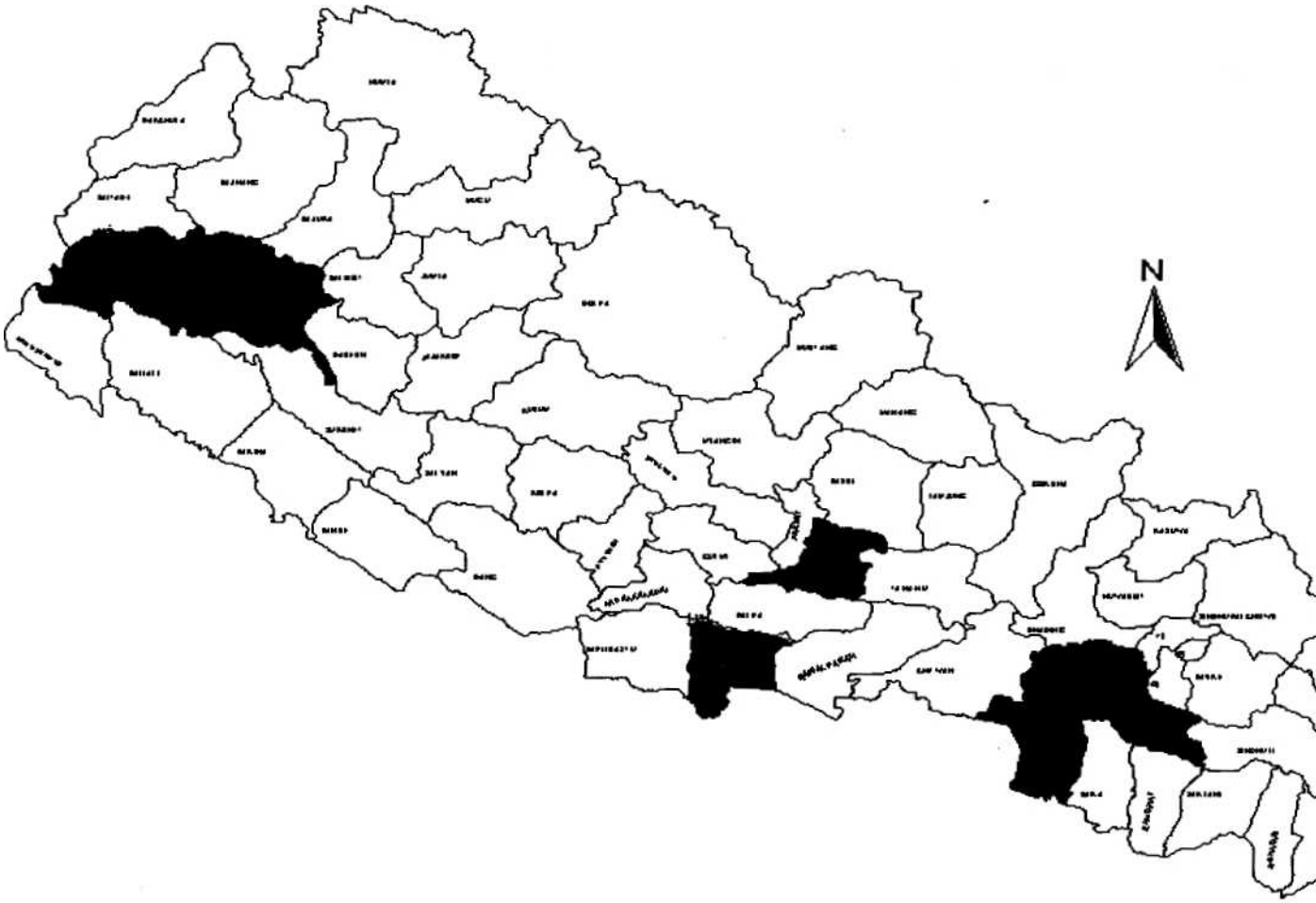
Participatory Planning and Management of HIV/AIDS (NEP/97/003) `'

Mid Term Evaluation Report
Government of Nepal/NCASC/UNDP
December, 1999



NEPAL

Districts under Participatory Planning and Management of HIV/AIDS

NPC GIS Facility Singha Durbar

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Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
CDO	Community Development Officer/Chief District Officer

DACC	District AIDS Coordination Committee
DALO	District AIDS Liaison Officer
DDC	District Development Committee
DHO	District Health Officer
EU	European Union
FCHV	Female Community Health Volunteers
FHI	Family Health International
HIV	Human Immunodeficiency Virus
HMG/N	His Majesty's Government Nepal
IDU	Injecting Drug User
INGO	International Non Governmental Organisation
LDO	Local Development Officer
LGP	Local Governance Program
NACC	National AIDS Coordination Committee
NCASC	National Center for AIDS and STD Control
NEX	National Execution Modality
NFE	Non Formal Education
NGO	Non Governmental Organisation
NPC	National Planning Commission
NPD	National Program Director
NPM	National Program Manager
PDDP	Participatory District Development Program
PPM	Participatory Planning and Management of HIV/AIDS Program
PWHA	People living with HIV/AIDS
REDP	Rural Energy Development Program
RTI	Reproductive Tract Infection
SAPAP	South Asia Poverty Alleviation Project
STD	Sexually Transmitted Disease
TBA	Traditional Birth Attendee
TOR	Terms of Reference
TOT	Training of trainers
UH	University of Heidelberg
UNAIDS	United Nations Joint and Co-Sponsored AIDS Program
UNDCP	United Nations Drug Control Programme
UNFPA	United Nations Family Planning Association
UNDP	United Nations Development Program
UNICEF	United Nations Children's Fund
UNV	United Nations Volunteers
USAID	United States Agency for International Development
VDC	Village Development Committee
WHO	World Health Organisation

I. Executive Summary

A mid-term review of the UNDP/Nepal project, Participatory Planning and Management of HIV/AIDS (NEP/97/003) was conducted in November 1999. The purpose was to review the design, implementation and management of the project, to reinforce initiatives that demonstrate potential success and to provide a basis for future directions and continued UNDP support. Over three weeks, the review team met with over 130 key stakeholders in Katmandu, Sunsari, Morang, Syangja and Rupandehi.

The review has concluded that this project has made significant progress associated with improving the awareness, capacity and response to HIV/AIDS at District and Village levels. The outcomes supported by the project should be commended. The aim of the project is to attain a multisectoral and community focussed AIDS prevention program that will minimise the social and economic impact of HIV. The project works through a local development strategy that catalyses District AIDS Coordinating Committees and the local Village Development Committees to plan, implement and monitor their own multisectoral programs in cooperation with NGOs and the private sector. Overall, the review recommends that this approach is very relevant and that in the remaining two years there should be an increased depth of focus on improving prevention and care services delivery that will reduce the impact of HIV on the community as a whole.

Since the time of project formulation in 1997, the epidemic has steadily grown in Nepal. Currently there are 1337 reported infected persons with a conservative estimate of 30,000 infections since the beginning of the epidemic. Over half of the majority of reported cases are young men ranging from 20-29 years old. Heterosexual transmission continues to be the predominant mode of reported transmission, but new evidence from the National Center for AIDS and STD Control demonstrates a recent and alarmingly increase in injecting drug users where the national prevalence has now reached 40%.

A diverse range of factors make Nepal a vulnerable country to the HIV epidemic. Large numbers of Nepalese migrate to India and other countries for work. Rural communities often have one person from each family that is working away from home. Trafficking of young Nepalese women to Mumbai and other urban centres in India fuels the epidemic as does the sex trade within the Nepalese borders. In addition to the free movement of people across the Indian border, black market trade has provided a steady stream of relatively inexpensive injectable drugs into Nepal. Sexually transmitted diseases other than HIV are not uncommon. Services to address a number of these risk factors are often lacking at local levels. The cumulative effects of all of these factors on the course and outcome of the epidemic is not known.

Given the context of the epidemic and the country response, the review felt the original design was relevant and capable of strengthening local responses to the epidemic. The majority of conclusions and findings will reflect that there is a need for greater focus on strengthening service provision within local initiatives to have a greater impact on the epidemic.

Summary of Findings and Conclusions:

Increased Local Commitment and Expanded Multisectoral Response

The review found most of the DACCs have developed strategic plans for HIV/AIDS and that over 52% of the VDCs in 9 districts have been sensitised to HIV/AIDS. The local governance structures have increased their commitment to HIV/AIDS substantially with allocation across the Districts totaling over 4 Million Rupees or 27% of the combined HIV/AIDS budget. The multisectoral nature of the response has increased with over 104 NGOs, several line agencies and local industries now implementing HIV/AIDS programs. Peer education programs with youth have also begun. In the future, local initiatives that move beyond awareness raising to focus on improving the access to prevention and care services need to be strengthened and expanded. In addition, to improve the chances of sustainability of a multisectoral response, there is a need for line agencies to receive national guidelines and a plan of action that institutionalises their local responses.

Strengthening the Depth of the Local Programs

Through the advocacy, research and capacity building initiatives, the local development structures now know the risks of HIV/AIDS in their communities. General awareness has grown among the majority of the population with some exceptions among the most marginalised communities. Education programs that have catered to the local language will continue to be the most effective. Beyond basic awareness, the local development structures recognise the need for improved prevention and care services to their communities. Many communities have identified that the management and treatment of STDs, greater access to condoms, and counselling and testing services are required. Continued technical support and enhancement of local initiatives for the provision of these services will improve the depth and quality of local responses.

Localised Harm Reduction Strategies

Local communities and governance structures are aware that injecting drug use is fuelling the epidemic especially around border areas. Prevention awareness programs have been conducted with the general community and with many school youth. Local development authorities generally feel that rehabilitation centres are required to address the drug use problem within their communities, however, these are costly strategies. There is very little awareness or experience about what harm reduction means or the components of a harm reduction program. Local advocacy

and capacity building which includes the involvement of the NCASC, NGOs who implement harm reduction programs, UNAIDS, local authorities and affected communities is required. With a greater understanding of the range of harm reduction strategies, local initiatives could be supported to expand the access to education, and prevention and care services to drug users in these Districts.

Care and Support for People Infected with HIV/AIDS

In most Districts there are a growing number of persons infected with HIV/AIDS. Education programs are promoting a non-discriminatory attitude towards people living with HIV/AIDS and some local initiatives to strengthen counselling and care services are beginning to be developed in a limited number of districts. At a national level, there is

some involvement of people living with HIV/AIDS in advocacy, education and awareness programs. HIV testing services are not available in all Districts, but where they are available, it is primarily provided through the private sector laboratories, who are often not comfortable with telling people their status. Reports from the District and Village level suggest discrimination towards known or suspected HIV infected persons is high. Local initiatives that improve the care and support for people living with HIV/AIDS will enhance the effectiveness of the prevention efforts. Counselling services linked to testing facilities are required to enhance prevention efforts. Support for persons infected on a psycho-social and health service level is required. In addition, basic access to income generation opportunities for infected migrant returnees and their families is growing.

UN, National and International Cooperation

There has been very good cooperation between this project and other UNDP projects at a District/Village levels. The outcome has been excellerated implementation and expanded education across the Districts. The project has been able to utilise the existing social mobilisation groups established by PDDP and SAPAP to enhance awareness and participation in HIV/AIDS education programs. In addition, cross District learning is improving the capacity and response time for newly initiated District programs. At a national level, the project has facilitated the involvement of key Parliamentarians and worked to enhance the awareness with key policy makers. At an international level, individuals are sending letters to their families who are working in India to ensure their awareness of the risks of HIV/ AIDS.

In the future, UN cooperation opportunities should continue to enhance the access to prevention and care services at a local level. At a national level, the project should continue its cooperation with the NCASC, UNAIDS and other partners to support the development of a national plan of action for HIV/AIDS that is informed

by their District/Village programs and that includes Line Agencies. At an international level, the project should also continue its cooperation with these partners to engage cross-border discussions in the Districts and to link to HIV programs in India, especially Mumbai.

The UNDP Project in the Context of Increasing Demands

The UNDP project has helped to raise awareness that is causing an increase in demand for local service provision in prevention and care. The UNDP project must now see its District Level role as a facilitator and coordinator of technical assistance to improve the quality and availability of local services. With the epidemic advancing, it is not possible for the UNDP project to implement all of the requirements across a prevention to care continuum. However, the UNDP project is well placed to assist in the local capacity development for implementation of services through existing networks and organizations. In some places this has already started to be the mode of operation for the project, it must be continually reinforced and strengthened. Cooperation with key technical partners, from across the country and within the region, who can offer capacity building in developing local service delivery, should be the goal for the next two years.

Recommendations:

The full list of recommendations are found in Chapter VIII. The major recommendations can be summarised as follows:

Strengthen Depth not Breath

1. The project should complete its expansion of basic education to the rest of the VDCs in their current Districts. However, the project should not expand to additional Districts until District Strategic Plans are operationalised. Based upon District priorities, the project should ensure demonstrated improvement of the quality and availability of prevention and care services within the current 9 Districts.

Improve Access to Condoms

2. Local innovative strategies to improve condom promotion and distribution should be expanded to allow easy access for people engaging in high risk behaviour, (eg., condom boxes in pubs, hotels, factories and distribution through peer education networks including youth).

Improve STD Referral and Case Management

3. Strengthening the referral system for STD case management will continue to improve access to STD care and management. The already planned training in STD case management training should be completed with Health Assistants and

Auxiliary Nurse Midwife at health posts and the Auxiliary Health Worker at the subhealth post level. Providing training for STD referral should be completed with chemist and medical shop owners and consideration should be given to providing them training in syndromic management of STDs.

Address the Emerging Epidemic in IDUs

4. Advocacy and trainings in harm reduction strategies at a District and Village level should be conducted with key partners. Capacity building and the implementation of harm reduction programs should be a priority for integration and strengthening over time especially in Districts on the border of India.

Enhance Counselling, Testing and Support Services

5. A greater access to care and support services including voluntary counselling and testing is required to improve the overall effectiveness of the current prevention efforts. District programs should develop cooperative counselling and testing services with public health services, private laboratories and NGOs to improve the effectiveness of prevention and care strategies.

Develop Care and Support Services for People Infected

6. Discrimination for people living with HIV/AIDS will only be reduced when communities see that caring and supporting persons with HIV/AIDS is not dangerous. Training the existing village based health network and NGOs in home based care is necessary for developing community based strategies for people infected with HIV/AIDS.

Provide Access to Income Generation for People at risk or Infected with HI VIA IDS

7. Pilot projects in cooperation with other UN programs should be tested to provide people with HIV/AIDS access to credit and skills in income generating projects.

Cooperation with Programs with Specific Technical Expertise

8. The PPM project and staff should continue to see their role as facilitators to technical expertise to improve local responses. The management and utilisation of expertise from other organisations and projects should be enhanced to improve the technical quality of programs and services at District and Village levels (STD case management, harm reduction, counselling/testing, involvement and support of PWHA).

Sustain Funding for Focused Intervention Services

9. Next year the project's budget is decreasing in half. This is being supplemented by UNFPA to improve education and referral services with the existing health service network. However, funding levels to District level contracts should be sustained to provide additional capacity building and implementation of specific services including: STD case management, Counselling/Testing and Care, and

Harm Reduction. The priority of services should be based upon local decisions.

Cross Border Strategies

10. Cross border meetings at the District level should be facilitated by the NCASC and the project to define priority interventions for crossborder areas (eg., counselling centres/STD services).

Support National Planning and Coordination

11. At a national level the project has been requested to assist the Government in developing a National Plan of Action for HIV/AIDS. This assistance should occur by supporting UN involvement through cooperation within the UNAIDS framework and with the NCASC. The project is well placed to facilitate the involvement of the DACCs and some VDCs so that the National Plan of Action reflects the needs and programs from the grassroots level. The project should also facilitate central Line Agency involvement in the national planning process.

II. Introduction

1. Purpose of the Evaluation

The purpose of the mid-term evaluation was to provide basis for:

- addressing particular issues or problems in design, implementation and management;
- reinforcing initiatives that demonstrate potential success;
- providing future directions of the Programme and continued UNDP involvement and support.

2. **Objectives of the Evaluation**

The objectives of the evaluation are to provide all members of the program with:

- a critical assessment of the Programme's overall performance;
- a record of lessons learned;
- an improved direction of performance in the future.

3. Methodology of the Evaluation

The review team consisted of two external consultants who were hired by UNDP and one member of HMG/N from the NCASC. The team members were: Dr. Jeanine Bardon, Team Leader; Dr. Khim Sharma, Independent Consultant; and Mr. Pranay Upadhyaya, NCASC Representative. Detailed briefings were held with UN, NCASC and project staff in Katmandu and the TOR reviewed (Annex A). Site visits took place in four districts: Morang, Sunsari, Syangja and Rupandehi. The itinerary can be viewed in Annex B. Project staff, DDC members, DACC members,

VDC members, NGOs, private sector partners, beneficiaries and potential partners were met in each site of visit (Annex C). Meetings in Katmandu with training institutions, local NGOs, INGOs, UN agencies and other donors also took place. A broad range of questions relating to relevancy, efficiency, quality, cooperation and future recommendations were discussed. A total of over 130 persons were interviewed for input into this report. An extensive literature review was conducted (Annex D). A draft copy was circulated with the management structure before finalising and shared at the December 1999 Tripartite Review.

4. Limitations of the Evaluation

The review was primarily limited by time. Each site visit was approximately 1.5 to 2 days which allowed only a certain level of depth and familiarity with the project inputs and outcomes. There was also not enough time to travel to the Far West for site visits, although DALOs from all three districts, and one DDC Chairperson from Doti, were met in Katmandu. In addition, the evaluation team did not visit Districts who do not receive UNDP assistance for comparison purposes. Finally, time constraints also reduced the possibility of having second rounds of discussions concerning the findings and recommendations with the majority of project stakeholders and beneficiaries.

III. Project Context, Concept and

Design 1. Context

Epidemiology of HIV, STDs and Behavioural Risk

The project design for PPM was developed in 1997. At the time of project design the epidemiological context was assessed in the light of the official figures of 863 reported cases of HIV, 153 reported cases of AIDS and 83 deaths. Estimates of the total numbers of persons infected ranged from 15,000-30,000. The predominant mode of transmission was suggested to be heterosexual contacts. HIV was reported to have existed mainly among sex workers, their male clients and women in the general community. In the mid 1990s, little was known about the level of infection within injecting drug users outside of Kathmandu, however, the prevalence was relatively low within Kathmandu.

According to the NCASC there has been a steady increase in the epidemic over the last few years with over 1300 cumulative persons reported with HIV/AIDS as of November, 1999. Over sixty percent of these are male with the majority in the age range of 20 - 29 years. Heterosexual transmission continues to be the predominant mode of transmission among reported cases.

Since the mid 1990s, there has also been a significant newly emerging threat among injecting drug users (IDU) across the country. Rapid assessments carried out by the

NCASC in early 1999 with 725 drug users found that 40% of those injecting drugs were HIV positive. There is currently a rough estimate of approximately 20,000 IDU in Nepal with approximately half reporting to have multiple sexual partners. The potential for IDUs to be heavily affected by HIV infection and disease while also simultaneously becoming an active `reservoir' for further infection to their sexual partners is very real in Nepal today.

Based upon a number of current findings, a very conservative estimate of the total number of persons in Nepal infected since the beginning of the epidemic is 30,000 with a projected doubling of this figure in the next five years.

It is widely agreed that the presence of an STD facilitates the infection and transmission of HIV. Since 1996 several studies have shown an increasing prevalence of HIV among STD patients in Nepal. For example, in Mahendranagar District, the NCASC and University of Heidelberg (UH) study has shown an increase from less than 1 % to over 4% HIV prevalence from 1996 to 1998 among STD patients. Another study, published in 1998 by the NCASC in cooperation with the UH, found that among 268 women in Katmandu and Nepalgunj attending gynaecological outpatient departments 82% complained of STD related symptoms. Candida albican was the most commonly detected infection (33%) followed by Trichomonas vaginalis (12.5%), with the detection of Chlamydia and Gonorrhoeae much lower (4.2% and 1.8% respectively). Nonetheless, active or recent syphilis rates were relatively high (5.3%).

In summary, there has been a continued increase in HIV infection across Nepal since 1997, with an epidemiological shift to increases in HIV prevalence among injecting drug users. While knowledge about HIV/AIDS and its prevention among persons engaging in high risk behaviour is high, there are still major gaps in behaviour change. In the area of health seeking behaviour concerning STDs, it is known that men primarily seek services at private clinics and chemists, while women's access to services remains low.

Overall, Nepal has a large number of risk factors that place the country in a very vulnerable position. The large number of migratory men and women who work primarily in Mumbai followed by the Middle East and South East Asia put them at great risk of infection. There is an existing sex trade within Nepal and also regular trafficking of women for this trade in India. The free movement across the Indian border facilitates not only the migration of persons but also drugs that are sold legally in India, but illegally in Nepal. Drug use around the border and in major urban areas is not uncommon and the NCASC's recent study showed that 70% of drug users inject drugs and over 50% have multiple sexual partners. Data on sexual behaviour in the general rural population is scant, however, in some areas wives of migrants have multiple sexual partners while their husbands are away. The synergistic effects of all of these risk factors on the course and outcome of the epidemic in Nepal is not

known.

Country Response

The National AIDS Coordination Committee (NACC), chaired by the Ministry of Health was established in the early 1990s. To date, however, the activation or involvement of this committee in the national response has been as a minimal oversight committee. Within the Department of Health Services, the NCASC was established as a semiautonomous centre and responsible for the implementation of the Strategic Plan for HIV/AIDS in Nepal. For the past several years the Centre has faced a fairly regular change in leadership every year and constraints in staffing. The current stability within the overall government will now hopefully provide consistent leadership and an improved number of staff for the Centre. Even with these constraints, the Centre has still implemented trainings in several key technical areas and more recently critical research among drug users. The Centre also coordinates a number of multilateral and bilateral programs and works closely with a range of non-governmental organisations, both international and national.

The HMG/Nepal Strategic Plan for HIV/AIDS in Nepal (1997 - 2001) was developed in 1998. This identified key policy areas for implementation (see Annex E). This document has largely been used as a national framework, however, its use as plan of coordinated action for the country has been limited.

At the District Level, the District AIDS Coordination Committee (DACC), chaired by the head of the District Development Committee (DDC) with member of line agencies and NGOs, is responsible for planning and implementing the District AIDS response. At a village level, the Village Development Committees (VDCs) are similarly responsible within their respective villages for HIV/AIDS planning and activities in cooperation with other local sectors.

UNDP's Development Approach and HIV/AIDS

UNDP's Country Cooperation Framework for 1997-2001 in Nepal is hallmarked by a sustainable human development focus on: poverty reduction, advancement of women, regeneration of environment; creation of sustainable livelihoods and good governance. UNDP's role in supporting decentralisation and building the capacity at district and village levels for participatory planning and implementation is central to all UNDP's projects. In addition, UNDP has strived to create linkages between policy formulation at a central or *macro* level, the capacity building at districts or *meso* level, and direct interventions at the village and community or the *micro* level. Cooperation across UNDP projects is highly encouraged. In the area of HIV/AIDS, UNDP's approach involves the establishment of linkages between governance and people- centered HIV/STD prevention interventions that are integrated in a multisectoral approach.

Other Development Assistance

UNAIDS co-sponsors each have some aspect of their programs that address HIV/

AIDS or STDs. WHO has historically provided assistance to the NCASC in the areas of technical assistance for surveillance, STD case management and counselling. WHO currently does not have a fulltime staff member addressing HIV/ AIDS issues. UNICEF's primary program addresses youth in the country, but recently it has developed a strategy in communications aild HIV/AIDS. UNDCP no longer has an office in Nepal and although some discussion about addressing harm reduction from New Delhi has taken place, no program has yet materialised. UNFPA has a program in reproductive health and is currently in negotiation with the PPM project to integrate HIV/AIDS and STDs in its training program the for village and district workers. UNDP's regional office is initiating a new program in the trafficking of women that will address cross-cutting issues relating to HIV/ AIDS. In addition, UNDP's regional HIV/AIDS program is interested in improving the involvement of persons living with HIV/AIDS. Finally, a new UNAIDS Country Program Adviser is coming to the country and his background is in Harm Reduction, a much needed expertise within the Nepal.

Other Bilateral Donors and INGOs include, USAID, GTZ, EU with the University of Heidelberg, SCF/UK, SCF/US and others. Their programs, with emphasis on prevention, range from research and surveillance to education and service delivery at a local level. Several districts are shared between programs though there could be greater technical and planning cooperation across all players.

2. **Design**

The Development Objective of the program as designed in the Project Document is the attainment of a multisectoral and community-focussed national programme for AIDS prevention in order to minimise the social and economic impact of the disease on individuals, families and communities.

The key Project Objectives identified in the project document are:

- Advocacy.
- Understanding of Risk Behaviours/Research.
- Capacity Building with National and District Level.
- Interventions through multisectoral programmes.
- Networking between organisations.

The project design identified an overarching Programme Strategy or Approach which included: providing leadership, empowering communities, multisectoral response and addressing socio-economic issues at local levels. The management of the project is through the NEX modality executed by the NCASC under the Ministry of Health, HMG/Nepal with support from the UN Office for Project Services. A project management team was developed including central and district

staff (see Annex F).

The project document identified these "End of Programme" situations as evidence of project success:

- Community based intervention programmes exist.
- Increased understanding of risk taking behaviour and its socio-economic impact.
- Increased capacity of district and village bodies to advocate, plan, implement and monitor activities.
- HIV seen as a development problem rather than just a health problem.
- Increased skills of institutions to provide technical support in research, planning. STD management, advocacy, peer education, community based condom promoting, monitoring and evaluation at district level.
- Increased involvement of the private sector in STD treatment and condom promotion.
- Increased acceptance of people living with HIV/AIDS.

3. **Relevance**

The project document clearly identified the problem to be addressed and took into account the current institutional context and donor assistance. However, since the writing of the project document the epidemiological context has shifted to include an increasing prevalence of HIV among injecting drug users which is not reflected in the

original design. Project beneficiaries are now identifying this area as a growing need. To address this emerging need, the project is well placed at the District level to respond to District requests for more information and education on harm reduction strategies (See Chapter VI).

The institutional arrangements are still appropriate and relevant. National execution with the provision of technical assistance through the project staff is still required for program implementation. However, the complexity of the NEX modality has caused some confusion with partners at times during the project. Particularly, the project staff are in a position of having two potential lines of responsibility and two potential `bosses'. It is important that there is an ongoing capacity development within all partners to understand and utilise the NEX modality to its fullest extent.

The overall design to assist in mounting a multisectoral response at District and Village levels linked to a National multisectoral strategy is extremely difficult. It is important to understand the large demands that are placed on the overall management of this project due to the advancing epidemic. There are a growing

number of persons infected with HIV/AIDS who also need strategies for support and care. As the project is successful in expanding the number of partners at a local level, the project staff at District levels have an ever enlarging number of demands for their time and expertise. It is increasingly important to understand that the project's role is in providing technical assistance for locally identified needs. The project will increasingly need to rely on facilitating technical expertise from other projects and resources to improve the technical quality of local services and responses.

IV.Operational Issues

Management Issues

There are a few operational issues that have effected the timeliness of program implementation and assistance. The signing of the project document occurred in February of 1998. During 1998, the project faced several issues that caused a number of delays in the program. Initial staffing at a district level was through United Nations Volunteers (UNV) which proved not to be an adequate arrangement. The recruitment of project staff was done between July and November to provide stability to the project. Constraints in 1998 were also due to the differences in financial calender years of the Government (July - June) and the project (Jan. - Dec.). The staff planned programs according to the Government calender, but had to implement them according to the UNDP calender year. The outcome was that the bulk of expenditures were from July to December.

In later half of 1998 there was a consolidation of District Plans and there was also an expansion of the programme to three new districts: Rupandehi, Sunsari and Makwanpur. With all of the delays, the overall expenditures for 1998 were under the planned budgets for the year (Annex G).

In 1999, the project could be summarised by 'excellerated progress". There was better coordination between the Government and UNDP project calender years and plans at a District Level were in place. There was excellerated implementation of programs and expenditures are set to reach budgetary allocations (Annex G). In addition, local District and VDC allocations increased markedly and were being utilised.

For the years 2000 - 2001 there are overall plans to reduce the project's operating budget in half. This will severely restrict the ability for the project to realise the current investments made in strengthening local response. Although, UNFPA plans to allocate $100,000 for the project, these funds are tied to improving the implementation of education strategies through FCHVs and NFEs at District and Village levels.

The review team urges that sustaining the District level commitment to strengthening

key prevention and care services will enhance the overall impact of the project and improve the long- term sustainability of local achievements (see Chapter V).

Programmatic Issues

At a programmatic level the project has faced an enormous amount of work at a District and Village level. With only two DALOs per District, they have faced a huge workload in developing the commitment of local committees in each VDC. Their efforts should be commended. In addition, the project has faced the need to develop local capacity to respond to the epidemic from the ground up. Project partners, including local authorities, private sector and NGOs, have needed to be trained on all aspects of HIV programming. In some Districts there are very few partners with the capacity to respond in a timely, flexible and innovative way. The need to develop capacity through existing partners and organizations, who often have limited capacity, will continue to be a challenge for the project at District and Village levels. The project should look for opportunities to develop services through organizations or networks that can cover a number of Villages where possible.

V. Project Performance and Results

1. Immediate Objective

Community based interventions developed for HIV/AIDS/STD prevention through a multisectoral approach.

Success Criteria:

- *60% of VDCs in programme areas have community based interventions*
- *HIV/AIDS prevention planning integrated in multisectoral programmes at District level.*
- *Increased number of partners undertaking HIV/AIDS prevention work in multisectoral setting at a National level.*
- *All school students from 8 - 10 classes in eight project districts will have HIV/AIDS/STD awareness education by year 3.*

Achievements

Local Governance Structures Increase Commitment Substantially

- VDC Coverage: 52% of a total of 526 VDCs over 9 districts are now involved in HIV/AIDS programmes (Annual Progress Report, 1999). The VDC coverage has increased significantly in 1999.
- Total Number of local NGO partners is now 104 across 9 districts (Annual Progress Report, 1999).
- Most DDCs have multisectoral Strategic Plans in HIV/AIDS. A couple district plans are five years in length.
- Eight out the nine DDCs are allocating their own resources to HIV/AIDS programmes.

•DDCs/VDCs have allocated over 4 Million Rupees during 1998-1999 which represents 27% of the total budget for HIV/AIDS programming. This local funding
represents an 800% increase in allocation from the previous year across the program.

- Local funds have been utilised primarily in community education programs.
- Almost 100% of the VDCs covered have developed workplans in HIV/AIDS.

Multisectoral Approach Expanded

- Some line agencies and private sectors are including HIV/AIDS in their training programs (eg., Women's Development Office, Department of Health, Department of Education, Department of Agriculture, District Chamber of Commerce, Commercial Industries).
- School students are increasingly becoming aware of HIV/AIDS through a range of multisectoral interventions.

Constraints

- Primary focus has been the District level due to the difficulty of instutionalizing a multisectoral response at the national level. Line Agencies have taken up activities in HIV/AIDS at a District level, however, they still do not have national guidelines to institutionalize the programs for ongoing sustainability.
- Overall, there is a need for better coordination among all implementors, especially with NGO and INGOs, at a District and Village level to improve a concerted effort and the impact of education.
- Primary focus of local strategies is information and awareness which does not provide a systematic access to prevention and care services (especially STD case management and harm reduction).

Conclusions:

The project has been able to successfully utilise, strengthen and activate the involvement and commitment of local governance structures, including DACCs, for HIV/AIDS prevention education at the District and Village level. In addition, the number of partners involved in HIV awareness activities has increased markedly in the past year. District and Village programs could run more effective HIV/AIDS programs by receiving guidelines from the HMG on their roles and responsibilities and by moving beyond awareness raising activities to provide improved access to specific prevention and care services.

2. **Output 1: Advocacy**

Advocacy undertaken with elected representatives, private sector and sectoral ministries at the national, district and village level on HIV and development.

Success Criteria:

- *50% of elected women ward members oriented on HIV/AIDS/STD issues*
- *A representative forum to advocate on HIV and development at the national level is created and functional.*
- *Advocacy training integrated into two institutions training policy makers.*
- *DACC member oriented on HIV/AIDS/STD prevention issues meet regularly*.

Achievements

Central Level

- Advocacy with the Parliamentarians from the program districts was conducted in Katmandu in cooperation with the Honourable Minister of Health and Honourable former Prime Minister Mr. Girija P. Koirala and other partners.
- Nepal Administrative Staff College has now incorporated HIV/AIDS training to selected Government personnel including policy makers and civil servants as a part of their original work with the UNDP project. It has also included people infected with HIV/AIDS in their advocacy programs.

District/Village Level

- Total of 486 elected women representatives are oriented on HIV/AIDS.
- 100% of the elected DDC members have received advocacy and orientation in HIV/AIDS.
- DACCs are meeting approximately 3 times per year on average across all Districts.
- Advocacy with the private sector industries in certain districts has improved the number of projects being implemented within the workplace.
- Advocacy and orientation has been conducted among VDC Chairman, Vice Chairman and others members totaling 1178 persons.

Constraints

- A representative forum was not considered feasible and this output was changed to the Social Committee of Parliament as a possible advocacy forum for HIV/ AIDS. This possibility will be explored in the future.
- There is still an ongoing need for advocacy at a District and Village level as some still see HIV as a health issue and infrastructure is still seen as a priority over social issues.

•The involvement of persons infected or affected by HIV/AIDS has not yet become a regular part of advocacy neither at the National nor at the District and Village Levels.

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Conclusion:

Advocacy has been undertaken to raise the awareness of elected representatives, private sector and some sectoral ministries at many levels on HIV and development. Most key influential persons know about the threat and risks of HIV/AIDS, however there remains many competing priorities and an impression that many issues are too difficult to tackle. There is now a need for more targeted advocacy with the goal to improve the acceptance, support and provision of basic prevention and care services for people infected and at risk of infection. These services could include voluntary counselling and testing, STD case management, expanded condom access, harm reduction strategies, and care and support of people infected with HIV.

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3. **Output** 2: **Research**

Increased understanding of risk behaviour with regard to HIV/AIDS/STD transmission among sexually active men and women in Nepal and its socio-economic impact.

Success criteria:

- *Report on risk taking behaviour with adolescents is available in project areas and at the national level.*
- *Data collected by community researchers on patterns of sexual behaviour and health care seeking behaviour forms the basis for planning interventions.*
- *Specific studies undertaken on socio-economic impact of HIV/AIDS/STD on industries and agriculture and disseminated to policy makers.*

Achievements

- A number of community based researchers have been trained in each district on participatory research techniques.
- Every district has initiated a community based research project and all districts are now able to recognise the risk behaviours present in their communities.
- In at least four districts (Morang, Sunsari, Doti and Syangja) research results have been compiled to inform analysis of risk in Districts and programme planning.
- In at least one district the research results could provide a basis for monitoring

behavioural change if the research was repeated in the future.

Constraints

- There has been no follow up to the initial training of researchers.
- The majority of research projects did not have programme monitoring component for

behavioural changes in mind while developing their protocols and questionnaires.

- There is need for greater analysis of health care seeking behaviour.
- Behavioural sentinel surveillance (BSS) is used by other projects to provide means

of monitoring behavioural changes and impact of the program, but this tool has not

yet been used by this project.

- Available research within the country from other partners has not yet been compiled for use by the project for planning and monitoring purposes.
- Little research by the project has been done with drug users.

Conclusions

The project has built the capacity to undertake research at a community level and in several Districts research has been implemented. Given that several Districts have not completed their research reports it is difficult to judge the overall outcome of this component. However, there is a real need for future research to not only assess behavioural risks, but also to monitor trends in behavioural changes as evidence of program impact. Secondly, this component should be expanded to address research with drug users and persons infected with HIV/AIDS as needed within the Districts. Finally, available research from other sources in the country should be utilised to inform program planning at a District level.

4. Output 3: Capacity Building

Capacity building of partner organisations at the national and district level.

Success criteria:

- *At least two academic institutions trained to provide technical support in research.*
- *At least one NGO in district provides training on social mobilisation and peer education.*
- *At least one organisation provides training on syndromic management of STDs for private sector.*

Achievements

- The capacity of all DDCs and VDCs have been improved to assess the risks of

HIV infection in their communities and to educate their communities in ways to prevent HIV/AIDS.

- Staff College developed curriculum for training community based researchers and it was implemented in all districts in cooperation with two consultants.
- A large number of local NGOs (104) across all districts are implementing community mobilisation and a,majority are focussed on peer education.
- The project has cooperated with the University of Heidelberg for TOT trainings in at least four districts for STD case management. These trainers are now training in cooperation with the HMG Health staff at a District level.
- In at least one district, Accham, there is a network of counsellors, health workers and community workers developing counselling centres to address care and support of people infected with HIV/AIDS.

Constraints

- Training for STD case management has not been completed in all districts.
- There has been a lack of specific training in harm reduction strategies.
- There is a growing need for training in the area of care and support activities including the linkage of counselling and testing.
- The private sector health services including chemists are not included in district level trainings.

Conclusions:

Capacity building has taken place with the local governance structure in general awareness, local community researchers have increased skills, and in limited areas there has been training in STD case management and counselling. Capacity building now needs to be more targeted to provide skills at a District and Village level for specific prevention and care services. The project should continue to utilise expertise from other partners and NGOs with skilled experience to provide training in STD case management, harm reduction strategies, counselling and care and support of persons infected with HIV/AIDS.

5. Output 4: Interventions

HIV/AIDS/STD prevention interventions focussed on vulnerable men and women integrated into multisectoral programmes based on international and national best practice.

Success Criteria:

- *60% of all VDCs in programme districts undertake community based interventions focussed on sexually active men and women.*
- *At least three industries initiate workplace interventions.*
- *Media policy for reporting on HIV/AIDS/STD developed and operational.*

•*Increased number of condoms distributed by partner organisations.*

Achievements

Increases in Awareness across the District

- The majority of VDCs are involved in community based education on HIV/ AIDS prevention with sexually active men and women.
- There continues to be increased awareness within the community about HIV/ AIDS and STDs and their modes of transmission and means of prevention.
- More than three industries have initiated workplace interventions education which address HIV/AIDS with the assistance of NGOs (eg., Birgunj sugar industries, Sunsari factories, Rupandehi industries).
- Six out of nine Districts have completed media training. Other partners (e.g., Johns Hopkins University) are focussing on national level training for media.
- The overall results of the interventions are that more people are willing and able to discuss sensitive issues about HIV/AIDS including sexual practices and drug use at a Village and District level.

Constraints

Behaviour Change Communication

- Although messages provide information and education, strategies which empower changes in social and behavioural norms in sexual relations and drug use have yet to be achieved.

Condom Availability and Promotion

- Condoms are not readily available in rural areas except in health posts. In addition, even in urban areas condoms are not readily available in the evening when shops are closed.

STD Case Management

- There is still a need to improve the access to properly trained STD case management.
- There is still a need to improve knowledge about where to go to get the symptoms of STDs treated.

- There are some constraints concerning access to drugs for treatment of STDs.
- Women find it difficult to go to male health workers for STD diagnosis and treatment.

Harm Reduction Strategies

- Although there are five Districts that have identified drug use as a major risk for their community, there are extremely limited number of programs in harm

reduction currently being funded by the project or the local governance structures.

Support to people with HIV/AIDS

- Very few people have been trained in counselling and care in all Districts. Meanwhile facilities capable of testing blood, including private sector laboratories and blood banks, are not equipped to tell people that they are infected.

Income Generation for People with HIV/AIDS

- There is only one organisation of PWHA that is in the process of developing in Katmandu. Its membership is 200 PWHAs. It suggests that beyond counselling and support its priority is providing access to work to provide an income for their families.

Conclusions

The project is aimed at developing a multisectoral response through local planning and implementation and to initiate community based interventions on HIV/AIDS/ STD to minimise the socio-economic impact of disease on individuals, families and communities. Internationally it has been shown that to reduce the burden associated with communities at risk or affected by HIV/AIDS, it is essential to have access to sexual health services, condoms, harm reduction programs, counselling and testing and non-discriminatory care and support for persons infected with HIV. All partners at local levels need to move beyond awareness and advocacy and improve the access to these services at District and Village levels.

6. Output 5: Networking

Networking between various organisations working on HIV/AIDS/STD prevention on cross border issues (national and international) lead to better access to sexual health services by vulnerable sections of society.

Success Criteria:

- *Linkages with projects dealing with migratory men and women from project districts developed nationally.*
- *Dialogue held between key programme implementors from Nepal and other countries where Nepalese reside.*
- *Field visits undertaken by policy makers to different projects dealing with migratory men and women from Nepal.*

Achievements

- Key policy makers from the District levels have visited other districts with more advanced programs to see the potentials for their districts.

•Some migrants in India have received letters and greeting cards from their families,
DDCs and VDCs making them aware of the epidemic and safer sexual practices.
- Last year the TPR was held in the field for program policy makers to get a sense of
the progress and issues faced in implementing and HIV/AIDS project.

Constraints

Coordination is Needed

- There is a lack of coordination between organisations nationally and in addition there are no national projects that deal with migratory people to network with.

International Cooperation is Needed

- International linkages with Indian organisations that could potentially have access to Nepalese residing are not yet established except the recent meeting in Kuala Lumpur/Bhutan for the National Program Director during Asia regional HIV/ AIDS meetings.

- Cross border discussion from the District level cannot occur without Ministerial initiation of discussion with Indian counterparts.

Conclusions

This component has begun to address linkages with migratory men in India through innovative strategies including letters and communications. However, a strategic approach through regional meetings to improve the access to prevention and care services for Nepalese residing outside Nepal has not yet taken place. This project could work closely with UNAIDS and the Theme Group to coordinate a regional meeting, that

includes District level key policy makers, between Nepal and projects in Mumbai, to specifically address sexual transmission, and in Manipur to learn about harm reduction policy and strategies. Cross-border meetings that could provide a forum for the development of cooperative strategies at a District level with India could be initiated by the NCASC. To improve networking across Nepal itself, the project should work closely with the NCASC and UNAIDS to respond to the request to improve national planning and coordinated implementation of a new national plan of action.

VI. Additional Issues

Collaboration with other UNDP projects

The review team witnessed that collaboration with other UNDP projects is currently underway within some Districts. For instance, in Syangja, collaboration between the PPM and SAPAP has clearly been beneficial to expand awareness throughout a number of VDCs where SAPAP is working. In addition, collaboration in Rupandehi between PPM and PDDP has allowed for the HIV/AIDS program to utilise the social mobilisation programs developed by the PDDP. Other program collaborations are occurring in Accham, Dadeldhura (REDP and PDDP) and Sunsari (LGP). The result has been a quickened response and incorporation of HIV/AIDS activities and improved awareness. Future cooperation should not be focussed on expanding to other Districts in the next two years, but rather explore strategies to provide more indepth services including but not limited to access of loans for vulnerable populations, such as migratory families and persons infected with HIV/AIDS, to provide income.

Collaboration with UNFPA

The proposed additional funding and activities from UNFPA for expansion of the UNDP project will help the project. These funds are aimed at improving the capacity of FCHV, TBAs and VHWs to strengthen the link of the project with the existing Health Service Delivery structure and with the NFE to reach the community through non-formal education. This improved education and awareness must be linked with improved access to health services that will treat STDs and care for those infected with AIDS. Training to the existing health service delivery workers should cover universal precautions, the recognition of STDs and management of STDs, HIV/AIDS related illness and home based care. The project needs to strive to provide strong linkages between the Family Health Division and the NCASC in this regard.

Technical Assistance

Technical assistance from the project to the District and Village level has been adequate to accomplish an education and HIV/STD awareness raising program. Senior DALOs and DALOs, many having limited prior experience in HIV/AIDS, were trained to provide technical assistance to programs that are being implemented at a local level. With increasing demands, it must be realised that DALO's jobs should be primarily in the area of coordination and planning of technical assistance.

Now the programs in the field need technical assistance beyond general awareness raising to capacity building in specific technical fields covering prevention. services and care. The number and range are described in Annex H. Overall, the project teams do not

have the experience in all these technical fields to provide timely and adequate assistance. The PPM must therefore rely on and manage the assistance from other partners including the Government, INGOs and local NGOs with greater expertise in these technical areas.

Staff Development

Although the first infections of HIV/AIDS in Nepal were in the 1980s, development of a comphrensive, multisectoral response to AIDS is relatively new. For instance, harm reduction strategies are implemented by only a few people in Nepal. In addition, the experience of counselling and testing for HIV/AIDS is very new to Nepal. Finally, due to the multisectoral nature of HIV/AIDS it is never possible to have staff trained in all areas of program and technical expertise from human rights and legal reform to health services and marketing of condoms. While the project will continue to utilise expertise from other partner organisations in key technical areas relating to HIV, it is necessary to continue to develop staff expertise, including staff from the NCASC, in these key technical areas as well.

Monitoring the Project

The original project design had only a limited number of success criteria to measure the impact of the project on meeting the goal of the program. Due to increased progress in the last year, a number of the success criteria have been met or will be met within the next year. However, additional areas for further depth and focus should be incorporated within the monitoring framework for the project. These should include:

- Improved capacity for counselling and testing services at a District level;
- The number of Health post and Sub-Health post trained in STD case management;
- The number of harm reduction programs in Districts with drug users;
- The number of home based care education programs in Districts.

Finally, ongoing support for the involvement of the NPD in monitoring the progress and outcomes of the project at a District level is necessary. The NPD has the important capacity and role in advocating for the National Policies at a local level. The involvement of the NCASC is necessary for ongoing technical input into the project. Monitoring visits should occur on a quarterly basis to at least one district and coordinated where possible to allow other line ministries to be involved in site visits. This will improve the connection and cooperation between the Center and District/Village levels.

Sustainability

The overall design of the project is suited to improving the sustainability of responses at local levels given the involvement of the DDCs and VDCs. Local allocation of time, funding and human resources are measures that the project has laid the groundwork for sustainability, especially in the area of general awareness and education programs.

VDCs are particularly well placed to sustain their programs in the absence of project

related funding. Nonetheless, the epidemic is relatively new to Nepal. The country is facing a changing epidemiology with increasing number of IDUs rapidly becoming infected. In addition, communities are experiencing an increasing number of persons infected, in need of care and dying. The country is moving into a new phase in relation to the epidemic. There is a strong local need for increased skills to address these emerging issues. Prior to expecting that prevention programs can be sustainable increased capacity must be built to address the provision of prevention and care services at local levels.

VII. Lessons Learned

Local Organizations Can Be Mobilised to Respond to HIV/AIDS

The fact that local DDCs and VDCs have developed strategic plans and allocated their own resources for HIV/AIDS shows that they can be mobilised to respond to the epidemic. This has included a change in resource allocation to some extent away from regular priorities towards the emerging threat of HIV/AIDS. This change in resource allocation often reflects new thinking for some local VDCs about the priorities that they see for their communities.

Synergism Across UNDP Programs Can Improve Efficiency

The collaboration across the UNDP projects to improve education and to utilise existing social mobilisation groups have shown that excellerated implementation of education programs can occur. In several Districts where close association is occurring between UNDP projects there has been improved acceptance and integration of HIV/ AIDS and STD education into ongoing programs. In some areas resources are being shared is occurring on the human, technical and institutional level. This cooperation has improved the efficiency and effectiveness of the responses.

Greater Depth Required

The key lesson learned from this project is that education and awareness alone is not adequate for changes in behaviour and access to prevention and care services. Institutional and community mobilisation, analysis of risk and awareness of prevention methods lays a firm ground work for effective HIV/AIDS programs. To minimise the social and economic impact of the disease a greater depth of access to prevention services is now required.

The Prevention and Care Continuum

The most effective HIV prevention strategies include people who are infected with HIV/AIDS. To include individuals already infected non-discriminatory care and support programs have to be available. The care and support continuum includes access to harm reduction strategies, STD case management, counselling and testing services and ultimately a community based strategy for care of persons sick and dying and support to their families. Nepal is experiencing a growing number of people infected

and dying with HIV/AIDS. Without an increase in services for people infected the awareness/prevention programs in Nepal will not be successful. There needs to be a multisectoral strategy that will allow greater involvement of people with HIV/AIDS in prevention programs and a greater availability and utilisation of care and support services. The UNDP project is now experiencing greater demand for a depth of services along the prevention and care continuum (Annex H). The project is well placed to facilitate technical assistance from qualified organizations in each of the technical areas along the continuum and to build local capacity to provide these services.

Harm Reduction

It is clearly recognised at a National, District and Village level that injecting drug users are increasingly vulnerable to HIV infection. In addition, the infection rate in IDUs will have a direct impact on the wider community. There are still a number of constraints within the Government to mounting a comprehensive approach to reducing the harms associated with injecting drugs. Nonetheless, NGOs and private sector Organizations are implementing harm reduction strategies and have shown that they are tolerated by the wider community. There is a lack of understanding among most partners about the range of services provided within a Harm Reduction Approach (Annex I). The PPM must strengthen the linkages between with national partners, including the NCASC, UNAIDS and LALS with the local organisations at a District and Village level. The aim of this approach should be to improve the understanding of Harm Reduction and to strengthen the capacity for implementing harm reduction strategies at a District/Village levels.

Counselling and Testing

Testing for HIV should always be considered an opportunity for prevention education. Testing for HIV is currently undertaken in blood banks and at private laboratories in the Districts. No counselling facilities were available in the Districts visited by the review team. Labs and blood banks are not equipped with the practical skills to counsel individuals about their status even though some have been trained to do so. Recruitment agencies or agents bring individuals to private labs to get a HIV test. The lab personnel do not counsel the individuals about their status or risks when they travel. They inform the recruiter who then decides for himself about what to tell the person infected. In addition, equipment for laboratory testing is currently not available in the Government health network. Therefore, locally defined strategies to link existing testing facilities (private labs) with proper counselling and support services are needed. Counselling is often best placed in NGOs or community based organisations with a commitment to care.

Gender and HIV/AIDS

The project has experienced that women's involvement, concern and commitment to responding to the HIV/AIDS epidemic is strong. At local levels, women have been

empowered to learn, teach one another, seek STD treatment and access condoms. However, in an epidemic spread by heterosexual transmission, women have little negotiation power and are extremely vulnerable due to the behaviour of men. The project has provided forums for discussion about gender inequities and has improved the confidence and ability for women to express their concerns, fears and needs. However, increased prevention and care services that address the needs of women are necessary for real empowerment of women in the face of HIV/AIDS. Syndromic STD treatment protocols do not address the majority of women who are infected with an STD because they have no symptoms. This is true across the world. Women are left with the need for primary prevention of STDs which means condom use. Ultimately the majority of decision makers in sexual relations are men and a condom can only be worn by a man. Realising greater `gender equity' in HIV/AIDS programs then requires that men's involvement and ultimate behavioural responsibility must be central to successful prevention and care programs in a heterosexual epidemic.

In addition, there is growing evidence in the country that one of the highest risk factors for female sex workers in Nepal is having been in Mumbai. The trafficking of girls and women is having a direct effect on the advancement of the epidemic in Nepal. UNDP Regional Programme is developing a project in trafficking. Linkages between the trafficking project and the District level programme is necessary, especially in the West.

VIII. Recommendations

Overall, the following recommendations should be seen in the context of the currently developed District Strategic Plans and locally identified needs. The goal of the next two years should be to make the District Plans operational, with a focus on improving the local capacity to provide prevention and care services, while continuing to support national and international cooperation.

Local Development Strategy with Enhanced Focus on Improving Services

1. The original strategy of PPM to mobilise local community based programs is correctly aligned and will provide the basis for the future. Several local plans identify the need for moving beyond awareness raising. The main focus of the program should continue to be implementation, however, moving beyond IEC to improving behaviour change communications while devloping local capacity to offer increased access to prevention and care services.

Strengthen Depth not Breadth

2. The project should complete its expansion of basic education to the rest of the

VDCs in their current Districts. However, the project should not expand to additional Districts until District Strategic Plans are operationalised. Based upon District priorities, the project should ensure demonstrated improvement of the quality and availability of prevention and care services within the current 9 Districts.

Improve Access to Condoms

3. Local innovative strategies to improve condom promotion and distribution should be expanded to allow easy access for people engaging in high risk behaviour, (eg., condom boxes in pubs, hotels, factories and distribution through peer education networks including youth).

Improve STD Referral and Case Management

4. Strengthening the referral system for STD case management will continue to improve access to STD care and management. Provision of training for STD referral should be completed with chemist and medical shop owners. In addition, the already planned training in STD case management should be completed with Health Assistants and Auxiliary Nurse Midwives at health posts and the Auxiliary Health Workers at the

subhealth post level. STD case management should be integrated into current primary health care services.

Address the Emerging Epidemic in IDUs

5. Advocacy and trainings in harm reduction strategies at a District and Village level should be conducted with key partners. Implementation of harm reduction programs should be a priority for integration and strengthening over time especially in Districts on the border of India.

6. Research needs to be broadened to address the rapid increase of HIV prevalence among IDUs. Future local research should include an increased understanding of the risk behaviours and potential harm reduction strategies associated with injecting drugs where IDUs are present.

Enhance Counselling, Testing and Support Services

7. A greater access to care and support services including voluntary counselling and testing is required to improve the overall effectiveness of the current prevention efforts. District programs should develop cooperative counselling and testing services with private laboratories, NGOs and other private sector partners to improve the effectiveness of prevention and care strategies.

Develop Care and Support Services for People Infected

8. Discrimination for people living with HIV/AIDS will only be reduced when

communities see that caring and supporting persons with HIV/AIDS is not dangerous.

Training the existing village based health network and NGOs in home based care is

necessary for developing community based strategies for people infected with HIV/AIDS.

Provide Access to Income Generation for People at Risk or Infected with HIV/ AIDS 9. Pilot projects in cooperation with other UN programs should be tested to provide people with HIV/AIDS access to credit and skills in income generating projects.

Cooperation with Programs with Specific Technical Expertise

10. The PPM project and staff should continue to see their role as facilitators to technical expertise to improve local responses. The management and utilisation of expertise from other organisations and projects should be enhanced to improve the technical quality of programs and services at District and Village levels (STD case management, harm reduction, counselling/testing, involvement and support of PWHA).

Monitor for Measurable Outcomes

11. Research should be conducted and compiled to be used as a monitoring tool to assess behavioural change within the subjects of the research (including condom use, STD health seeking behaviour, harm reduction strategies, gender relations). Implementation of a Behavioural Sentinel Surveillance would allow the project to

assess behavioural change at a local level and feed results into surveillance at the national level.

12. Project management should support the greater involvement of NPD and other line agencies to conduct regular visits to the Districts to improve the cooperation and impact of National/District and Village connections.

Target Advocacy Efforts

13. Advocacy now needs to be more targeted to improve the acceptance and implementation of best practices for behavioural change depending upon the requirements within the District or Community. The following areas are key for improved advocacy:

- Understanding national HIV/AIDS policies at local levels
- Involvement of people infected and affected with HIV/AIDS in advocacy and education and where appropriate.

•Sex and drug education with youth
- Gender, the involvement of men and empowerment of women
- Condom use and social acceptance
- Harm reduction strategies
- Private health sector and chemist involvement in STD case management
- DDC allocation of local staff to the program

Enhance Local Coordination

14. DACC and DALOs must have full information about other INGO working in HIV/AIDS in their Districts. DACCs should be encouraged to have local networking meetings with all organisations working in their Districts.

Sustain Funding for Focused Intervention Services

15. Next year the project's budget is decreasing in half. This is being supplemented by UNFPA to improve education and referral services with the existing health service structure. However, funding levels to District level contracts should be sustained to provide additional capacity building and implementation of specific services including: STD case management, Counselling, Testing and Care, Harm Reduction. The priority of services should be based upon local decisions.

Cross Border Strategies

16. Cross border meetings at the District level should be facilitated by the NCASC and the project to define priority interventions for crossborder issues (eg., counselling centres/STD services).

Access and Utilise Regional Expertise

17. The project should utilise the regional email (sea-aids) program to gain access to organisations in other countries working with Nepalese.

18. The project should cooperate with the NCASC and UNAIDS to provide study tours for policy makers including representatives from the District level to areas of India. For example, Mumbai for access to migrant Nepalese and Manipur for exposure to a state with a policy and program in harm reduction strategies.

Support National Planning and Coordination

19. At a national level the project has been requested to assist the Government in developing a National Plan of Action for HIV/AIDS. This assistance should occur by supporting UN involvement through cooperation within the UNAIDS framework and with the NCASC. The project is well placed to facilitate the involvement of the DACCs and some VDCs so that the National Plan of Action reflects the needs and programs from the grassroots level. The project should also facilitate central Line Agency involvement in the national planning process.