Alessandra

PROJECT OF HIS MAJESTY'S GOVERNMENT OF NEPAL WITH THE COOPERATION OF THE GOVERNMENTS OF AUSTRALIA, THE UNITED KINGDOM, UNITED STATES OF AMERICA AND UNAIDS, UNDP

Assistance for an expanded rights-based response to the concentrated HIV/AIDS epidemic in Nepal

Project Document

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Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
AusAid	Australian Agency for International Development
BCC	Behaviour Change Communication
BCI	Behaviour Change Intervention
BSS	Behavioural Surveillance Survey
CBO	Community-Based Organization
DFID	Department For International Development
EC	European Commission
FES	Focused Ethnographic Studies
FHI	Family Health International
FSW	Female Sex Worker
GON	Government of Nepal
GPA	Global Programme on AIDS
HIV	Human Immunodeficiency Virus
HMG	His Majesty's Government
IEC	Information, Education and Communication
IDU	Injecting Drug User
INGO	International Non-Governmental Organization
MoH	Ministry of Health
NCASC	National Centre for AIDS and STD Control
NHRC	National Health Research Council
PHSC	Protection of Human Subjects Committee
SCF	Save The Children
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TWG	Technical Working Group
USD	United States Dollars
VCT	Voluntary Counseling and Testing
WHO	World Health Organization
UNAIDS	United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Fund
USAID	United States Agency for International Development

A CONTEXT

A.1 Description of the Sub - sector

The official figures in Nepal show a cumulative total of 1,703 HIV positive cases as of September 30th 2000[1]. Of these, 415 have progressed into AIDS. The actual number of people with HIV/AIDS in Nepal is, however, much higher. The WHO/UNAIDS[2] estimates by the end of 1999 approximately 34,000 people were living with HIV/AIDS in Nepal, and that in 1999, 2,500 AIDS-related deaths had occurred.

Compared with other countries in Asia and the world, available epidemiological data suggests that Nepal can be considered a low prevalence country. However, this low population prevalence masks increasing prevalence in several groups, and new epidemiological data suggests that HIV may be increasing more rapidly than expected in certain sub-groups. In fact it is now apparent that Nepal has entered the stage of a "concentrated epidemic", i.e. the HIV/AIDS prevalence consistently exceeds 5% in one or more sub-groups. These include injecting drug users nationwide, female sex workers in urban areas, and returning sex workers from India.

The dynamics of the epidemic are especially dramatic in the Katmandu Valley where HIV/AIDS prevalence was 2% or below among female sex workers (FSWs) and injecting drug users (IDUs) in the mid-1990s. It now exceeds 50% among IDUs and is approaching 20% among FSWs, and is over 70% among FSWs who also report being IDUs. Without effective interventions in Nepal, it is predicted that there may well be a generalized epidemic by the end of the decade with an estimated sero-prevalence of 1-2% in the age group 15-49 years. This would make AIDS the leading cause of death in this age group.

The dynamics of the epidemic follow a predictable pattern of a rapid increase in the most vulnerable groups (e.g. FSWs and IDUs), then a spread via "bridge populations" (e.g. clients of SW, partners of IDUs) into the general population (e.g. partner/wives of clients). The window of opportunity to contain the epidemic in the most vulnerable groups in which it is currently concentrated and to prevent a generalization of the epidemic is closing very quickly in Nepal.

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

[1] NCASC, September 2000
[2] WHO/UNAIDS, Global Report, June 2000

Sexually transmitted diseases (STD) also form a significant part of the epidemic. It is estimated that 200,000 episodes of STD occur annually in Nepal. The STD prevalence rate in women is about 4.7% ranging from 2.7% - 5.4%. Access to STD services is still very poor, especially for women. In addition, the use of condoms for effective infection prevention is not yet commonly known or accepted. Similarly, condoms contributed to only 1.1% of the total contraceptive prevalence rate. More permanent methods of contraception are emphasized which puts women at a disadvantage while negotiating condom use for infection prevention.

As the development of the epidemic was taking a dramatic turn in the last three years, neither the public sector, nor communities were prepared to address the needs of marginalized and stigmatized groups, whose access to services and information was already restricted. Denial of the seriousness of the epidemic is still common, and recent data[3] show a very low level of HIV awareness and risk perception, especially among women. Moreover, the social and political environment needed for successful interventions is far from supportive. Common reactions include stigmatization and exclusion, which inhibit effective targeted risk and harm reduction interventions.

A.2 Host Country Strategies

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

HMG/Nepal adopted a national policy for AIDS prevention, with 12 key policy statements, in 1995. In 1993, HMG/Nepal accepted the need for multi-sectoral involvement for AIDS and STD control and different focal points were appointed in various sectoral ministries. However, due to frequent political changes neither the National AIDS Coordination Committee, nor the multisectoral coordination and cooperation was fully functional.

The National Policy includes: priority to HIV/AIDS and STD prevention programmes, the need for a multi-sectoral and decentralized response, the acknowledgment of NGO implemented programmes, coordination, evaluation, services for people living with HIV/AIDS, a non-discriminatory approach, confidentiality for test results, and blood safety. The National Centre for AIDS and STD Control (NCASC) was formed within the department of Health for the implementation of the AIDS prevention programme. Policy guidance for the NCASC comes from the National AIDS Coordination committee.

[3] UNICEF 1994-1999

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

In light of the fast changing epidemic, HMG/MoH embarked on an update of the national strategy[4], based on a situation and response analysis. Although the process is not yet finished, it is clear that the future strategy must define priorities and key-strategies, targeting the most vulnerable groups in order to prevent a generalization of the epidemic. In other words, HMG together with its partners, faces the challenge to effectively address the concentrated epidemic in the quickest possible way – and, against the background of limited resources, also in the most efficient way.

A.3 Prior and Ongoing Assistance

A number of donors, multilateral, bilateral and international NGOs are now supporting and promoting various kinds of initiatives aiming at preventing the spread of the epidemic in Nepal. The interventions are mainly in the area of targeted interventions for vulnerable groups, IEC, condom promotion, STD control, testing and counseling, surveillance, and operational research.

Between 1990-99, the UN System supported the National Response in Nepal with approximately US$ 5 million. This included capacity building, integration of HIV/AIDS into reproductive health services, support for a decentralized response at district and village level, and IEC.

WHO

Before December 1st 1996, WHO was supporting the NCASC through the extra budgetary funds available through the Global Programme on AIDS (GPA) of WHO. Since then WHO has been providing support through country budgetary funds allocated for Nepal. The main areas of WHO support are in the areas of training, surveillance, health promotion, STD case management, and care and support.

UNICEF

UNICEF is currently in the process of defining its role in the area of AIDS prevention in Nepal. UNICEF wants to include HIV/AIDS into its ongoing programmes and is at present piloting interventions targeting adolescents (peer education, school based IEC, media). Youth and Women are the key focus areas for UNICEF's worldwide inputs to HIV/AIDS/STD control and providing support to communication.

UNFPA

[4] expected end December 2000

UNFPA has integrated HIV/AIDS/STD prevention messages in the various reproductive health programmes. UNFPA provides for the bulk of the condom programming at all levels of the health delivery system. It also contributes to the essential drugs at the health centre level. HIV/AIDS/STD prevention messages have been included in the IEC materials produced for reproductive health. HIV/AIDS has also been incorporated in the population education programme both at the formal and non-formal sector.

UNDP

UNDP is implementing an HIV/AIDS project in 9 Districts aiming at a better district and village response. The five major areas of intervention are: (1) Action oriented data gathering (research), (2) Capacity Building, (3) Advocacy, (4) Interventions with vulnerable community groups (multi-sectoral interventions) and, (5) Developing linkages with various projects on cross borders (nationally and internationally) for accessing services (networking).

USAID

Beginning in 1993, USAID has emerged as the strongest player supporting HIV/AIDS prevention in Nepal. The bulk of the programme is working through the NGO sector with some input to the NCASC. The main focus has been work in sixteen Districts on the Birgunj - Katmandu highway and along the east- west highway. USAID also supports the national condom social marketing programme across the country.

European Commission

The EC initiative essentially is providing STD services to the HIV/AIDS prevention programme. The programme has been subcontracted to Heidelberg University. Key areas of support are training of health care providers, chemists and pharmacists on syndromic STD case management, and sentinental surveillance.

International NGOs (INGOs)

Several INGOs are working in the area of AIDS prevention in Nepal. Most of them implement their programmes with funds received from various donors. Prominent among them are: AIDSCAP/Family Health International (FHI) Nepal, Save the Children/US (SCF/US), Save the Children/United Kingdom (SCF/UK), CEDPA, UMN, Asia Foundation and Redd Barna. Many of them act as intermediary organizations and further subcontract the work to local and national NGOs. Although in terms of financial and human resources, the international assistance has contributed substantially to the national response, interventions have been spread all over the country, thus preventing an effective targeted response with high coverage.

The UN Theme Group on HIV/AIDS in Nepal committed itself in 1999 to develop an integrated workplan by the end of 2000, and expanded its technical working group in order to support national coordination efforts. The main objective of this phase was to facilitate the establishment of partnerships among multilateral, bilateral, INGOs and local partners. The intent was to better focus on the priorities regarding the spread of HIV/AIDS in Nepal, but at the same time to foster an understanding of underlying issues ("development context") and to embark on an expanded response.

A.4 Institutional Framework for the Sub-sector

In an effort to strengthen the implementation of the national HIV/AIDS prevention and control strategies, the Ministry of Health formed the National AIDS Coordination Committee (NACC) and related sub-committees. The Minister of Health chairs the NACC and its membership is composed of the secretaries of various ministries, the UN as well as representatives of NGOs working in the sector. The NACC, together with its various appointed sub-committees, provides technical and policy support to the National Centre for AIDS and STD Control (NCASC).

The Centre is part of the Department of Health Services where the project director reports to the Director-General of Health. The structure of the NCASC divides responsibility for dealing with the disease into three main sections. The Technical Section is responsible for surveillance, technical assistance, research, planning supervision and evaluation of health workers. The STD Section concentrates on control of STDs including infection with HIV and has responsibility for condom promotion. The Preventive Section has subsections to address IEC, training, counseling and NGO coordination.

As the Ministry of Health is leading the response, HIV/AIDS is still perceived as a "medical" issue with limited involvement of other ministries. Moreover, the NCASC traditionally had more of an implementing role and its limited capacity is absorbed in various activities, creating an obstacle to its management (coordination) functions. The NCASC cooperates closely with a number of individual, externally funded projects (e.g. the University of Heidelberg's STD programme, USAID/FHI's programme focusing on female sex workers (FSW) and truck drivers in the Terai) and INGOs.

Overall, competing priorities, limited coverage, and weak multi-sectoral coordination and cooperation characterize the national response to HIV/AIDS. Together with frequent changes of key-personnel in the NCASC, this has led to a delayed and scattered response. On the other hand, experience and competence has accumulated over the years in local and international NGOs, and multilateral/bilateral supported programmes in Nepal. One of the challenges in a future institutional setting for a national response can therefore be seen in better utilizing the capacity and competence of development partners, while at the same time developing the respective national managerial capacity and competence to effectively coordinate an expanded response.

B PROJECT JUSTIFICATION

B.1 Problems to be addressed

The latest estimates indicate that there are between 30,000 and 40,000 people living with HIV/AIDS in Nepal[5]. Until recently, the HIV/AIDS/STD prevalence among certain high-risk groups in Nepal was relatively unknown. In the last three years Family Health International (FHI) supported behavioral and HIV/STD prevalence studies among FSWs and truckers in the Terai, and among FSWs in Katmandu. Last year, the National Center for AIDS and STD Control (NCASC) also commissioned a national HIV/STD prevalence/behavioral study among injecting drug users (IDUs). Key findings include:

- Among all IDUs in Nepal (estimated number 30,000), approximately 40% are HIV positive, and among IDUs in Katmandu (estimated 15-20,000) the rate increases to around 50% [6]. In addition, the most recent survey of 300 female Katmandu sex workers[7] revealed that 15 self-reported ever having injected drugs, representing 5% of the total sample. However, of these 15 women, 11 were found to be HIV positive.

- In this same seroprevalence survey in Katmandu, 52 out of 300 FSWs (17%) were HIV positive. A mere four years ago, in 1996, HIV prevalence among Katmandu FSWs was 2.7%. These data also suggest a strong link between HIV and STDs. Among the 300 FSWs in this study, 58 women (over 19%) had untreated syphilis. Of these 58 women with untreated syphilis, 15 (25.8%) were HIV positive. Of the 242 women negative for untreated syphilis, only 37 (8.9%) were HIV positive. The total estimated number of FSWs in the Katmandu valley is between 7,500 and 10,000.

[5] WHO/UNAIDS, Global Report 2000.
[6] NCASC. 1999
[7] Family Health International, May, 2000

- Among a sample of 400 FSWs in the Terai, 16 (3.9%) were HIV positive and 77 (18.8%) had untreated syphilis[8]. Two statistically significant correlates for HIV infection were having worked in India, especially Mumbai, and having untreated syphilis. Of 16 women who reported working in Mumbai, half or 8, were HIV positive. Among the 400 FSWs in this study, 9 of the 77 (11.7%) women with untreated syphilis were HIV positive. Only 1.3%, or 4 out of 333 women without untreated syphilis were HIV positive.

- Most recent data from ANC sentinental surveillance sites (N=2,030) indicate that the overall seroprevalence among the general population remains relatively low at 0.2%[9].

These data indicate that Nepal has passed from being a "low risk" country to being one with a "concentrated epidemic", that is, one in which HIV prevalence is consistently over five percent in one or more defined sub-populations. In Nepal, core subgroups are found among IDUs nationwide and FSWs in Kathmandu and the Nepal-Indian border.

These populations represent a potential epicenter for the diffusion of the epidemic to the general community. The time frame for generalizing may be as short as 3-5 years, based on the progress of the epidemic elsewhere. However, there exists a "window of opportunity" for an immediate response to contain and control HIV/AIDS within the groups represented in the concentrated epidemic in Nepal, and to prevent its spread to the general population.

Experience elsewhere also conveys one especially salient fact. No matter the merit of the initiative, failure to respond at a sufficient scale, i.e. reaching 80% or more in the high-risk groups, will have little or no impact on the course of the epidemic. Nepal is at a turning point. It can respond now, at a scale required to control the epidemic and to impede its spread to the general population. Nepal has to respond to this situation with an "emergency" approach addressing the immediate needs of these groups, but at the same time recognizing the broader (development) issue of HIV/AIDS. These issues include poverty, gender inequality, and reproductive rights.

This project is a "first" phase, addressing the urgent risk and harm reduction needs of FSWs, their clients and IDUs focused on the Kathmandu valley. It builds upon the foundation USAID has laid in supporting formal research, targeted interventions and capacity building in Nepal. This phase will bridge the time needed to develop a broader, expanded response for these groups by supporting advocacy, research and the design, but at the same time trying to increase coverage of services.

The key issues that this project will address are:

[8] Family Health International, 1999
[9] University of Heidelberg, 1999

Advocacy: In order to create a supportive environment for focused interventions, advocacy at all levels is a priority to reach a level of understanding and commitment necessary to address the needs of the most vulnerable groups and to enable behaviour change. Advocacy will focus on decision-makers and community leaders to encourage acceptance and support for harm and risk reduction interventions, and on the society at large. This requires an effective, focused advocacy strategy directed towards policy makers and gatekeepers in the community. The ultimate objective is to create an enabling environment for subsequent HIV harm and risk reduction initiatives.

Research: Too little is known about the behaviour determinants of the so-called "high risk groups", including clients of FSW such as their actual numbers, group dynamics, and needs. On the other hand, limited information exists regarding the capacity and competence of organizations currently working with these groups. In order to scale-up and expand the response, a "research cum intervention" approach will be used to obtain the necessary information about behaviour change products, the environment, needs, and the actual required capacity to address harm/risk reduction, while at the same time providing identified services to the target population.

Services for IDUs and FSW: The project will seek to expand the HIV harm and risk reduction services for FSW, their clients and IDUs. Components of harm/risk reduction already identified include behavior change communication, social marketing of condoms and harm reduction equipment, STD treatment, access to clean needles and syringes, and substitution therapy. At the same time "support" services such as counseling and care and support, will have to be established. The target population for expanded service delivery will be within and outside the Kathmandu Valley, as appropriate. This implies increased capacity building and information, education and communication.

Capacity building: The project will support a focus on capacity building within the government structures responsible for the national response in order to ensure leadership, sustainability, and effective coordination and cooperation among all actors.

Design of scaled-up interventions: The ultimate challenge in responding to a concentrated epidemic is to reach behaviour change coverage of at least 80% in the affected groups. The main issues in this respect are:

- The right "mix" on behaviour change products. Different sub-groups will have different needs, and as long as these needs are not recognized and addressed, high coverage is not possible. In combining (offering) different products for harm/risk prevention, more members of the target groups can be reached.
- The need for capacity building. To reach several thousand people with services and behaviour change messages, capacity is needed on a much larger scale. The challenge will be to design a system that can provide the needed quality services with available or appropriately increased human resources.
- Marketing: Even if behaviour change/harm reduction products are defined, the real issue will be a successful "marketing" strategy to reach as many clients as possible. This implies an effective management system which will act in a timely and coordinated fashion.

- Partnerships: The resource demand for scaled-up interventions is high and calls for partnerships of donors and local actors. New ways of approaching this issue have to be developed and effective partnership mechanisms with common management procedures will have to be established.

Monitoring and Evaluation: The rapid increase in seroprevalence among FSW and IDUs went unnoticed, as no effective surveillance systems were in place to inform the national response about these sudden changes. Monitoring and evaluation systems will be needed to follow the epidemic, to monitor the impact of respective interventions, and to allow timely action as regards strategy and methodology to prevent a fast spread to the general public.

B.2 Expected End of Project Situation (12 months)

The implementation of this project is expected to:

- lay the foundation for an expanded scaled-up risk and harm reduction response to FSW, clients and IDUs inside and outside of the Kathmandu Valley by establishing new partnerships and collaborating mechanisms;
- provide risk and harm reduction services (in this first phase) for at least 25% of FSW, clients and IDUs beginning in the Kathmandu Valley which will lead to behaviour change;
- lead to an overall costed design for targeted interventions including behaviour change products, service delivery mechanisms, management arrangements, and surveillance systems; and
- design and establish reliable monitoring and evaluation mechanisms and systems to monitor the epidemic among the target group and the general population.

In addition, this project should become a model for an expanded response to FSW, clients and IDUs in Nepal. The project expects to generate insights regarding advocacy, management, and social organization, and will provide capacity building for similar initiatives.

B.3 Target Beneficiaries

The primary beneficiaries from the proposed project activities will be:

- FSWs, clients, and IDUs within and outside of the Kathmandu Valley;
- affected families and people living with HIV/AIDS; and
- Government and non-governmental partners as regards capacity building and skill development training.

The secondary beneficiaries are:

- The national response which will obtain recent data on the epidemic and develop an effective monitoring system;
- Community groups involved in HIV/AIDS related activities.

B.4 Project Strategy, Execution and Coordination Arrangements

B.4.1 Project Strategy

The National AIDS Policy and the Strategic Plan for HIV and AIDS in Nepal (including the forthcoming update) will guide the project. The project will apply the following key strategies:

- facilitate ownership at all levels;
- develop, apply and monitor the quality of all interventions;
- utilize "research cum intervention" approach;
- encourage participation of the target groups in all stages of planning and implementation;
- advocate a rights-based, service oriented implementation;
- actively pursue a "partnership" approach with local and international partners.

B.4.2 Execution Arrangements

The project will be executed according to the rules and procedures in the UNDP Programming Manual, with the Director of the NCASC as National Project Director and an NGO as the Executing Agent. The National Project Director (NPD) will serve as the responsible focal point on part of the government and will ensure effectice communication between the partners and monitoring of progress towards expected results. More specifically, the responsibilities of the NPD will include:

- To act as the secretariat to the project steering committee;
- To provide guidance and support to the executing agent;
- To facilitate and ensure government involvement in all stages of the project;
- To lead the design phase of the longer-term programme;
- To identify capacity gaps on part of government institutions, specifically the NCASC, and to develop an action plan for capacity building which can be addressed within in the frame of this project;
- To lead and to ensure efficient and timely implementation of activities according to the respective ToRs (to be developed in the detailed workplans) which will be resourced from the project: i.e. monitoring and evaluation, 2nd generation surveillance, STD treatment, and capacity building within the NCASC; and
- To play an active role in advocacy.

HMG has agreed to process for an NGO execution in order to respond quickly to the concentrated epidemic. HMG will secure its leading role in the national response through the steering committee and the involvement of the NPD in all stages of planning and delivery. The same time capacity will be build within HMG to gradually take over the execution in a longer-term programme. Another reason for NGO execution was the foreseen close interaction with marginalized and vulnerable target groups, and the expertise and experience of NGO(s) to address the needs of these groups effectively.

The Executing Agent will have the overall management responsibility for the project and is accountable for managing the resources allocated to the project in accordance with the workplan and the project document, maintaining an up-to-date accounting system, recording the receipt and disbursement of funds, and to maintain an inventory that records the acquisition and disposal of equipment. The management procedures were discussed and agreed upon after a series of consultations with representatives of the donor governments, representatives of HMG, and UNDP.

UNDP will administer the cost-shared funds, monitor the progress of the project, and establish reporting mechanisms to HMG and the donor consortium. UNDP will release funds on a quarterly basis to the designated institution on receipt of an updated workplan ("rolling planning") and a completed and signed financial report containing both a justification of previous expenditures and a request for a new advance. Advances are also given on the basis of continued progress towards results.

Family Health International (FHI) was designated as the executing agency because it has a long working history with the most vulnerable groups in Nepal. More importantly, it has acted as the management unit for the USAID funded HIV prevention activities and developed both capacity and competence to effectively establish working relations with a number of NGOs (the implementing partners) and government institutions. FHI has also completed important groundwork research such as baseline and STD/HIV prevalence studies and behaviour research in cooperation with the NCASC inside and outside the Kathmandu valley.

During the period of the project, management systems will be established and strengthened. These will include the areas of programme planning, appraisal of project, selection of partners, contracting systems and systems for monitoring and evaluation. Sub-contracting and selection of consultants will be made through a transparent process with the active involvement of the NPD.

The project is co-financed through signed cost-sharing agreements with different development partners (UNDP, UNAIDS, DFID) with parallel funding from AusAid and USAID (which contribute to the aims and objectives of this project). AusAid will contribute in the first phase of the project with a situation assessment mission in January 2001, and in-kind support to the design activities foreseen in this project. USAID's parallel funding includes BSS and FES in Kathmandu as part of the formative research, and the present office/running costs for the FHI office in Kathmandu. The executing agency will work with a range of governmental and non-governmental implementing partners, and private sector entities.

The implementation will consist of four overlapping phases:

- Consolidation of all available data and ongoing research, including the AusAid funded situation analysis and subcontracted research (first 4 months);
- An advocacy initiative to facilitate an supportive environment for focused interventions (first 4 months) based on already available data and experience;
- Capacity building and expansion of service delivery, including the establishment of surveillance and monitoring systems;
- Facilitation of a future overall design (starting after completion of formative research and situational analysis).

The executing agency will draw on expertise and competence as regards implementation from all project partners, namely UNAIDS, UNDP, DFID, but also from USAID, AusAid and local partners. The design phase will be done in close consultation with all development partners, HMG and local organizations.

As this is the first attempt to a) assist Nepal in an expanded "emergency" response aiming at high coverage, and b) to develop joint management mechanisms for new partnerships, including the design of scaled-up interventions, implementation arrangements are kept as flexible as possible. The focus in the first phase of the project will therefore include quality assurance/quality control systems, capacity building of government and non-government institutions, and an early establishment of a monitoring and surveillance systems.

The design of the longer-term programme will be lead by the NPD and will be prepared with support of independent experts who will draw upon available data and accumulated experience. The NPD together with the executing agency will propose the ToR for the design phase to the steering committee for review and will facilitate and support stakeholder workshops and meetings. The steering committee will be involved in the selection process of the consultants for the design phase. It is expected that in kind contributions from the respective donors will minimize the consultancy costs.

Implementation will occur with the full participation of the target groups, communities and local authorities.

B.4.3 Coordination Arrangements

The NPD and the executing agent will be guided by a "steering committee" under the National AIDS Coordination Committee[10] including, but not limited to:

- HMG/ Ministry of Finance
- HMG/ National Planning Commission
- HMG/ MoH
- Representatives of the donor consortium (UNAIDS, UNDP, DFID, AusAid, USAID)
- Chairman of the UN Theme Group on HIV/AIDS in Nepal
- Representatives of municipalities covered by the project
- Representatives of other ministries as appropriate

This committee will be chaired by the Secretary of Health.
The NPD will act as the secretariat to the steering committee.

The proposed role (ToR) of the steering committee is:

a) To review and endorse a detailed three-month implementation plan (within the frame of a 12 month outline) which will be developed by the executing agent in consultation with the NPD and will define:
   - the specific objectives for the given period;
   - the expected outputs, outcome and related indicators;
   - key strategies;
   - and resource requirements. The implementation plan will also reference the parallel funded activities.

b) To review and comment the ToR's for sub-contracts, consultancies and human resources needed as prepared and proposed by the NPD and the Executing Agent.
c) To discuss and propose joint management arrangements for partnerships.
d) To review and comment on the evaluation at the end of the project.
e) To actively engage in advocacy if needed.

The steering committee will meet as soon as the project is formalized and:

- Review its Terms of Reference and its composition
- Agree on common reporting mechanisms
- Endorse an one year outline of an overall workplan, and a three-months detailed workplan

It is foreseen that the steering committee will meet quarterly. If need arises and/or on request of the executing agency, ad hoc meetings will be held.

[10] The NACC foresees the establishment of a National Executive Committee (NEC) with participation of selected ministries. In order not to duplicate structures, the steering committee will be embedded in the NACC as a NEC.

The NPD and the executing agency will receive technical guidance from an expanded technical working group (TWG). The TWG is comprised of technical and programme experts of all major stakeholders in Nepal and provides an appropriate platform for technical discussions and coordination. The executing agency will be invited to present the project and its progress/obstacles in quarterly intervals.

The NPD and the executing agency will maintain regular meetings with all implementing partners and local counterparts to facilitate the coordination and the information exchange.

B.5 Counterpart Support Capacity

Family Health International (FHI) is an USA-based, not-for-profit organization that works in more than 45 countries worldwide in HIV/AIDS/STI Prevention and Care. FHI established a presence in Nepal in 1993 with USAID bilateral support for its AIDSCAP program. This initiative was subsequently extended through a merit-based, competitive process. The FHI program continues to be supported by USAID through a Memorandum of Understanding with HMG's Ministry of Health. FHI works most closely with the National Center for AIDS and STD Control (NCASC) of HMG, providing programmatic support as well as coordinating all FHI program initiatives with the NCASC.

FHI's HIV/AIDS Prevention and Control Program: 1997-2002 (AIDSCAP II), is designed to build the capacity of Nepali organizations to conduct HIV prevention activities in order to reduce the sexual transmission of HIV in Nepal. FHI partners with non-governmental organizations, associations, private sector companies, private voluntary organizations and government agencies to mobilize mutually-reinforcing initiatives in local communities. The FHI program has supported both core and complementary interventions in selected areas on Nepal's primary east-west highway from Jhapa District to Kanchanpur District, and the primary north-south highway from Parsa District to Dhading District. The program's complementary intervention area extends west from Rupandehi to Kanchanpur in the Mid and Far-Western Regions, and Saptari and Siraha in the Eastern Region. Complementary activities include mass media programs, condom social marketing, and the training of chemists. These subprojects are designed to complement on-going outreach and STI control programs implemented by other international and national organizations working in the Mid-Western and Far-Western Regions. FHI's policy development and surveillance programming works in support of national level efforts by the National Centre for AIDS and STD Control to strengthen the national HIV sentinel surveillance system.

The availability of USAID Asia-Near-East funds for HIV/AIDS prevention and care, through FHI's IMPACT cooperative agreement, provides additional resources for subproject support to Nepal. This has included support for STI/HIV/AIDS seroprevalence and behavioral research, cross-border planning and interventions, girl trafficking and a counseling assessment. FHI/ARO and FHI/Nepal jointly develop subprojects, with USAID/Nepal Mission and NCASC concurrence.

B.6 Reasons for UNDP Support

An important global programme of UNDP is HIV and development. The UNDP role within the Joint UN programme on HIV/AIDS (UNAIDS) includes areas of governance and people centered HIV/STD prevention interventions.

The current programme addresses issues of advocacy, governance, capacity building, community participation, promoting sectoral linkages and ensuring gender access to services which falls within the country support framework of UNDP as agreed with the Government of Nepal.

Finally the initiative is aimed at promoting the concept of human development with a sustainable approach, all activities proposed are people-centered aimed at preventing the spread of the epidemic and at creating a more supportive environment to people living with HIV/AIDS. The concept of new partnerships to address the issue of HIV/AIDS in Nepal brings together not only agencies and programmes of the UN system, but also development partners in order to join efforts and resources.

B.7 Special Considerations

The project is notable for the special considerations it is making in the following areas: advocacy, participation of communities and individuals in planning and implementation, a partnership approach, integration of non-government organizations (NGOs) in the development process, and a focus on the most marginalized and deprived.

Advocacy
Advocacy at all levels will impact beyond the project's primary focus. Representatives of the UN system, the donor organizations, and other key-partners will be involved. The project will develop an advocacy strategy and respective material which then can be used by high level representatives of the primary stakeholders. A first step was already made in putting the UN Day together with the International Day of the Eradication of Poverty under the theme: Breaking the Silence on HIV/AIDS. Increased political commitment will not only provide an enabling environment for this project, but also for the nation at large.

Participation of communities and individuals in planning and implementation
The project is designed to involve local participants at all stages of project activities including data collection, planning and implementation. All work will be carried out in a transparent fashion and local institutions will be strengthened to carry out activities in a participatory approach. Special emphasis will be put on involvement of people living with HIV/AIDS.

Partnership approach
The project aims at developing and using joint management arrangements at the donors level. This will facilitate on one hand the information flow and coordination with the government, and on the other hand serve as a model for development partners to join efforts in responding on scale to the epidemic.

Integration of non-government organizations (NGOs) in the development process
This project is being executed by an NGO, and implementation will occur mainly through local organizations and NGOs. This provides a unique opportunity to widen the involvement of NGOs in the implementation of a major international project. Capacity building, management assistance, and cooperation with government institutions will further strengthen the NGOs as valuable partners in the development process.

Focus on the most marginalized and deprived
As this project targets FSWs, and IDUs, it puts its focus on marginalized and deprived groups. Often seen by communities as "outsiders", they have restricted access to services and suffer often under harassment and stigmatization. A focus on the most deprived is also in line with the forthcoming UNDAF for Nepal (a rights based approach to development).By supporting a human rights approach to interventions, this project recognizes the need to protect the rights of people infected with HIV and the most vulnerable groups of society from further marginalization and discrimination. It will seek to uphold the rights of these vulnerable populations with regards to privacy, health, education and services.

C DEVELOPMENT OBJECTIVE

The development objective of the project is *to prevent the spread of HIV/AIDS into the general population.*

The overall goal is to stabilize and contain the concentrated HIV/AIDS epidemic among FSWs, clients and IDUs beginning in the Kathmandu Valley through targeted behavioural change and harm reduction interventions. This project will bridge the time needed to design and operationalize interventions at scale for the most vulnerable groups in Nepal. It will lay the foundation for an expanded response, build capacity, advocate for a supportive environment and initiate activities related to risk and harm reduction.

The project will contribute to the development objective through advocacy, formative research needed for the design of a longer-term strategy, capacity building and activities focused on behaviour change among the target groups of the project. To achieve this, the project will work closely with community members and institutions during research, planning and implementation; address their needs in management strategies; and build close interactions wherever possible based on local knowledge. The specific activities supported in this project will meet the following five immediate objectives and contribute to the longer-term development objective:

D IMMEDIATE OBJECTIVES, OUTPUTS AND ACTIVITIES

The five objectives of this initiative are interrelated. Together they are designed to facilitate the development and implementation of an emergency response to the presence of a concentrated HIV/AIDS epidemic among high-risk groups, i.e. sex workers, clients and injecting drug users, in the Kathmandu Valley and beyond. Through this response the specific activities supported will meet the following immediate objectives, and contribute to the longer-term development objectives.

Objective 1: To create the necessary enabling environment among policy makers, local authorities and communities for concerted action in HIV harm and risk reduction.

Objective 2: To increase behavior change among individuals at high risk for HIV and STDs, including FSWs, their clients, and IDUs

Objective 3: To enhance the capacity and quality of HIV/STD surveillance systems and their use in key decision-making

Objective 4: To support and facilitate the design of a costed, long-term (5 year) strategy for HIV risk and harm reduction among FSWs, clients and IDUs in Nepal

Objective 5: To develop and implement a monitoring and evaluation system to inform the national response and to monitor and evaluate the program.

Given the dynamics of the rapidly expanding epidemic in Nepal, project implementation will be based on a process of continual learning and adoption of best practices informed by systems of continuous monitoring and assessment against quality assurance criteria. The immediate objectives will be addressed through these strategies and activities as delineated below:

D.1 Objective 1

To create the necessary enabling environment among policy makers, local authorities and communities for concerted action in HIV harm and risk reduction.

Problem Statement: The purpose of this strategic component is to create the necessary enabling environment for concerted, sustained action in risk and harm reduction, particularly public and political commitment. Too many key actors remain uninformed, misinformed or ill informed. A major constraint to effective risk and harm reduction interventions, for example, has often been the perception of high-risk behaviours as socially or even criminally "deviant", and the consequent marginalization of those at risk. These perceptions must be addressed, redressed, through advocacy and education directed toward key policy makers, gatekeepers and stakeholders. Such an enabling environment is essential to the rapid, scaled-up response required to contain and control the spread of HIV/AIDS to the general community.

Strategy: This project will seek to build community support. When faced by a perceived threat such as injecting drug use or sex work, communities often respond by demanding punitive action which can prevent or delay effective responses. This project will support the "normalization" of HIV/AIDS prevention work. It will closely monitor the current social climate through government and NGO networks and public media. New mass information campaigns will emphasize the importance and effectiveness of "risk reduction" approaches as best for public health.

Because of the sensitivities surrounding IDU interventions, the project recognizes that supportive national policy and local level support from community groups and local law enforcement agencies are necessary for the introduction of harm reduction interventions. In addition, the active involvement and participation of IDU in the design and implementation of the above interventions is vital for success. IDU are not to be considered passive recipients of services, but must be viewed as playing a vitally important role in the prevention of HIV/AIDS.

Activities:

- GON/NGO workshops/symposiums on harm reduction and supportive environmental/ advocacy/policy interventions. These workshops will be conducted under the aegis of the Coordinating Ministries and will 1) review and familiarize participants with international evidence for reducing HIV among IDU; 2) allow participants to discuss the recent findings of the multiple site assessments of IDU in Nepal; 3) discuss barriers, unmet policy and implementation needs; and 4) seek consensus on approaches, including the roles of various GON and NGO entities who can contribute to solutions.

- Exposure visits for key persons within the Asia region and the review and synthesis of public policies and laws related to harm reduction and project target group behaviours. Briefing materials for key persons in the public and private sectors as well as the media will be developed. No key persons should be able to claim to be uninformed by the end of Year 1.
- Work with local government and communities to promote support for 'risk-reduction' strategies and to help ensure safety for FSW. Efforts will be made to influence local governments and other authorities, managers, pimps, and others whose livelihoods are linked with sex work. The project will provide advocacy support to local governments to assist them in promoting risk reduction and STI services as the most effective and appropriate strategies.
- Develop supportive strategies for promoting risk perception and reduction by involving people living with HIV/AIDS (PLWHA). In a low prevalence country such as Nepal, HIV/AIDS remains a very distant and unreal threat to most of the population. FHI will promote the participation by skilled representatives of the PLWHA community who can personalize the face of AIDS, helping communities to understand the risk of infection and the impact on lives. PLWHAs are the most powerful advocates of human rights of HIV+ people. Such input can help ensure that the activities and messages of the program do not increase stigmatization of those infected through insensitive and inaccurate messages.
- Prepare briefs for different constituencies -- Possible target audiences include policymakers, leaders and members of the communities under surveillance, program managers in government, NGOs, and CBOs, mass media, and the general public. Many forms of dissemination including technical reports, policy briefs, mass media briefings, and group and individual meetings, will be required to reach all target audiences. Target audiences will be encouraged to act on this information.

Outputs	Indicators	Means of Verification
1.1 Policy makers, local authorities and communities are informed about the need and effectiveness of HIV risk and harm reduction 1.2 Advocacy strategy 1.3 Regular advocacy information regarding HIV/AIDS is distributed to stakeholders	No effective resistance to risk and harm reduction from authorities and communities	• Attendance at meetings, workshops and study tour • Supportive reporting in official documents, the media and the public forum coverage

D.2 Objective 2

To increase behavior change among individuals at high risk for HIV and STDs, including IDUs, FSWs, and their clients.

Problem statement: While knowledge and awareness of transmitting and avoiding STI/HIV infection may be relatively high among the target groups, a sense of personal risk, or conversely personal benefits, remains low. Many beneficiary communities remain unconvinced of their vulnerability to HIV and unconvinced of the health risks of STI, including Hepatitis B and C. NGOs have only recently been formed to serve the key target groups of FSW and IDU. Many of these still suffer from symptoms of organizational infancy such as high turnover of staff, limited management and financial skills, reliance on one or few funding agencies, and a competitive versus collaborative posture towards other organizations. In addition, technical skills such as conducting outreach to high risk groups and developing effective behavior change interventions are also limited.

The following section describes these enhanced interventions separately according to targeted high risk group.

D.2.1 Female sex workers (FSW)

Problem statement: Few Nepali sex workers are brothel-based, the majority work in less accessible locations and are "street-based." Furthermore, many FSW are highly mobile, traveling across districts and even borders to work. In the absence of inexpensive, accurate, and simple diagnostic and screening tests, the high prevalence of STI is due to the frequently asymptomatic nature of STI and the lack of systematic application of effective algorithms for syndromic management. Providing acceptable, effective, and affordable STI care to adequate numbers of FSW remains a challenge. Attempts to assist reproductive health services to re-orient services to meet FSW needs have not appeared to be cost effective due to low levels of utilization by FSW. Public sector services such as FPAN clinics are underutilized even after upgrading. FSW who can afford it seek private care, others self treat and many do not get services at all. In addition FSWs are marginalized, face threats to their personal safety, under pressure from clients not to use condoms, and often resort to illegal abortions; all of which place them at increasing risk.

Strategy for FSW: This project will provide HIV/STI prevention services for FSW through a combination of models. Based on a building set of evidence, this project will work with selected providers to promote a multi-component STI treatment program for FSW which consists of 1) second generation syndromic management of vaginal discharge and genital ulcers; 2) regular serologic testing and treatment for syphilis in areas where prevalence is high; and 3) counseling and condom promotion. All of these approaches necessitate user-friendly clinical services which appeal to FSW so that their treatment-seeking behavior leads them to appropriate services. This project will incorporate a marketing approach in collaboration with partner agencies who are building STI services to FSW and will seek to address the socio-economic context within which FSW live and work.

Activities:

- Conduct formative research on STD health seeking behavior and sexual networks among FSWs in the Kathmandu Valley.
- Initiate discussions with the national government on existing STD guidelines based on what is currently being recommended for second generation syndromic management of vaginal discharge and genital ulcers.

- Support NGOs serving areas with high density FSW to develop comprehensive behavior change interventions which address environment, risk behaviors and service needs. BCC will be provided through outreach and peer communication, using appropriate support materials.
- Develop condom social marketing strategy linked with high-risk areas where more specific messages and promotional materials may be acceptable. Collaborative project development will be encouraged in order to achieve comprehensive approaches and lessons learned across sites.
- Implement a multi-component STD intervention program for street-based FSWs through STD providers. Project clinics will be supported to provide syndromic management of vaginal discharge and genital ulcers, serologic tests for syphillis and treatment; and counseling and condom promotion. Approaches will necessitate user-friendly services to appeal to FSW.
- Build capacity for voluntary counseling and testing

D.2.2 Clients of FSW

Problem statement: Behavioral research often identifies mobile men from the transport sectors, migrant laborers, military, police and other posted personnel as the male audiences with the highest rates of commercial sex activity. Nevertheless, while male clients of FSW have personal experience with STI, many believe that all such diseases can be cured and are unaware of asymptomatic disease. Such perceptions, added to a generally negative perception of condoms, make men reluctant to adopt condom use as a protective practice. STI treatment-seeking behavior often leads to inappropriate treatment or self treatment. The problem is compounded by the fact that clinics providing appropriate STI care are scarce.

Strategy for clients of FSW: This project will provide behavioral risk interventions by establishing links between BCI/STI projects targeted to vulnerable groups in the Kathmandu Valley and beyond as deemed appropriate. The intervention will emphasize concepts which have been successful in projects along the highways of Nepal, which decrease the sense of 'blame' or stigmatization and encourage condom promotion.

Activities

- Develop a profile of clients of FSW in the Kathmandu Valley through formative research.
- Design and implement a rapid assessment bringing together existing NGOs working in project areas to identify additional sex work areas and opportunities for STI treatment and condom outlets for men.
- Recognizing that most symptomatic men do not go to clinical services for STI treatment, conduct a feasibility assessment for the production and distribution (possibly including social marketing) of prepackaged urethritis treatment for men.
- Expand client-centered BCI/STI services through linked BCI and STI interventions for men whereby outreach and promotional materials will affect STI treatment-seeking behavior to move men (and FSW) to upgraded STI services.
- Increase condom acceptability and accessibility. Condom promotion and social marketing strategies will ensure condom promotion is integrated into other BCC and BCI activities as well as support outlet expansion and promotional activities.

D.2.3 Injecting Drug Users (IDU)

Problem Statement: IDU constitute the population sub-group in which HIV threatens to rise most rapidly and where both governmental and non-governmental organizational capacity, policy and advocacy efforts are least positioned to mount an effective response. Behavioral research among IDU in Nepal clearly indicates that needle sharing, the major risk factor for HIV, is common.

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

Strategy for IDU: In order to prevent a rapid HIV epidemic among IDU in Nepal, the project will implement a harm reduction approach. The guiding principle of this strategy is based on international lessons learned in keeping HIV prevalence low in IDU populations. These lessons recognize and stress that drug use itself does not cause HIV infection, nor does drug injecting. The sharing of contaminated drug equipment is the major risk for rapid HIV spread.

The harm reduction approach gives drug users options of reducing their risk at various levels and focuses on supportive, rather than punitive strategies. The approach recognizes that while stopping drug use is often the ideal goal, several intermediate goals such as safer injection techniques and drug treatment (including drug substitution therapy) are helpful in reducing HIV infection.

The implementation of a harm reduction approach consists of 1) gaining the support of policymakers and stakeholders; 2) penetrating the social networks of IDU in community locations where they frequent and meet; 3) establishing an effective outreach team and drop-in centers to access IDU; 4) building a peer-driven program whereby IDU network leaders are involved in the actual implementation of harm reduction program and condom promotion; and 5) creating necessary linkages to drug treatment and substitution programs, voluntary HIV counseling and testing, and primary health services.

Activities:

- NGO capacity assessment and planning for outreach. NGOs will be assessed for their capacity to conduct outreach to IDU, including the penetration of IDU social networks, the development of peer-based interventions, management of outreach programs, and linkages to other services.
- Conduct pre-intervention research including refinement of IDU networks mapping, analysis of BSS IDU data, and additional qualitative research.
- Build NGO capacity in outreach, peer strategies, and linkages to other services. This initiative will develop the capacity to train outreach and peer educators and develop educational strategies. This work will be closely monitored during the first year of implementation. It will serve as a major resource and provide feedback on the quality of outreach as well as linkages to other services such as voluntary HIV counseling and testing, treatment, and primary health care.
- Develop and promote behavior change communication materials to desensitize the community to injecting drug use
- Build capacity and expand harm reduction for IDU
- Conduct rigorous operations and behavioral research will accompany the IDU interventions. On-going qualitative interviews with IDU, and interviews with service providers, will be used to guide future interventions promoting reductions in behavioral risks among IDU in other sites.
- Develop and institutionalize the capacity for counseling as a pre-requisite to effective VCT programs.

Outputs	Indicators	Means of Verification
2.1 Baseline assessment on the capacity for harm reduction among IDU and expanded STI and HIV risk reduction to FSWS and their clients. 2.2. IEC and BCC materials developed for each target group 2.3. Increased understanding of risk behaviors of FSW, their clients and IDUs 2.4 Condom social marketing strategy 2.5 Scale up social marketing among target groups 2.5 Appropriate STI care services for FSWs and their clients developed 2.6 Capacity for outreach, peer education, counseling, STI care, etc.established 2.7 Definition of quality interventions for harm and risk reduction	•Increased coverage with risk and harm reduction interventions •STD treatment services utilized by project target groups •Increased distribution of condoms in the Kathmandu Valley	•Formative research •Monthly progress reports for implementing agencies, Site visits •Monitoring condom sales at distribution points •Data collected from targeted STD clinics •Behavioral surveillance

D.3 Objective 3

Enhanced capacity and quality of HIV/STI surveillance systems and their use in key decision making.

Problem statement: Surveillance systems that measure and track trends in HIV, STI, and behaviors are key to an effective and efficient prevention response. In the absence of quality surveillance, decisions for resource allocation are often made on the basis of anecdotal evidence, invariably leading to misguided and misplaced interventions.

In all countries, HIV/STI/behavioral surveillance necessitates careful planning of key design components such as sampling strategies, sample size calculations, accurate laboratory testing, appropriate questionnaire instruments, proper analysis techniques, and the maintenance of ethical standards of human subject informed consent in surveillance studies. Deficits or lack of forethought in any of these categories results in a compromised surveillance system which provides questionably useful data for decision-making.

GON and NGOs are currently implementing several surveillance systems. However, a preliminary analysis of these shows that their designs and sample sizes will be insufficient to discern trends. Upgrading and possible re-designs may be needed so that surveillance resources are efficiently used and provide useable results.

Strategy for surveillance: This project proposes an integrated HIV/STI/behavioral surveillance system based on WHO/UNAIDS Second Generation Guidelines. The UNAIDS/WHO guidelines encourage governments to choose surveillance groups on the basis of epidemic stage (low grade, concentrated, or generalized) and to carefully follow methodologies set forth in the guidelines to maximize accuracy and precision. While integrated in terms of providing estimates of trends in behaviors, STI, and HIV in the same catchment areas, the recommended system is actually a set of independent surveys. Given Nepal's current level of the epidemic, the key groups for surveillance are: FSW, IDU, and selected male "bridge" groups.

Activities:

- Conduct baseline HIV/STD prevalence surveys among FSW and IDU and BSS among FSW, their clients and IDU during the first year in the Kathmandu valley
- Establish the basis and capacity for integrated second generation surveillance in Nepal in cooperation with the government and others.
- Conduct a sexual networks study and injecting network study that will investigate the "bridge" between high-risk and lower-risk groups, a proven methodology to better understand epidemic spread.
- Assist the national response in interpreting surveillance data and planning its dissemination by conducting national consensus workshops on the HIV epidemic and behavioral trends – Such workshops will be for the GON MoH, NGOs, and research organizations to debate and discuss existing data and their implications. International consultants will be available to review data and forecast the trajectory of the HIV epidemic.
- Ensure ethical issues in surveillance and intervention linked research are appropriately addressed. All local studies will be initially be reviewed by the GON National Health Research Council and by FHI's Protection of Human Subjects Committee (PHSC) which reviews all protocols for studies involving human subjects to ensure that all risk and benefits are elaborated and that all procedures to maximize protection of participants are in place. Additionally, the project will ensure that written procedures are implemented in country by providing close supervision of the research team.

Outputs	Indicators	Means of verification
3.1 Baseline behavioral (qualitative and quantitative), STD and HIV seroprevalence data among target groups 3.2 Basis for 2nd generation sentinel surveillance established in Kathmandu and sites beyond	•Data used for further planning •Seroprevalence data in the Kathmandu Valley generated by 2nd generation surveillance system	•2001 HIV/STD prevalence and BSS data among target groups •Dissemination papers

D.4 Objective 4

To support and facilitate the design of a costed, long-term (5 year) strategy for HIV risk and harm reduction among FSWs, clients and IDUs in Nepal

Realization of the longer-term development objectives requires program interventions over an extended period. This one-year initiative is meant to lay the foundations for this effort, in part, by informing and facilitating the development of a longer-term strategy to control and contain the HIV/AIDS epidemic among high-risk populations. This component will enable the design of set of risk and harm reduction interventions meant to reach at least 80% of sex workers, clients and injecting drug users in the Kathmandu Valley. This effort will be aided by the activities being conducted as formative research, including the BSS and FES. The project will mainly facilitate and support the design of the longer-term strategy, as a team of independent experts together with HMG (under the leadership of the NPD) and the donor consortia will develop the actual design.

However, FHI will participate in the design phase and be represented with one or more technical specialists as members of the design team.

In addition, FHI's execution of this 12 month project and FHI's participation in the design phase will not preclude FHI from competing for the subsequent longer term program.

Outputs	Indicators	Means of Verification
4.1 Overall design for costed scaled up interventions reaching at least 80% of FSW, their clients and IDU in Nepal	•Consensus of stakeholders to overall design	•ToR for design phase developed and accepted •Design is used for resource mobilization and program development

D.5 Objective 5

To develop and implement a monitoring and evaluation system to inform the national response and to monitor and evaluate the project.

Problem Statement: This project recognizes the difficulty of assessing program impact defined as "reducing the rate of HIV infection" since direct measures of this can only be obtained through expensive and logistically complex sero-incidence studies. Quantitative targets of specific project indicators are also difficult to calculate because of the complex and unpredictable nature of sexual behaviors, and other "intervening factors" that are beyond our control.

Strategy: As outlined under the proposed upgrading of surveillance, the proposed HIV/STI repeated cross-prevalence surveys of FSW, their client and IDU are optimal for providing impact-level biologic indicators. This project will build the capacity and support designs with high scientific rigor to guarantee accurate estimates.

The project will promote the continued use of BSS, as outlined in the surveillance discussion, to provide outcome level indicators of behavioral change. The BSS would be supplemented by qualitative studies of target group members and key informants to understand factors that facilitate behavior change, as well as those that act as barriers. This project will strive to set realistic and achievable targets for each of our key indicators to serve as guideposts for its progress. A variety of approaches will be used to help implementing organizations to monitor the quantity and quality of the services being delivered.

Quantity will be measured through process indicators, which will be collected by implementing partners on a monthly basis. These indicators will be linked to project activities, and will include such items as numbers of target group members reached, STI clients treated, and condoms sold.
Quality can be described as the manner in which communications messages and services are delivered, and the degree to which they achieve their desired effects. Qualitative participatory methods will be used to evaluate movement along the "continuum of change" such as changes in attitudes and levels of "readiness to change". Qualitative information in the form of vignettes and successful case studies from implementing organizations and individuals will also be utilized as means of quality assurance.

Activities

- Develop indicators
- Institute systematic data collection
- Develop appropriate reporting mechanisms for implementing partners
- Develop quality assurance system to monitor the quality of the project components
- Facilitate external evaluation and external auditing of end of project

Outputs	Indicators	Means of Verification
5.1 Regular feedback to stakeholders and management partners 5.2 Functioning monitoring and evaluation system 5.3 External evaluation report	•Project reacts in timely manner •Performance of project visible • Opportunities for, and obstacles to, project implementation are identified and addressed	•Workplans •Project reports •Publications •Media coverage

E INPUTS

As this project will build the bridge between an emergency response to the concentrated epidemic among FSW, clients, and IDU's and a longer term overall strategy for an expanded, scaled-up response focusing on these groups, the inputs will finance the following:

In-Kind Contributions

USAID will contribute to the overall management in supporting the FHI office running costs, and manpower both at the managerial and at the technical (programme) level. USAID's contribution to this initiative totals US$ 564,133.

AusAid will fund the assessment mission in January 2000, which amounts to US$ 100,000.

Financial Resources

E.1.1 Project Management

The project foresees resources for the following:

1 accountant: The additional accountant will mainly deal with resource administration of this project and will provide technical assistance to implementing partners as regards accounting and financial reporting, as capacity building of local partners is one of the main aims of this project.

3 Programme officers: The three additional programme officers (one for FSW and clients, one for IDU's, and one for formative research, data collection) will be charged with the management and coordination of respective sub-components of the project. Under the direction of senior program staff partially supported by this initiative, their tasks include the monitoring, management backstopping of local partners, to facilitate and coordinate technical assistance, and to manage the respective sub-contracts from a programme perspective. Focus is again on capacity building of local institutions and organizations as regards implementation of activities, including capacities for monitoring, quality assurance and control, and technical support.

Equipment	Computer equipment will be provided for the additional human resources within the Executing Agent. If the Executing Agent changes for the longer term programme, this equipment will be transferred to the new designated organization.
Sub-total	A total of USD 88,397 is allocated for this component. Additionally USD 104,000 are budgeted for local travel costs, supplies and other direct costs, i.e. sundries.

E.1.2 Advocacy

The advocacy component of this project includes a targetted advocacy strategy on decision makers and communities as regards an enabling environment for targetted risk and harm reduction, but also a broader advocacy initiative as regards the epidemic in Nepal, responses, and best practice. Data and information will be synthesized, compiled and distributed in an appropriate format and language. Developed material will also be accessible for local organizations not involved in this project.

The project foresees resources for the following:

1 communication specialist	Main tasks include the development of an advocacy strategy (together with an international consultant), the compilation of data, development of communication briefs, reporting, advocacy and IEC material development, dissemination of information and networking, organization and facilitation of advocacy workshops/seminars.
1 international consultant	Main task to assist the communication specialist to develop an advocacy strategy.
Operational costs	Will be used to sub-contract professional services as regards material development, and to produce and distribute material.
Sub-total	Allocated USD 17,104 for consultancy and national communication specialist, USD 150,000 for subcontracts, printing, production, and dissemination.
Exposure visits	Exposure visits for decision makers are foreseen in the advocacy component of this project and include visits in India and in Thailand.
Advocacy workshops	A number of short advocacy workshops targeting decision makers and local communities are foreseen to facilitate the establishment of an enabling environment.
Sub-total	An overall total of USD 284,315 is allocated for this component.

E.1.3 Formative Research

The formative research component includes national and international consultancies and operational costs for sero-prevalence studies, database development and maintenance, size estimation, and focused ethnographic surveys. It will be done through output oriented sub-contracts with competent local organizations and individuals.

Sub-total	The overall total for this component amounts to USD 84,000.

E.1.4 Design of Long Term Strategy

Funded in this project are three international and three national consultants for the design of the longer term strategy/programme (3 weeks each). It is expected that in-kind contributions of the respective donors will further support the actual design (e.g. consultants). In order to include all accumulated experience and competence, a stake-holder workshop is foreseen to discuss and finalize the future design.

3 international consultancies	Total of 63 days (fee, travel, DSA), allocated USD 36,144
3 national consultants	Total 63 days (fee), allocated USD 6,300

Stake-holder workshop	Calculated for 40 persons, three days workshop, translation, full board, supplies and transport, USD 7,760
Sub-total	Total for this component: USD 50,204

E.1.5 Service Delivery

Main items in this component include the AusAid funded situation assessment, training, capacity building of local partners, consultancies, and procurement. One of the targets is the strengthening of local capacity to a) scale-up training (e.g. counsellors, peer-educators), b) to give technical support for expanded activities and to implement quality assurance/control systems, and c) to enable local partners scaling up of activities. In order to facilitate sustainability, it is foreseen that local capacity is supported to perform a number of tasks (e.g. substitution therapy, training) for which the necessary resources are then provided through sub-contracts.

Training	Training is calculated as non-residential workshops, the project only providing the venue, meals, and training material
International consultancies	International consultancies are foreseen for: development of a social marketing strategy for condoms and injection equipment, capacity building for substitution therapy and harm reduction activities, feasibility assessment for rehabilitation, capacity development for counseling, and STD treatment.
National consultancies	Development of national substitution guidelines, and peer-education.
Sub-contracts for service delivery	These sub-contracts with local organizations and institutions will provide the resources (operational costs) for training, supervision, monitoring, technical assistance and expansion of services. They will be output oriented and support the establishment of local capacity for management and implementation of sub-components of this project.
Procurement	In a first phase procurement (e.g. methadone, needles and syringes, bleach, etc.) will be done centrally through the Executing Agent in order to save costs and to facilitate the process. The EA will use capacity and competence for procurement from UN agencies and development partners.
Social marketing	A substantial amount (USD 220,000) is allocated to start social marketing for non-traditional products (condoms, injection equipment, etc.).
Total	An overall total of USD 1,566,158 was allocated for this component, including the monitoring and evaluation delineated below.

E.1.6 Monitoring and Evaluation

The design and the implementation of effective monitoring and evaluation systems are an important component of this project. Subcontracts for technical assistance, external evaluations, and compilation of data are included in the overall allocation of this component.

Total USD 100,000

E.1.7 NGO Execution Fee

An NGO execution fee covering the indirect administrative and management costs of USD 286,892 is foreseen for this project.

F RISKS AND SUSTAINABILITY

Social and political environment: The main risk factor in this project is the social and political environment, which may hinder the implementation of activities – or, in a worst case scenario, even make the implementation of certain activities impossible. An effective advocacy strategy should minimize the obstacles to implementation, but the time needed to create an enabling environment may be longer than foreseen. Access to the target groups and the access of these groups to the means of behaviour change may be restricted because these groups are marginalized and partly criminalized. Accessibility is directly connected with the social and political environment, and the same worst case scenario applies. Direct involvement of these groups in planning and service delivery, and providing products which meet their needs should minimize some of the obstacle to accessibility.

Advocacy: Until now the social and political environment for targeted interventions among marginalized groups is far from supportive. An effective implementation/expansion of risk and harm reduction activities will depend mainly on an enabling environment, and can only start if a certain degree of understanding both at political and at community level is reached. Successful advocacy may open the door for an expanded response to HIV/AIDS in general, and will impact beyond this current project's geographical focus. All activities will be planned and implemented in close collaboration with local stakeholders so that the objectives can be realistically achieved within the timeframe of the project.

Capacity building: At present only limited local capacity exists to address the needs of the target groups. In order to obtain a high degree of coverage and to scale-up (eventually reaching 80% of target populations), capacity building at all levels is an essential pre-requisite for the longer term strategy. Capacity building will be designed to develop quantity while assuring quality. Organizations and individuals from outside the Kathmandu valley will be encouraged, where possible, to participate in capacity building activities, thereby strengthening the national response.

Research and data collection: Because research and collection of baseline data are important components of the project, also for monitoring and verifying positive results of the project, it will be crucial to involve experienced researchers in the design and the implementation of activities. This will be achieved by collaborating closely with relevant local and international experts, using regional competence and experience, and in networking with other initiatives in the region.

Service delivery: Service delivery of behaviour change products and means will have to be designed in a way that long term sustainability is at least partially secured. In this respect, social marketing will be a key strategy, even for non-traditional products such as safe injection equipment and STD treatment. A balanced public/private sector mix (e.g. testing, STD treatment, rehabilitation) will be another approach to needed services. These will be designed and piloted in the project period.

G PROJECT REVIEWS, REPORTING AND EVALUATION

As this project favours a "partnership" approach of different development partners and the national response, common management procedures will replace to the extent possible individual reporting.

- In accordance with UNDP's Programming Manual, the project will prepare and update a quarterly workplan, and quarterly financial reports for UNDP, on the basis of which funds will be disbursed. In order to fulfill different donor requirements, the format of both the workplan, and the narrative reports will be decided in the first meeting of the steering committee (based on a proposal by the Executing Agent). UNDP will share with all stakeholders (HMG, donors, etc.) the respective reports.
- The project steering committee will discuss, suggest and endorse the workplans.
- The NPD and, in particular, the Project Management (executing agent) will ensure regular monitoring of progress, using detailed indicators for field level monitoring covering both quantitative and qualitative information, and provide reports to UNDP.
- Reviews of progress made will be done with the participation of the stakeholders, taking into account feedback from the project steering committee.
- The Executing Agent will prepare and submit to UNDP the Annual Report for discussion at the Tripartite Review Meeting.
- The Annual Tripartite Review Meeting will be held together with the final meeting of the project steering committee.
- The project will be subject to an external evaluation 2 months prior to the expected completion date. Findings of this evaluation will serve as input to the parallel design of the longer-term strategy.
- The project will be externally audited at the project end. The external overall audit will replace respective individual reports to the donor's group and will follow criteria which were approved by all involved donors.

H LEGAL CONTEXT

This document shall be the instrument referred to as such in Article 1 of the Standard Basic Assistance Agreement between His Majesty's Government of Nepal and the United Nations Development Programme. The following types of revisions may be made to this document with the signature of the UNDP Resident Representative only, provided he or she is assured that the other signatories of the document have no objections to the proposed changes.

a. Revisions in, or addition of, any of the annexes of the document;
b. Revisions which do not involve significant changes in the immediate objectives, outputs or activities of the programme, but caused by the rearrangement of inputs already agreed to or by cost increases due to inflation; and
c. Mandatory annual revisions, which re-phrase the delivery of agreed inputs or increased expert or other costs due to inflation or take into account agency expenditure flexibility.

Inputs from participating donors will be secured by third party cost or in kind sharing agreements between UNDP and each of the participating donors.

I BUDGET

See attached

NEP/00/013 - Assistance to the concentrated HIV/AIDS
Budget "A"

Main Source of Funds :01- UNDP-IPF/TRAC-(Trace1.1.1 & 1
Executing Agency:NGO(INTL)- International Non -Governmental

SBLN	Donor	Funding		Total	2001	
103 Third Party cost sharing						
103.01	UNAIDS	UNAIDS	Net Contrib.	145,631	145,631	
			Co Adm%	3		
			Co Adm	4,369	4,369	
			Total	150,000	150,000	
103.02	DFID	DFID	Net Contrib.	2,258,335	2,258,335	
			Co Adm%	3		
			Co Adm	67,750	67,750	
			Total	2,326,085	2,326,085	
103.99 Line Total			Net Contrib.	2,403,966	2,403,966	
			Co Adm%	3		
			Co Adm	72,119	72,119	
			Total	2,476,085	2,476,085	
109 COST SHARING TOTAL			Net Contrib.	2,403,966	2,403,966	
			Co Adm%	3		
			Co Adm	72,119	72,119	
			Total	2,476,085	2,476,085	
999 NET CONTRIBUTION			Net Contrib.	60,000	60,000	
			Total	60,000	60,000	

PROJECT LOGICAL FRAMEWORK

Project Name: Assistance for an Expanded Rights-based Approach to the Concentrated HIV/AIDS Epidemic Among Sex Workers, Clients, and Injecting Drug Users in Nepal

Country: Nepal

Narrative Summary	Indicators	Means of Verification	Assumptions
Goal			
To prevent the spread of HIV/AIDS into the general population	•HIV prevalence among ANC clinic attendees remains under 1% (long term)	•HMG HIV ANC surveillance system	•ANC attendees represent general population
Purpose			
Beginning in the Kathmandu Valley, to stabilize and contain the concentrated HIV/AIDS epidemic among FSWs, their clients and IDUs through target risk and harm reduction interventions	•HIV prevalence shows signs of stabilization in 2 years among IDU and FSW • STD prevalence declines among FSW	•Results of STD and HIV prevalence study among target groups •2001 BSS	•Required sampling design is met for the STD and HIV prevalence study and the BSS •Coverage and behavior change rate is high enough to stabilize the epidemic

United Nations Development Programme
NEP/00/013 - Assistance to the concentrated HIV/AIDS
Budget "A"

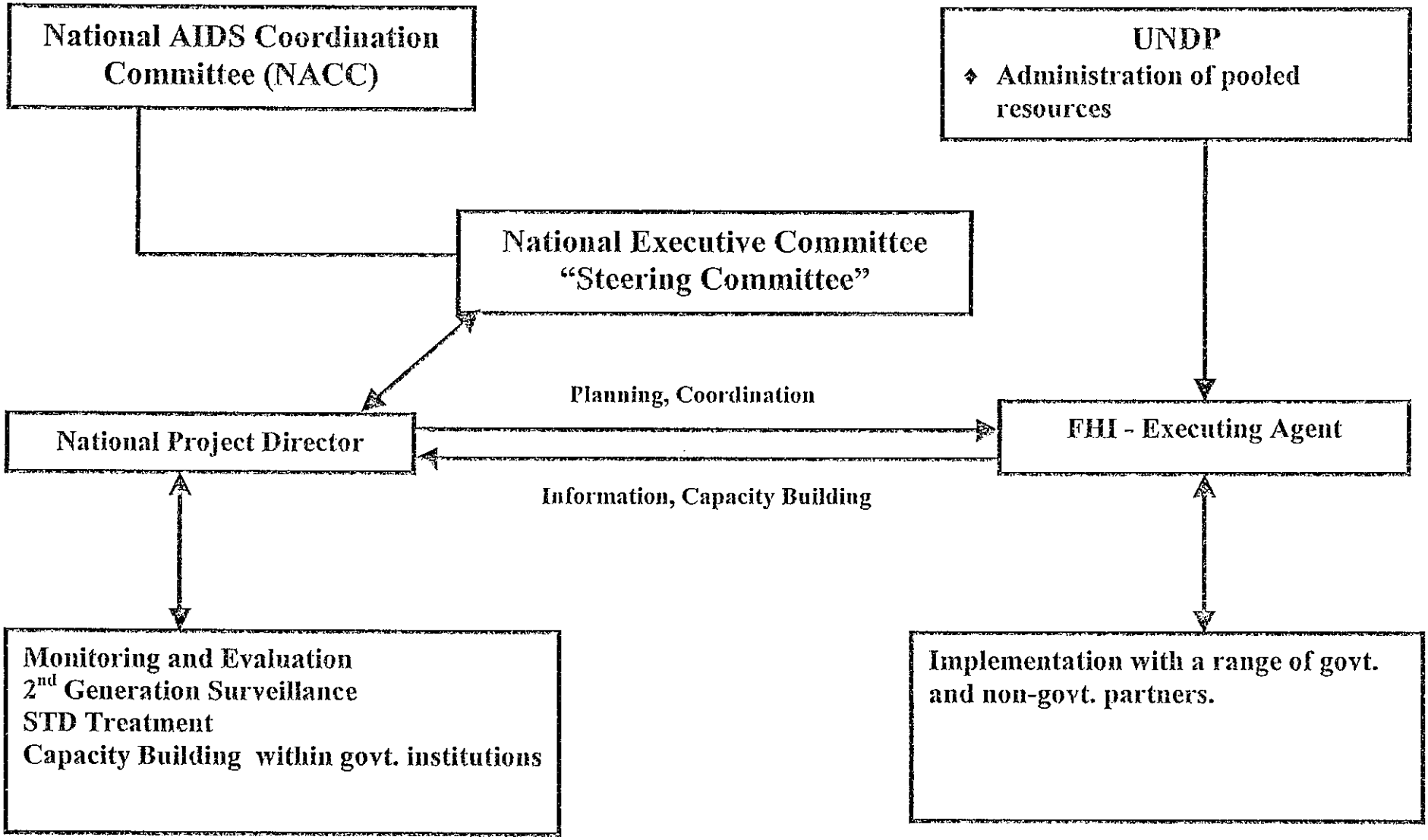
Main Source of Funds :01- UNDP-IPF/TRAC-(Trace1.1.1 & 1
Executing Agency:NGO(INTL)- International Non -Governmental

SBLN	Description	Implementing		Total	2001	
010	Personnel					
011	*International Consultants*					
011.01	International Consultants	NGO (INTL)	Net Amount	281,424	281,424	
			Total	281,424	281,424	
011.99	**Line Total**		Net Amount	281,424	281,424	
			Total	281,424	281,424	
013	*Administrative Support*					
013.01	Administrative Support Staff	NGO (INTL)	Net Amount	71,597	71,597	
			Total	71,597	71,597	
013.99	**Line Total**		Net Amount	71,597	71,597	
			Total	71,597	71,597	
015	*Monitoring and Evaluation*					
015.01	Travel costs	NGO (INTL)	Net Amount	2,000	2,000	
			Total	2,000	2,000	
015.99	**Line Total**		Net Amount	2,000	2,000	
			Total	2,000	2,000	
017	*National Consultants*					
017.01	National Consultants	NGO (INTL)	Net Amount	43,120	43,120	
			Total	43,120	43,120	
017.99	**Line Total**		Net Amount	43,120	43,120	
			Total	43,120	43,120	
019	*PROJECT PERSONNEL TOTAL*		Net Amount	398,141	398,141	
			Total	398,141	398,141	
020	*CONTRACTS*					
021	*Contract A*					
021.01	Sub-contracts	NGO (INTL)	Net Amount	1,222,873	1,222,873	
			Total	1,222,873	1,222,873	
021.99	Line Total		Net Amount	1,222,873	1,222,873	
			Total	1,222,873	1,222,873	
029	*SUBCONTRACTS TOTAL*		Net Amount	1,222,873	1,222,873	
			Total	1,222,873	1,222,873	
030	*TRAINING*					
031	*Fellowships*					
031.01	Training	NGO (INTL)	Net Amount	35460	35,460	
			Total	35460	35,460	
031.99	*Line Total*		Net Amount	35460	35,460	
			Total	35460	35,460	

NEP/00/013 - Assistance to the concentrated HIV/AIDS
Budget "A"

Main Source of Funds :01- UNDP-IPF/TRAC-(Trace1.1.1 & 1
Executing Agency:NGO(INTL)- International Non -Governmental

SBLN	Description	Implementing		Total	2001	
039	*TRAINING TOTAL*		Net Amount	35,460	35,460	
			Total	35,460	35,460	
040	EQUIPMENT					
045	*Equipment*					
045.01	Non expendable Equipment	NGO (INTL)	Net Amount	16,800	16,800	
			Total	16,800	16,800	
045.02	Procurement (Medical Items)	NGO (INTL)	Net Amount	400,000	400,000	
			Total	400,000	400,000	
045.99	**Line Total**		Net Amount	416,800	416,800	
			Total	416,800	416,800	
049	*EQUIPMENT TOTAL*		Net Amount	416,800	416,800	
			Total	416,800	416,800	
050	*MISCELLANEOUS*					
053	*Sundries*					
053.01	Sundry	NGO(INTL)	Net Amount	102,000	102,000	
			Total	102,000	102,000	
053.02	UNDP NGO Support Cost	UNDP	Net Amount	1,800	1,800	
			Total	1,800	1,800	
053.99	*Line Total*		Net Amount	103,800	103,800	
			Total	103,800	103,800	
059	*MISCELLANEOUS TOTAL*		Net Amount	103,800	103,800	
			Total	103,800	103,800	
090	*EXECUTION FEE*					
094	*NGO Execution Fee*					
094.01	NGO Execution Fee	NGO(INTL)	Net Amount	286,892	286,892	
			Total	286,892	286,892	
094.99	*Line Total*		Net Amount	286,892	286,892	
			Total	286,892	286,892	
099	*BUDGET TOTAL*		Net Amount	2,463,966	2,463,966	
			Total	2,463,966	2,463,966	


National AIDS Coordination Committee (NACC)
UNDP
Administration of pooled resources
National Executive Committee "Steering Committee"
Planning, Coordination
National Project Director
FHI - Executing Agent
Information, Capacity Building
Monitoring and Evaluation
2nd Generation Surveillance
STD Treatment
Capacity Building within govt. institutions
Implementation with a range of govt. and non-govt. partners.

File: HIV/AIDS: pacminute2

UNDP NEPAL

PROJECT APPRAISAL COMMITTEE
MEETING OF 20 DECEMBER 2000

NEP/00/013 – Assistance for an Expanded Rights-based Approach to the Concentrated HIV/AIDS Epidemic in Nepal

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Participants:

HMG

Dr. B.D. Chataut, Director General, Department of Health Services
Dr. T.N. Jha, Director, National Centre of AIDS and STD Control
Mr. Sundar Man Shrestha, Under Secretary, Ministry of Finance
Ms. Padma Mathema, Under Secretary, National Planning Commission Secretariat

Australian Embassy

H.E. Mr. Crispin Conroy, Ambassador

DFID/Nepal

Mr. Alex Harper, Deputy Head
Ms. Pratima Pradhan, Programme Officer

Family Health International

Mr. Jim Ross, Country Director
Ms. Asha Basnyat, Programme Officer

USAID

Catherin Thompson, Chief Technical Advisor

UNICEF

Mr. Stewart McNab, Representative, Chairman of the UN TG on HIV/AIDS

UNAIDS

Dr. Michael Hahn, Country Programme Advisor

UNDP

Ms. Alessandra Tisot, Resident Representative, a.i.
Ms. Lalita Thapa, Assistant Resident Representative
Mr. Ranjit Lama, Programme Associate

I. Presentation of project (origins, background, general justification)

The Project Appraisal Committee (PAC) meeting for NEP/00/013 – Assistance for an Expanded Rights-based Approach to the Concentrated HIV/AIDS Epidemic in Nepal was held on 20 December 2000 in UNDP. In her opening remark, Ms. Tisot welcomed all participants and explained that the purpose of the PAC meeting was to review whether the project has been formulated in line with UNDP's rules and regulation. She requested everybody to provide his/her comments on project design, objectives and correlation between various aspects as well as on allocation of human and financial resources to the project. She further stressed that this project reflects an innovative approach as a donor partnership was established to support the national efforts.

Dr. Michael Hahn presented a summary of the proposed project. He informed that the formulation process of the project has been initiated under an "emergency situation" and that Nepal has entered the stage of a "concentrated epidemic He stressed that without effective interventions HIV/AIDS would be the number one killer in Nepal in the age group of 15-49 years by the end of the decade. The major aspects of the proposed project as summarized by Dr. Hahn are as follows:

The Real Issues

The real issues in designing the project were related to *Time, Capacity, Resources and the Opportunity*. It was designed in line with a new approach in joint funding and joint programming and a mechanism for quick disbursement of resources and delivery of outputs.

Approach

The approach followed in designing the project was as follows:

- **Partnership** – Ownership
- **Immediate** response (emergency)
- **Capacity building**
- **Research**
- **Design** of a longer-term programme
- **Efficient monitoring and surveillance** system (s)

Assumptions

The following aspects were the assumptions when formulating the project:

- **Coverage** needs capacity and cooperation (participation of target groups) and coordination among different actors;
- **Capacity building** takes time and requires resources (technical and financial)
- **Design** needs research and external technical inputs and a national leadership
- **A high level of technical and managerial capacity** is needed for all of the above.

How can this be achieved? "Key Strategies"

The key strategies adopted when formulating the project were as follows:

- **Government involvement and leadership** (decision, coordination, etc.);
- **Focus on capacity building and delivery**;
- Initially **outsourced** project management, administration (inputs), and technical support;
- Design process embedded in, but "disconnected" from the project.

Management Vision

The management of the project has been based on the following visions:

- **Resources** UNDP administered
- "**Board of Directors**" (HMG, donor consortium) as decision making body
- **Executing Agent** (FHI) with **management, administration**, and **technical** capacity
- Involvement, capacity building and delivery through result oriented **subcontracts** to a range of actors (government, NGO)

Immediate Objectives

The immediate objectives of the project are as follows:

Objective 1 (Advocacy)

To create the necessary enabling environment among policy makers, local authorities and communities for concerted action in HIV harm and risk reduction;

Objective 2 (Service Delivery "Emergency Response")

To increase behavior change among individuals at high risk for HIV and STD, including Female Sex Workers (FSWs), their clients, and Injecting Drug Users (IDUs).

Objective 3 (Research)

To enhance the capacity and quality of HIV/STD surveillance systems and their use in key decision-making;

Objective 4 (Design)

To support and facilitate the design of a long-term (5 year) strategy for HIV risk and harm reduction among FSWs, clients and IDU in Nepal;

Objective 5 (Monitoring and Evaluation)

To develop and implement a monitoring and evaluation system to inform the national response and to monitor and evaluate the programme.

Execution Arrangement

The following are the key features of the execution arrangement:

- Design of a 12 months work-frame and a 3 months detailed, costed activity proposal including the ToRs for sub-contracts (together with the NCASC and other stake-holders);
- Steering Committee ("board of directors") comments, and endorsed the proposal;

Financial Arrangement

- UNDP advances the required resources for the 3 months period;
- After 3 months : narrative and financial report to the steering committee, new 3 months activity proposal;
- Review of progress with the participation of stake-holders.

Implementation

The project implementation will address the following aspects:

- Consolidation of all available date and ongoing research, including the AusAid funded situation analysis and subcontracted research (first 4 months);
- An advocacy initiative to facilitate an supportive environment for focussed interventions (first 4 months) based on already available data and experience;

- Capacity building and expansion of service delivery, including the establishment of surveillance and monitoring systems;

- Facilitation of a future overall design (starting after completion of formative research and situational analysis)

- Implementation is done by a variety of actors (government, non-government) with "result" oriented contracts

- The project will provide the needed resources to build capacity and to delivery according to the ToR of the respective subcontract.

Inputs (US$)

- DFID 2,326,085
- UNAIDS 150,000
- UNDP 60,000

In kind

- AusAid 100,000
- USAID 546,133

II. Summary of Discussion

1. Ms. Tisot opened the floor for discussion by saying that the project design has followed the innovative idea so that different stakeholders and partners would be involved. She said that several options, including the National Execution (NEX) modality were considered when designing the project. In the NEX modality, another 3-6 months would be required to assess the counterpart capacity, appoint the National Project Director and National Project Manager. She informed that since time was an important factor, the project has been designed in such a way that every single day would be used to deliver the outputs.

2. Dr. Chataut pointed out that the project has proposed to set up a new steering committee, consisting of all partners involved in the project, which might be a parallel committee as a national committee on HIV/AIDS already exists. He further questioned about the sustainability of the project if it is going to be executed by an outsider. He suggested that the permanent body like NCASC should be responsible in executing the project mainly because the Government should be in the driving seat. He said that he has no comment on channeling the funds. He further requested to clarify the point mentioned on page 13 of the project document, i.e., expansion of service delivery, including the establishment of surveillance and monitoring systems.

3. Ms. Tisot thanked Dr. Chataut for his valuable comments. She explained that the question of sustainability after 12 months would be vital and the NGO execution rather than national execution was selected because of its flexibility in service delivery. She said that during the design of the longer-term (5 years) programme national execution would be considered. Especially as this phase also includes the strengthening of national institutions.

4. Mr. Harper said that the formulation of an one-year programme was to buy the time and create space for the longer-term intervention, in providing services immediately and designing the longer-term strategy. He commented that the document did not say more on the Government being in the driving seat; however they have been included in the steering committee. He said that there is an opportunity of strengthening NCASC's capacity if needed.

5. Ms. Mathema said that the objectives, activities, indicators all have been explained well in the project document. She explained that the ownership aspect was not clearly spelled out. She noted that in the project document it has been mentioned that the Executing Agency would be guided by a steering committee (page 14). She however said that as the issue of HIV/AIDS was a multisectoral issue, there was no mention of other ministries in the steering committee. She said that if the ownership has not been clearly mentioned, the implementation would not be successful.

6. Ms. Thompson said that USAID has made contributions in kind to the project. She explained that the idea of choosing the NGO, i.e., FHI was to move very quickly. She said that we have to move forward with this project and design the building process for the bigger project. She further said that in order to move immediately there were windows of opportunity through FHI which could move very fast as they had all facilities.

7. Mr. Shrestha said that the fund channeling mechanism should be transparent and the Government should have a leading role.

8. Mr. McNab said that the annual outlay of the NCASC was between US$ 200,000 to $300,000 which represented a small scale outlay as compared to the considerable funds proposed to be made available for quick disbursement. He said that it was not the question of money putting through FHI, but of building capacity of national institutions. He said that there should be some tuning up in the project document, e.g., ownership and restructuring of the committee.

9. At the request of Dr. Chataut, Ms. Tisot sought the opinion of the floor on the execution modality of the project, i.e., NGO or National Execution. She however cautioned that under the NEX modality many procedures, e.g. the recruitment of international consultants would take long time.

10. Mr. Ross said that the 12 month's proposal would be different from a longer-term proposal of 5 years. He suggested that gaps in the Government, NGO and private sector should be identified and strengthened. He further said that the first year of the project has been designed to immediately address the epidemic. He informed that the in terms of the capacity of FHI, it has been working here since 7 years and systems were in place to ensure transparency and accountability. FHI has excellent working relationship with NCASC. He agreed that the Government should be in the leadership role and timeliness in the delivery of outputs was the main issue.

11. Ms. Tisot informed that the major contributions expected from FHI were to mobilize international and national expertise, and prepare subcontracst in short period of time (ToRs, workplans, etc.). She informed that all comments would be valuable in designing the main phase project.

12. Dr. Hahn said that the designation of NCASC as the executing agent would be more efficient and effective in the long-run for which capacity of NCASC would be built. He further said that the capacity building was needed with a range of actors including the Ministry of Health. Agreeing to the fact that the Government should be in the driving seat, he proposed that: (a) FHI should remain the Executing Agency as mentioned in the project document; (b) a position of a National Project Director, to be nominated by the Government (e.g. Director NCASC) would be created; (c) the main role of the NPD would be to act as the focal person within the Government and to be responsible for the implementation of certain activities; he/she would not be involved in the channeling of funds or signing out sub-contracts; and (d) the Government's leadership role would be clearly mentioned in the project document.

13. Dr. Chataut informed the participants that he is in agreement to the above proposal. He proposed that the role of secretariat to the steering committee should be shifted from FHI to NCASC.

14. H.E. Mr. Conroy agreed that the Government should sit in the driving seat.

15. Ms. Thapa said that it would be an innovative approach from the point of view of FHI as an executing agency and a NPD from the NCASC.

16. Mr. Harper also agreed to the above proposal and requested that the project document should be revised accordingly.

17. Ms. Tisot said that an agreement has been reached by introducing an innovative approach and considering the priority of the project. She further said that necessary work would be done including deliverables of the project within the time frame and parallel funding. She thanked all who contributed the deliberation.

III. Recommendation

The meeting agreed to the following recommendations:

1. The execution modality of the project, i.e., NGO execution, will be unchanged and retained. FHI will be the Executing agency as mentioned in the project document.

2. The NCASC will appoint the National Project Director (NPD).

3. The NPD will not be involved in administrative issues like fund release and sub-contracting.

4. A smaller steering committee (as sub-committee of the NACC), comprising the concerned partners involved in the project will be established.

5. The Government's leadership role will be clearly mentioned in the project document.

6. The Secretary of the Steering Committee will be the NPD.

7. The project document will be circulated to the concerned Donors before it is submitted to the Government for approval.

UNITED NATIONS DEVELOPMENT PROGRAMME
Project of His Majesty's Government of Nepal

Project number:	NEP/00/013
Project title:	Assistance for an expanded rights-based approach to the concentrated HIV/AIDS epidemic in Nepal.
Project short title:	Response to HIV/AIDS in Nepal
Estimated start date:	1-Jan-01
Estimated end date:	31-Dec-01
Management arrangement:	NGO Execution
Designated institution:	Family Health International
Programme support/project site	Nationwide
Beneficiary country:	Nepal

Summary of UNDP & cost-sharing inputs
(as per attached budgets)

UNDP:		
TRAC (1&2)	$	60,000
TRAC (3)	$	
STS	$	
Other	$	
Cost-sharing:		
Government	$	
Third Party		
UNAIDS	$	150,000
DFID	$	2,326,085
Total	$	2,536,085
Administrative and operational services		
Administrative Cost	$	72,119

Donor In-Kind Contributions US$

USAID	$	564,133
AusAid	$	100,000

Classification Information

ACC sector and subsector: Health; Disease Prevention and Control

DCAS sector and subsector: Health; Immunization and Other Disease Control Campaigns

Government sector and subsector:

Primary areas of focus/sub-focus: Prevention of HIV/AIDS

Secondary areas of focus/sub-focus: Programme Development

Primary type of intervention: Behaviour change;Capacity-building

Secondary type of intervention: Direct Support; Advisory Services

Primary target beneficiaries: Sex workers, Clients, Injecting Drug Users

Secondary target beneficiaries: Government, NGOs

LPAC review date: 20 December 2000
BPAC review date: N/A **Programme officer:** UNDP

Brief Description:

Data indicate that Nepal has passed from being a "low risk" country to being one with a "concentrated epidemic", that is, one in which HIV prevalence is consistently over five percent in one or more defined sub-populations. In Nepal, core subgroups are found among IDUs nationwide and FSWs in Kathmandu and the Nepal-Indian border.

This project is a "first" phase, addressing the urgent risk and harm reduction needs of FSWs, their clients and IDUs in Nepal. This phase will bridge the time needed to develop a broader, expanded response for these groups by supporting advocacy, research and the design, but at the same time trying to increase coverage of services for the mentioned groups beginning in the Kathmandu Valley.

Approved by:	Signature	Date	Name/Title
Government		26.04.01	U.S. Sunder Man Shrestha, Under secretary
UNDP		26 APR 2001	Henning Karcher, Resident Representative