB medication is free, there are still catastrophic costs that are borne by the patients and their families. According to him, Nepal has committed to reducing or eliminating these costs, but there is an urgent need to act upon this commitment.

While TB itself can include an intensive treatment regimen, when an individual contracts multi-drug resistant TB (MDR-TB), the international guidelines for adherence become much more strict and intense. For individuals without the resources to regularly make visits to DOTS-plus centers for treatment, this can become a heavy burden for those already suffering from a difficult-to-cure disease. Due to the heavy burden on families, this creates a financial issue on top of the already strongly enacted familial and societal stigma resulting from perceptions about MDR-TB. In a pilot intervention study conducted through DOTS-plus centers, a varying amount of support was offered to patients undergoing treatment. Groups were separated into counseling, combined counseling and financial support, and no support (for control). In the evaluation of the study, it was reported that both solo counseling and combined counseling with financial support were valued interventions by patients, as the amount of perceived social stigma decreased in both cases. While the intervention group with the financial support appreciated it more, there was no significant difference between the intervention arms, implying that social support for people living with TB alone was highly beneficial to patients undergoing MDR-TB treatment (Baral, et al. 2014).⁹⁸

Some key informants have also noted that there are very few regulations and procedures when it comes to the training of health care providers and implementation of programs. One worker at a DOTS clinic with a 33-year career in TB treatment stated that he had only received two trainings on TB modular procedures, and has never received any protocol or guidelines on TB infection protections (KII, TB focal person at hospital).⁹⁹ Another key informant expressed her concern over the current federal system of disseminating DOTS medicine, which could result in a shortage problem (KII, Health post in-charge).¹⁰⁰

In another intervention conducted by the same organization, the study population included the urban poor, factory workers, prisoners, refugees, monks, nuns, people living with HIV, and populations at close contact with TB patients. The TB REACH program worked with intensified case-finding strategies such as mobile clinics and health facility-based sites. The results of the study indicated that the highest yield of new cases came from people living with HIV, household

⁹⁷ Joshi B, Chinnakali P, Shrestha A, Das M, Kumar AM, Pant R, Lama R, Sarraf RR, Dumre SP, Harries AD. (2015). *Impact of intensified case-finding strategies on childhood TB case registration in Nepal*. Public Health Action 5(2), 93-98.

⁹⁸ Baral S, et al. (2014). The importance of providing counselling and financial support to patients receiving treatment for multi-drug resistant TB: mixed methods qualitative and pilot intervention studies.

⁹⁹ TB focal person, Tikapur Hospital. 25 July 2017.

¹⁰⁰ Health post in-charge, Pratapur Health Post. 25 July 2017.

contacts, and the urban poor, indicating that these high-risk groups may benefit from such intensive case-finding strategies and better access to care (Khanal et al. 2016).¹⁰¹ Another recommendation revolved around providing transportation costs to female community health volunteers to support their efforts to make community and family DOTS programs more effective (KII, health post in-charge).¹⁰²

Based on the interventions identified during the desk review and fieldwork, the following interventions are proposed for consideration under funding streams other than human rights funding streams: (see Annex Table 2).

- **Enhance the counseling skills of HCT, TB and OCMC counselors.** Update counseling curriculum and re-train HCT, TB, and OCMC counselors to enable the provision of enhanced counseling services to address HIV, TB and violence in an integrated manner and also address the psychosocial needs of people living with HIV and/or TB and other key populations.
- **Increase availability, accessibility and quality of health services for key and vulnerable populations.** Integrate health services for HIV, TB, OST, and violence with general health services, etc. *Female-only centers needed for women who inject drugs and female sex workers to prevent abuse and mistreatment.*
- **Cross-border initiative to protect Nepali migrant health while in India.** Provide avenues for local leaders to scale-up successful cross-border pilot program to support migrants to access services for HIV and TB.
- **National evaluation/assessment of health care and protections provided to prisoners.** Conduct a national assessment in prisons to understand health care in terms of access to HIV and TB treatment, protection from dangerous living conditions leading to TB, protection from sexual violence, protection from discrimination and arbitrary isolation.
- **Evaluations to assess the effectiveness of new/scaled approaches to remove human rights barriers to HIV and TB services.** Evaluate selected approaches (e.g. integrated, one-stop shop services, training/transport costs for FCHVs to increase TB case identification and referral, etc.) to determine efficacy/effectiveness at removing human rights and other structural barriers to HIV and TB.
- **Mobile outreach to increase TB case identification.** Support the offer of routine mobile testing for TB to increase case identification among hard-to-reach populations (women, children, the urban poor, etc.)
- **Range of interventions to increase TB case identification.** To increase access to TB care and treatment for children with TB:

¹⁰¹ Khanal S, Baral S, Shrestha P, Puri M, Kandel S, Lamichanne B, Elsey H, Brouwer M, Goel S, Chinnakali P. (2016). *Yield of intensified tuberculosis case-finding activities using Xpert MTB/RIF among risk groups in Nepal*. Public Health Action 6(2), 136-141.

¹⁰² Health post in-charge, Pratapur Health Post. 25 July 2017.

- Provide funding for travel costs for children/parents to TB centers;
- Train/empower/support Female Community Health Volunteers to provide TB screening and referral via home visits;
- Consider family-centered DOTS programs for children, as opposed to using community DOTS program – also consider involving teachers to support DOTS for children with TB.
- Support local leaders to train traditional healers to identify TB cases that require critical care and refer TB patients to national TB program.
- **Enhanced ability of FCHVs to identify TB cases.** Formalize role of Female Community Health Volunteers and provide financial compensation for transport costs incurred in their work.

Costs for comprehensive programs to remove human rights related barriers to TB services

The total amount expended on the TB response in Nepal in 2016 was 17 million USD. No investments were identified in programs to reduce human rights-related barriers to TB services. Estimated costs for the recommended interventions for the five-year comprehensive program are set out in the table on the following page. Detailed intervention areas and costs are set out in Annex 3.

Costing for 5-year comprehensive program – TB

TB Human Rights Barriers Program Area	Year 1	Year 2	Year 3	Year 4	Year 5	Total
PA 1: Stigma and discrimination reduction ^	113,976	68,592	67,667	75,259	75,259	400,764
PA 2: Reducing gender-related barriers to TB services	0	0	0	0	0	0
PA 3: TB-related legal services^	1,240	1,120	1,120	1,232	1,232	5,944
PA 4: Monitoring and reforming laws, regulations and policies relating to TB services^	3,678	360	360	396	396	5,190
PA 5: Knowing your TB-related rights^	81,818	60,618	81,018	50,010	73,470	346,932
PA 6: Sensitization of law-makers, judicial officials and law enforcement agents^	15,808	6,521	6,293	6,922	6,922	42,466
PA 7: Training of health workers on human rights and medical ethics related to TB^	31,749	24,371	24,371	26,808	26,808	134,107
PA 8: Ensuring confidentiality and privacy#	0	0	0	0	0	0
PA 9: Mobilizing and empowering patient and community groups	9,180	9,180	9,180	10,557	10,557	48,654
PA 10: Programs in prisons and other closed settings*	0	0	0	0	0	0
Total	257,449	170,762	190,018	171,184	194,644	984,056

^ These costs are split with the HIV response, as program activities will cover both TB and HIV. Costs were split 60% HIV and 40% TB. # No programmes were recommended for these programme areas, therefore no costs have been estimated. *Not enough information was available on the health situation of prisoners in Nepal, including on their access to TB services. A formative study is needed to fully understand the situation in prisons before programs could be recommended.

Limitations, Measurement Approach and Next Steps

Limitations

Given the rapid nature of this assessment, it is possible that some programs or interventions that have been conducted to address the human rights-related barriers to HIV or TB services in Nepal have been missed. However, the inclusion of several stakeholder meetings, such as the inception meeting, prioritization meeting and validation meeting as part of the assessment, allowed for several opportunities for program implementers and funding agencies to share documentation about issues and programs that were missing from the review.

Another limitation is that only six focus group discussions with key population representatives were conducted during the fieldwork, and thus views from all the different geographical regions in Nepal are not represented. However, there were several opportunities for networks of key populations to inform the assessment, and the CCM validated the comprehensive response ultimately proposed for the catalytic funding. The analysis of the focus group and key informant interview data suggests that saturation was reached on both the human rights-related barriers to HIV and TB services and programmatic responses to address them.

It was not possible to apply the tool to assess the effectiveness of the program approaches identified, namely because so few were evaluated in a manner that would enable such an assessment. However, rich details on the programs identified were gathered, including implementer perceptions of what worked well and what could be improved, which informed the comprehensive response proposed.

Measurement approach for assessing impact of scaled up programs to remove human rights-related barriers to services

Qualitative Assessment

In order to understand how the comprehensive response is influencing human rights-related barriers to HIV and TB services, it will be critical to conduct midline and endline qualitative assessments. Such assessments will provide more nuanced understanding of the various approaches being implemented and will help to understand the combined influence of the structural, community-level and individual-level interventions being proposed. Qualitative assessments could also shed light on new programs, such as organizing and supporting patient advocacy groups for people living with TB, that have not been previously implemented in Nepal.

Quantitative Assessment

While it may not be possible to quantitatively evaluate all of the programs implemented as part of the comprehensive response, Nepal should consider strategically evaluating some of the interventions. For example, it will be important to determine if the stigma and human rights training for police leads to fewer criminal charges brought against people who use drugs and increased referral to harm-reduction services. Likewise, it would be important to evaluate the influence of awareness raising and “know your rights” campaigns for young migrants over time, to see if this information helped them to access health services while in India, and/or helped prevent new HIV infections. In addition to evaluations of specific programs, the impact of the

comprehensive response can be assessed with several outcome and impact level indicators, most of which are already being collected in Nepal as part of the national monitoring systems for HIV and TB. The indicators, baseline values (where possible), data sources and proposed level of disaggregation are described in Annex 4. Data sources included: the 2016 Nepal DHS, the 2011 PLHIV Stigma Index, the 2015 and 2016 indicators reported to UNAIDS as a part of Global AIDS Monitoring (GAM), the 2016 IBBS survey, the 2011 TB Sentinel Survey, and the NTP 2016 Annual Report. Outcome indicators are proposed for people living with HIV, key populations, people living with TB, the general population, health workers, institutions and financing.

Measurement Limitations

It will not be possible to directly link the activities supported under the comprehensive response with key outcomes and impacts, however, comparison of baseline values with values collected at midline and endline, and examination of the findings of the repeated qualitative assessments, will provide a sense of how the addition or expansion of efforts to remove human rights-related barriers to HIV and TB services has influenced Nepal's progress towards reaching the 90-90-90 targets for HIV and the NTP targets for TB.

Next steps

This baseline assessment will be used as the basis for dialogue and action with country stakeholders, technical partners and other donors to scale up to comprehensive programs to remove human rights-related barriers to HIV and TB services over the next five years. Towards this end, the Global Fund will arrange a multi-stakeholder meeting in country where a summary of the key points of this assessment will be presented together with a draft five year plan, for consideration and discussion towards using every opportunity to include and expand programs to remove human rights-related barriers to HIV and TB services.

Setting priorities for scaling up interventions to reduce human rights-related barriers to HIV and TB services

Given the nature of barriers in Nepal, it is recommended that the early focus be on activities to update or develop curricula on stigma and discrimination reduction and human rights for key duty-bearers and the integration of these curricula into the appropriate professional training schools and colleges. In addition, the establishment of various systems to capture experiences of stigma and discrimination and support redress should be prioritized, including a national monitoring system, with a linked hotline, as well as a rapid response unit for survivors of violence and other abuses that require immediate support. It is recommended that a program officer with the Prime Recipient be initially supported to oversee the implementation of the comprehensive response proposed. However, for long-term sustainability, plans should be made to appoint, mentor and supporting a human rights point person in the National Human Rights Institute or Ombudsman's office. This person should be trained to take over management of the comprehensive response, but in the shorter term, could help ensure consultations and collaboration across various stakeholder (i.e. key population networks, CBOs, government

ministries, etc.) and support the process to begin replacing or updating the problematic laws and policies identified in the 2015 Legal Environment assessment in Nepal. The development/updating of advocacy and legal literacy tools and subsequent training for advocacy groups should also be prioritized, to ensure that networks and patient advocacy groups are able to actively support the comprehensive response throughout its 5-year implementation. Discussions with the Indian Government about migrant health towards the development of a Memorandum of Understanding should also begin early in the response. This MOU should address the need for access to health care services for Nepali migrants while they are residing in India.

Following the completion of these initial activities, the next stage in the response would focus on training-of-trainers and training of instructors/professors, followed by the rollout of routine training/re-training of key duty-bearers both pre-service and in-service. Linked with the scale-up of training activities, mid-term efforts should focus on developing and implementing appropriate monitoring tools for the various duty-bearers (i.e. health workers, police, prison staff, teachers, lawyers, judges, etc.) with a feedback loop for institutional administrators to ensure appropriate action and support following the trainings. In addition, this phase of the response would also include outreach and engagement with *pro bono* lawyers and paralegals to support clients utilizing the new monitoring mechanism or the rapid response unit. The PLHIV Stigma Index should be implemented in year three or 4, with additional funding support to PLHIV networks to conduct follow-on advocacy and awareness raising activities in the final year of the comprehensive response.

The capacity of community-based organizations, public institutions and government agencies to implement the proposed comprehensive response is fairly strong for HIV, but capacity strengthening will be needed for the proposed programs to remove human rights barriers to TB services. Nepal has a supportive legal environment and a long history of supporting efforts to reduce stigma towards people living with HIV and reach marginalized and key populations with HIV and TB services. Coordination efforts will be critical to ensure that the HIV and TB communities are working together to collectively address the human rights barriers identified. Once the finalized response is agreed, the implementation capacity need can be revisited and informed by specific recommendations.

VI. List of Annexes

Annex 1: Chart – Comprehensive programs to reduce human rights-related barriers to HIV services

Annex 2: Chart – Comprehensive programs to reduce human rights-related barriers to TB services.

Annex 3: Calculations for retrospective costing of programs to remove human rights-related barriers to HIV services.

Annex 4: Calculations for costing the comprehensive response

Annex 5: Costing considerations

Annex 6: Baseline indicators and values for comprehensive response

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