**FUNDING REQUEST APPLICATION FORM**

**Full Review**

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| **SUMMARY INFORMATION** |
| **Applicant** |  **CCM Nepal** |
| **Component(s)** |  **HIV** |
| **Principal****Recipient(s)** |  **Save the Children**  |
| **Envisioned grant(s)****start date** |  **16 March 2018** | **Envisioned grant(s)****end date** |  **15 March 2021** |
| **Allocation funding request** |  **USD 21,964,144** | **Prioritized above allocation request** |  **USD 11,800,000** |

***IMPORTANT:***

**To complete this funding request**, please:

- Refer to the accompanying ***Funding Request Instructions: Full Review****;*

- Refer to the Information Note for each component as relevant to the funding request, and other guidance available, found on the [Global Fund website.](http://www.theglobalfund.org/en/applying/funding/resources/)

- Ensure that all mandatory attachments have been completed and attached. To assist with this, an application checklist is provided in the Annex of the *Instructions*;

- Ensure consistency across documentation.

**Applicants are encouraged to submit a joint funding request** for eligible disease components and resilient and sustainable systems for health (RSSH).

**Joint TB/HIV submissions are compulsory for a selected number of countries with highest rates of co-infection.** See the related [guidance f](http://www.theglobalfund.org/en/applying/funding/resources/#coreinformationnotes)or more information.

**This funding request includes the following sections:**

**Section 1**: Context related to the funding request

**Section 2**: Program elements proposed for Global Fund support, including rationale **Section 3**: Planned implementation arrangements and risk mitigation measures **Section 4**: Funding landscape, co-financing and sustainability

**Section 5**: Prioritized above allocation request

**SECTION 1: CONTEXT**

This section should capture in a concise way relevant information on the country context. Attach and refer to key contextual documentation justifying the choice of interventions proposed. To respond, refer to additional guidance provided in the *Instructions*.

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| **1.1 Key reference documents on country context** |
| List contextual documentation for key areas in the table provided below. If key information for effective programming is not available, specify this in the table (“N/A”) and explain in Section 1.2 how this was dealt with within the context of the request, including plans, if any, to address such gaps.Applicant response in table below. |
| **Key area** | **Applicable reference document(s)** | **Relevant section(s) & pages nb.** | **N/A** |
| **Resilient and Sustainable Systems for Health (RSSH)** |
| Health system overview | Nepal Health Sector Strategy 2015-2020 | p i,6,24  | ☐ |
| Health system strategy | Nepal Health Sector Strategy 2015-2020 |  | ☐ |
| Human rights andgender considerations(cross-cutting) | Progress Report on Gender Equality and Social Inclusion for NHSP-2, 2013/14  |  | ☐ |
| **Disease-specific** |
| Epidemiological profile (including interventions for key and vulnerable populations, as relevant) | AIDS Epidemic Model: Impact Modelling and Analysis for Fast Tracking the HIV Response in Nepal (2015); IBBS among Key Populations 2015IBBS among Key Populations 2016IBBS among Key Populations 2017National HIV Infection Estimation, 2016, NCASC Mapping and size estimation of FSW, MSM, MSW, TG and PWID in Nepal, 2017Nepal Demographic and Health Survey Key Indicators, 2016 GAM 2017 report | p 22P 4,11, P 4,5,7p 4,5, 15 | ☐ |
| Disease strategy(including interventions for key and vulnerable populations, as relevant) | National HIV Strategic Plan 2016-2021 | p 1,3,5,6  | ☐ |
| National HIV Testing and Treatment Guidelines 2017 | p 13  |
| Operational plan,including budgetary framework | National HIV Investment Plan 2016-2021 | p34 | ☐ |
| Program reviews and/or evaluations | Joint GF & USAID/PEPFAR Key Population HIV Cascade Assessment (July 2017)  | p 7 | ☐ |
| Assessment of Laboratory Support to HIV, TB and Malaria Programmes in Nepal | p 16  |
| Nepal National AIDS Spending Assessment (NASA) 2013-2014 | p 23 |
| Human rights andgender considerations(disease-specific) | Gender Assessment of the National Responses to HIV and TB in Nepal 2016 | p 16 | ☐ |
|  | Assessment of the Legal and Policy Environment in Response to HIV in Nepal 2015 | p 8,9  |  |
| *Add rows as relevant, for any additional key area as relevant to the funding request* |

**1.2 Summary of country context**

To complement the reference documents listed in Section 1.1 above, provide a summary of the critical elements within the context that informed the development of the funding request. The brief description of the context should cover disease-specific and RSSH components, as appropriate, as

well as human rights and gender-related considerations.

**(maximum 2 pages per component)**

Nepal’s HIV epidemic remains concentrated among key populations, with HIV prevalence at 8.2% among men who have sex with men (MSM) and transgender people in certain parts of the country; up to 8.5% among people who inject drugs (and 8.8% among women who inject); 2.2% among female sex workers; and 0.4% among male labour migrants.[[1]](#footnote-1) The majority of new infections are occurring among ‘low risk’ women (from their spouses), male labour migrants and MSM (Fig.1).[[2]](#footnote-2) Estimated annual new infections have declined from 5,626 in 2002 to 942 in 2016, and the trend of AIDS-related deaths is also declining (from an estimated 2,238 in 2013 to 1,771 in 2016).[[3]](#footnote-3) The number of people accessing ART is increasing, particularly with Nepal’s recent adoption of the Test and Treat strategy. As of December 2016, 18,130 (55.38%) of the estimated 32,735[[4]](#footnote-4) people living with HIV in Nepal had been diagnosed and linked with HIV care, and 41% (13,447 as of 15th March 2017) were receiving ART[[5]](#footnote-5). In 2016, 86.6% of people on ART were still on treatment after 12 months.[[6]](#footnote-6) Although data on viral suppression are scarce due to the limited availability of viral load testing, in 2016, 6,209 (88%) out of 7,042 people on ART who were tested were found to have suppressed viral loads.[[7]](#footnote-7) In 2016, around 63% of all estimated HIV-positive pregnant women received ART,[[8]](#footnote-8) which provides protection against mother-to-child transmission, reduces the risk of HIV transmission to HIV-serodiscordant partners and improves maternal health.

Figure 1. Route of Transmission 1990-2020 (Nepal)



Figure 2. Treatment cascade in Nepal, 2016



Nepal’s Constitution guarantees access to basic health services, free of charge, as a fundamental right of all Nepali citizens.[[9]](#footnote-9) As HIV is considered a high-priority national development programme, these basic services include HIV testing services and first-line ARVs.[[10]](#footnote-10) Nevertheless, there are significant gaps in the prevention-treatment continuum (Fig. 2). Despite generally high coverage of HIV prevention services, delivered largely by CSOs and NGOs, the testing yield among key populations is low. Ensuring that people at risk are tracked across the HIV cascade, from reaching and testing to treatment and care, also remains a challenge.

At the same time, financial, socio-cultural, geographical and institutional barriers continue to prevent many people from accessing HIV and other health services. Women and girls, particularly in resource-poor communities, still occupy marginalised positions in society,[[11]](#footnote-11) making them more vulnerable to discriminatory treatment and violence, inhibiting their access to health care and affecting their overall wellbeing. Although Nepal was the first Asian country to recognise sexual and gender minorities in its constitution,[[12]](#footnote-12) members of key populations continue to face high levels of discrimination, and in some cases violence, in the community, from law enforcement personnel and in health care settings. Low awareness among health care workers of the specific health needs of transgender people and men who have sex with men,[[13]](#footnote-13) deters them from accessing critical STI and other services. PLHIV and key populations have very little protection of their rights vis-à-vis health care and employment, despite constitutional prohibitions on discrimination on the basis of sex or health status.[[14]](#footnote-14) Instances of PLHIV being denied access to essential treatment of investigative procedures for other diseases (e.g. dialysis, endoscopy), as well as the persistent reports of discriminatory treatment of KPs in health care settings, highlight the need for more attention to be paid to capacity building for health care workers on medical ethics, human rights, gender sensitivity and accountability, as well as for effective systems for community monitoring, advocacy and redress. For the upcoming funding period, these issues will be largely addressed through the proposed catalytic investments supported by the Global Fund and domestic resources.

There has been a substantial expansion in the number of facilities providing HIV testing, ART and eVT services, many of which are now available at the community (primary health centre) level. However, the fast tracking of the HIV response towards the 90-90-90 treatment targets (see below) is likely to put pressure on an already overburdened public health system. As acknowledged by the National HIV Strategic Plan 2016-2021 (NHSP) and the Nepal Health Sector Strategy 2015-2020 (NHSS), effective implementation calls for more robust collaboration, task sharing and partnerships between the government and other service providers in the community, NGO and private sectors; improving the quality of care (and accountability of service providers); and strengthening the quality and utilisation of evidence. There are clear opportunities for a rational redistribution and sharing of certain tasks to non-HIV specialists or trained lay health providers in the community, and by leveraging the use of mHealth technologies to improve patient monitoring, adherence, access to information, supply chain management and numerous other applications.

The NHSP 2016-2021 was developed in the context of Nepal’s commitment to reaching global, regional and national targets on health and AIDS, including the SDGs, the UN Political Declaration on Ending the AIDS Epidemic as a Public Health Threat by 2030. It was guided by the Nepal HIV Investment Plan 2014-2016 and the recommendations of the mid-term review, which recommended prioritized actions and a more strategic allocation of resources to reduce the country’s HIV burden.[[15]](#footnote-15) Amid rapidly declining external funding for HIV and AIDS (see Section 4), the NHSP urges the further integration of HIV service delivery within the existing health sector systems and structures, while maintaining delivery of essential services to key populations affected by HIV.

The NHSP 2016-2021, which was developed through a multistakeholder consultative process in which key populations played a central role, sets out strategies to fast-track Nepal’s HIV response towards achieving the 90-90-90 treatment targets by 2021 in order to end the AIDS epidemic by 2030. The strategy addresses critical gaps in the prevention-treatment continuum through significant investment in HIV prevention activities (in 2015, Nepal invested more than 40% of its total HIV funding in prevention) among key populations, focusing on the major sources of new infections; increasing HIV case finding through innovative approaches such as community-led testing; and case management. These strategies have been further articulated in the innovative Identify, Reach, Recommend, Test, Treat and Retain (IRRTTR) approach, which attempts to address the critical gaps in the prevention-treatment continuum by envisaging interventions across the entire HIV cascade, with a focus on case finding and case management. An accompanying Investment Plan (NHIP)[[16]](#footnote-16) details the targets and costs for the IRRTTR activities as well as critical programme and social enablers required to support effective implementation.

This funding request reflects the priorities identified in the NHSP and through the country dialogue process. The prioritised modules include prevention programmes for key populations (which will focus on identifying and reaching people at the highest risk and increasing demand for testing and other services); and treatment, care and support. Strategic investments to address the gaps in health and community systems and the gender and human rights barriers to access referred to above will help to maximise the impact of the basic programme interventions while contributing to the development of a more sustainable health system overall.

**1.3 Past implementation and lessons-learned from Global Fund and other donor investments**

a) List recent disease-specific Global Fund grants from the 2014-16 allocation period and summarize key lessons learned from their implementation.

b) Include lessons-learned from specific HSS grants or any HSS investments embedded in the disease-specific grant(s) from the 2014-16 allocation period as applicable.

c) Outline lessons learned from investments by other donors as applicable.

For each of the above, explain how these lessons learned are taken into account in this funding request.

**(maximum 1 page per component)**

The only active HIV grant is NPL-H-SCF, which was a costed extension of the Round 10 Proposal to contribute to the achievement of MDGs 4, 5 and 6.

1. **Comprehensive HIV prevention programmes for key populations** are implemented not only through the Global Fund and USAID FHI360360 (Linkages) programmes, but also by the National Centre for AIDS and STD Control (NCASC) using domestic sources. To implement the TI programme, NCASC subcontracts NGOs through the government procurement process, but due to the complicated and protracted procedure, implementation is often delayed. As a result, all parties have to work under pressure to achieve the spending and programmatic targets over a shorter period, leading to comprises in quality (the standard packages not being fully implemented), coverage gaps and service gaps. A key lesson learned is that domestic resources could be more effectively used now to build more resilient and sustainable systems within the public health system. This request therefore focuses Global Fund support on innovative community-based services to reach key populations with critical prevention and testing interventions, and improve retention among PLHIV. This will free up some domestic resources towards the GoN’s commitment to funding the eVT and TB-HIV programmes and 100% of ARV procurement by 2019, as well as the operational costs of service delivery sites. Certain comprehensive HIV prevention programme for KP will remain with NCASC. These include HIV services in prisons and closed settings, which requires close collaboration between the Ministry of Health (MoH) and Ministry of Home Affairs (MoHA), and HIV prevention among seasonal labour migrants to certain high HIV prevalence destinations in India.

1. In the last two years of the grant, opioid substitution therapy (**OST**) has been expanded to12 sites. However, enrolment and retention have remained challenging. It was recognized that significant improvements in results were unlikely without innovations that would enable clients to better integrate OST into their daily routines, and enhance clients’, service providers’ and policy makers’ understanding of the purpose and benefits of OST. This funding request therefore includes support for the following innovations: the phased initiation of satellite dispensing units to bring services closer to the clients; support for OST champions in the medical community to advocate to policymakers for (among other things) more client-friendly dispensing practices; demand generation and treatment literacy initiatives; and support for in-reach/outreach staff as role models to motivate OST clients.
2. A **cascade assessment** undertaken in July 2017[[17]](#footnote-17) showed that the HIV test yield across all key populations is very low. It therefore recommended a greater emphasis on partner testing and index testing; better characterization of risk; and exploring the social networks of positive people to increase case finding.
3. To address **high rates of loss to follow-up** among those in HIV care and to support retention, the cascade assessment recommended (i) incorporating peer navigation into the community care programme in order to track and provide better support to PLHIV as they initiate care/treatment services, (ii) introducing a differentiated care model, including decentralizing ART dispensing to primary health care centres (PHCs), which the GoN has initiated. This application proposes support for peer navigation, as well as training for HCWs and ensuring supplies of medicines at dispensing sites.

1. It has become apparent that Nepal’s current **viral load testing** set-up cannot adequately deliver timely viral load testing for the growing number of people on ART. Only three sites are functional, while various problems associated with sample transportation and handling are also impeding the provision of viral load testing services. There is growing recognition among the key agencies involved, including NPHL, that since there are now 31 GeneXpert machines in the country for the TB programme, most of which are currently underutilized, with additional machines planned, the country should rationalize the use of the GeneXpert platform for HIV viral load testing as well. This funding request proposes, among the RSSH interventions, a redistribution of existing and planned GeneXpert capacity in line with the needs of the decentralised HIV and TB programmes, as well as collaboration on equipment validation including GeneXpert cartridge for monitoring HIV viral load, staff training and development of sample collection, transport and storage systems.
2. The data on service utilisation (from programme M&E data) suggest that overall **service utilisation by women is lower** than that of men in all key population-related services. Factors that may be contributing to this have been articulated in recent gender assessments and through the country dialogue, and will be explored further in the assessment of human rights barriers commissioned by the Global Fund. The situation clearly demands more concerted and innovative approaches to remove gender and human rights-related barriers. In this application, interventions to redress the gender balance in term of service utilisation include specific, women-led services for women who inject drugs. Other interventions, including training on gender and human rights for health care workers and law enforcement agents, will be identified in the catalytic funding request.

These lessons learned are reflected in this funding application.

**SECTION 2: FUNDING REQUEST (Within Allocation)**

This section should describe and provide a rationale for the program elements proposed for this funding request. Attach and refer to completed **Programmatic Gap Table(s), Funding Landscape Table(s), Performance Framework and Budget**, and refer to national strategy documents as applicable.

To respond, refer to additional guidance provided in the *Instructions.*

Ensure that the funding request as described in questions 2.1 and/or 2.2 meets the focus of application requirement as outlined in section 2.3.

**2.1 Disease-specific funding request**

*Not applicable if the application is a standalone RSSH request.*

Given the context and lessons learned outlined in Section 1,

a) Describe the disease-specific funding request(s), the rationale for prioritizing modules and interventions, and how these choices ensure the highest possible impact with a view to ending the three diseases and removing human rights and gender-related barriers to accessing services.

For any priority modules for which gaps are difficult to quantify in the programmatic gap tables, explain here the barriers being addressed, the proposed interventions and the population or groups involved.

b) Explain how the funding request addresses the key funding gaps reflected in the Funding Landscape Table(s) for the disease program(s) in the current allocation cycle, and specify other actions planned to cover remaining gaps.

For funding requests including both HIV and TB components:

c) Describe the coordination of joint TB and HIV strategies, policies and interventions at different levels of the health system, including community systems, and expected impact and efficiencies from the joint programming.

Ensure the answer appropriately reflects the separate disease programs in addition to cross cutting modules where appropriate.

**(maximum 4 pages per component)**

The modules and interventions outlined below were selected in accordance with the NHSP priorities, gaps identified in the programmatic and funding landscape analyses, and the recommendations of the country dialogue process.

Further considerations for module selection included the constraints on the resource landscape for the upcoming funding cycle (see Section 4.1), which has left the HIV response with a significant programmatic and financial gap (see PGA and funding landscape tables). Country stakeholders have agreed to a realignment of funding in which domestic resources will be increased and focused on ARV procurement, eVT, TB-HIV and building resilient and sustainable systems for health (including operational & human resource costs at service delivery points). Key population interventions will be largely supported by the Global Fund (with the exception of the migrant, female sex worker and prison programmes – see below). This should ensure more standardised implementation and quality, and reduce the overall transactional costs to the programme associated with NGO/SR management and M&E.

To maximise the impact of the investments, several activities are proposed through the catalytic investments supported by the Global Fund and domestic resources. These will address prejudice and discrimination against key populations and people living with HIV, as well as gender-related violence that affects women and girls, transgender people and men who have sex with men, which remain key impediments to accessing treatment.[[18]](#footnote-18) The interventions include the operationalisation of the SMS2 service quality monitoring platform, which collects real-time feedback from clients and HCW on the services received/provided, to guide and track improvements; training for health care workers (HCW) on zero tolerance of discrimination, including sensitisation on the specific health needs and rights of different key populations; addressing self-stigmatisation through support groups/networking and training of key populations on identity acceptance and disclosure. The cost for these activities will be budgeted in the Catalytic Fund application; sensitisation for law enforcement agents on gender and human rights, particularly related to HIV-related interventions for key populations; referral to legal redress and support services for key populations.

The goal, objectives and modules proposed for funding are as follows:

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| **Goal** | To contribute towards the NHSP targets of 90-90-90 and equitable access to HIV services. |
| **Objectives** | 1. Accelerate and scale up comprehensive HIV prevention programmes among PWID, MSM, MSW and TG people.
 |
| 1. Expand access to and coverage of quality, equitable and gender-sensitive HIV diagnosis, treatment, care and retention through enhanced case management with strengthened health and community systems.
 |
| **Modules** |
| Comprehensive HIV prevention programmes for PWID & their partners | Identify, Reach, Recommend, Test |
| Comprehensive HIV prevention programmes for MSM |
| Comprehensive HIV prevention programmes for TG |
| Comprehensive HIV prevention programmes for (male) sex workers & their clients |
| PMTCT (eVT) | Treat and Retain – this application aims to provide training support to health service providers for eVT throughout the country |
| Treatment, care and support | Treat and Retain |
| Resilient and Sustainable Systems for Health (RSSH) |  |

**Comprehensive HIV Prevention Programmes for Key Populations**

Interventions are focused on a strategic mix of case-finding activities (in-reach, outreach and both community-led and facility-based HIV testing services) to increase testing coverage and yield, and facilitate earlier diagnosis of HIV. Programme districts were selected on the basis of key population size estimates, mapping and epidemiological data. Within districts, implementation will be guided by local level data and GIS mapping to enhance identification, targeting and reach, particularly of those at the highest risk.

The USAID/FHI360 Linkages programme will continue to support some interventions among FSW in 16 districts including MSM, TG, MSW in five districts in 2018-19, but no further external funding is envisaged from this or any other source beyond this time. Continued support for interventions in these sixteen districts beyond 2018 is therefore proposed in the Prioritised Above Allocation Request (see Section 5).

Interventions to cover 90% of migrants at high risk (those who migrate seasonally to high HIV prevalence states in India, and who engage in HIV risk behaviours) will be financed by domestic resources. Support for a study on migration patterns to guide the design and targeting of coverage targets and interventions is proposed in the Prioritised Above Allocation Request (see Section 5).

HIV interventions in prisons and other correctional facilities will continue to be implemented by NCASC in cooperation with the Ministry of Home Affairs, supported by domestic resources. To inform the planning and implementation of these interventions, an assessment of HIV risk and vulnerability in prison settings is planned under this grant (see RSSH). However, if possible, the assessment will be conducted in the current implementation period using savings from the current grant.

Global Fund-supported prevention programmes will continue to be implemented by community-led (where possible) NGOs working under experienced sub-recipients (SRs) with proven programme implementation, management and financial capacity. To rationalise management, standardize service delivery and improve cost-effectiveness, a clustering modality for KPs based on geographical prioritisation will be adopted, in which activities in two or more neighbouring districts will be grouped under a single SR.

Priority comprehensive HIV prevention programme for men who have sex with men, transgender people, male sex workers, and people who inject drugs, will comprise the core activities described in Box 1, as well as specific activities outlined under each key population.

Prevention interventions will be linked to the activities proposed for catalytic funding described above.

**Box 1. Common core activities of Comprehensive HIV Prevention Programmes for key populations.**

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| Community empowerment for key populations: community competencies will be built (at individual and organisational levels) to identify and reach more people at risk, recommend more people to access HIV testing as well as other interventions, and provide HIV testing for triage. Initial training will be consolidated through regular supportive supervision and mentoring.Behavioural interventions for key populations: NGO/CBO competencies will be strengthened on community/hotspot mapping and size estimations using local-level data, GIS and social media to improve identification, targeting and coverage of key populations. In-reach/outreach strategies, including information & education, risk reduction counselling, and recommending HIV testing, STI and other RSH services, viral hepatitis and TB services, will be used to reach wider and deeper into communities. Relevant, targeted approaches will be developed for more effective reach using social media and smart technologies (e.g. apps, interactive voice response, online materials on HIV & risk issues). NGOs/CBOs will provide referral (accompanied where necessary) to HIV testing, STI, eVT, ART, TB, CHBC and viral hepatitis services. Condoms and lubricant programming: condom & lube distribution will be supported by targeted IEC and training for in-reach/outreach workers on demand generation and condom negotiation skills. In addition, the condom/lube supply chain will be reviewed and strengthened to ensure adequate, regular supplies in all locations.HIV testing: 100% of sex workers, MSM, TG and PWID who are reached by the programme will receive an HIV test twice a year by 2021. Modalities include testing for triage in community settings, or PITC in SRH, ANC or TB settings, with accompanied referral to confirmation testing (from community settings) and/or linkage to treatment for people screening positive. Testing will include recommendation and or referral to partner testing, disclosure support. People with non-reactive tests will be continuously re-engaged and recommended for further testing and other services including risk reduction counselling. STI & other sexual health services.Prevention and management of coinfections and comorbidities: referral to TB services (training on symptomatic TB screening will be provided for HCW and community-led testing providers). To address high rates of HCV,[[19]](#footnote-19) diagnosis of viral hepatitis and HCV treatment for HIV-HCV will be provided for coinfected persons. Referral to mental health services where necessary.Interventions for young key populations: appropriate IEC materials and risk reduction strategies will be developed for young key populations; in-reach/outreach workers will be trained on risk reduction counselling. HCW will be trained on overlapping vulnerabilities of young key populations and their specific health needs and rights. To expand the evidence base for interventions for young KPs, the scope of the IBBS will be expanded to cover young and adolescent key populations, and the methodology and questionnaires updated accordingly (no cost). Support is requested for analysing and producing these disaggregated reports. |

1. **Comprehensive HIV Prevention Programmes for MSM, TG and MSW**

A defined package of HIV prevention and testing interventions for MSM, TG and MSW will be implemented in 23 districts, which will be grouped into 6 geographic clusters. Coverage of both prevention interventions and HIV testing will increase to 90% (57,702 MSM, 20,804 TG, 17,410 MSW) in 2020-21.

The proposed package includes the prevention interventions outlined in Box 1 above, as well as the following specific interventions for MSM, TG and MSW:

* HIV self-testing: will be conducted as an FHI360-supported pilot among MSM, TG and MSW in late 2017 and then, based on recommendations, rolled out to a larger cohort of MSM, TG, MSW and FSW in 2018 and 2019. After evaluation, Global Fund support may be requested to continue this intervention in 2019-20 and 2020-21 as part of the broader strategy to increase case finding.

PrEP: an FHI360-supported pilot of PrEP is planned for 2018-19 among FSW, MSM, MSW and TG who are at very high risk of HIV. Support is requested for the continuation of PrEP in 2019-20 and 2020-21, based on the findings from the pilot, among MSW, who were envisaged as the key target population of PrEP in the NHSP. Activities will include the finalisation of PrEP protocols and training, including recording and reporting, for clinicians, HIV counsellors and other health care workers.

* Hormone replacement therapy (HRT) counselling will be included in existing training package for TG, including counselling on safe injecting and interactions between HRT and ART.
* Harm reduction: risk reduction counselling and referral to OST and NSP services will be provided for MSM, TG and MSW who inject drugs.
1. **Comprehensive HIV Prevention Programmes for PWID**

A defined package of HIV prevention, testing and harm reduction services for PWID will be implemented in 26 districts, grouped into 9 clusters. Coverage of both prevention interventions and HIV testing will increase to 90% (29,522) in 2020-21. OST coverage is targeted at 10% of the PWID population in all three years (3280 in 2020-21), through 15 sites and up to 9 satellite sites by 2020.

In addition to the package of prevention interventions outlined in Box 1, specific interventions for PWID will include:

* Needle and syringe programming (NSP): NHIP targets for the coming funding period are based on the distribution of an average 10 needles/syringes per month for every person who injects drugs (actual need/distribution will differ from person to person). The NSP programme will include local-level advocacy meetings.
* Naloxone distribution for overdose prevention & management.
* Opioid substitution therapy (OST): As of July 2017, 1,054 PWID are currently on OST (864 on methadone, 190 on buprenorphine), at 12 sites (4 NGO-managed sites and 8 government hospitals). There is a strongly felt need among the PWID community for improved access to OST through more accessible sites and implementation modalities, more targeted demand generation interventions and better motivation and treatment literacy, which are expected to address the challenges of low uptake and retention. The role of the Social support units (SSUs) will be reviewed and SOPs developed to support improved retention and social reintegration. SSUs will be institutionalised as part of the hospital system where OST medical units are available.

The expansion of OST sites will include the introduction of satellite units at 2-3 sites initially, and then expanded to 7-9 sites in total (based on an assessment of the initial satellite sites) by 2020. Capacity building will be provided for technical facilitators, including regular review meetings and strengthening of recording/reporting and oversight. OST champions in the medical community will be identified, trained and supported to advocate to the Ministries of Home Affairs and Health. In-reach/outreach workers will have a comprehensive orientation to OST to empower them to act as role models, motivate and generate demand for OST. Relevant, compelling IEC materials (print, video) will be developed for treatment literacy and demand generation. However, if possible, evaluation of OST sites and drug use pattern will be conducted in the current implementation period using savings from the current grant

Global Fund support is also proposed for social support unit staff (NGO personnel) and the procurement of methadone and buprenorphine. GoN will cover the salaries of the medical doctors overseeing the sites.

* Interventions for women who inject drugs: As a means of improving women’s access to services, two needle-syringe sites for women, operated by women-led NGOs, will be established.
* Strengthening of PWID-led networks to coordinate and support increased uptake of NSP, OST and other harm reduction activities (including drug rehab/detox services), through short-term technical assistance.
1. **Treatment, Care and Support**

HIV case identification is expected to increase through the implementation of CLT, test and treat, more vigorous TB/HIV screening, and CCC. More people will also be retained on treatment. However, given the declining trend in prevalence among key populations and decreasing number of PLHIV,[[20]](#footnote-20) new case identification is expected to increase only until 2019, and decline thereafter. In view of this, the treatment targets are set at 58% of estimated PLHIV in 2018-19, increasing to 74% in 2020-21 (Figure. 3). These targets are based on the current infection estimates, which are annually updated.

Figure 3. Expected scale and impact of Global Fund support in Nepal



To help close the treatment gap and build greater sustainability into the treatment programme, the Government of Nepal has committed to increase its share of funding for treatment, contributing 80% of the cost of ARVs by 2018-19 and 100% from 2019-20 onward. Besides, operational costs and salaries of staff, including HIV counsellors at each ART centre and dispensing site will be funded by government from 2018.

Challenges and gaps related to the accessibility and quality of treatment and care, in the context of reaching the national targets for enrolling and retaining people in treatment and reducing their viral loads to undetectable levels, will be addressed through the following interventions.

Differentiated ART Service Delivery

The GoN is planning an ongoing expansion of HIV services from the current 66 sites,[[21]](#footnote-21) to all 75 districts of the country as well as decentralisation to ART dispensing units at selected PHCs. As earlier diagnosis and treatment are anticipated due to ‘test and treat’, there is an opportunity to make it easier for clients to access and stay on treatment by matching their individual needs to differentiated levels of care, as envisaged in the 2017 Treatment Guidelines.[[22]](#footnote-22) To support this, Global Fund support is requested for:

* Training on the updated guidelines and regular supportive onsite supervision/mentoring for clinicians, nurses, health assistants, HIV counsellors/case managers (including counsellors in the newly established dispensing units), lab technicians, M&E staff and logistics staff.
* Monthly ART coordination meetings (local health authority, hospital, ART centre, case management team, PLHIV networks and CCC/CHBC teams) for monitoring, performance review and planning. Community led testing through mobilisation of CCC/CHBC team for KPs in those districts where there is no KP led interventions in operation.
* Engaging CHBC teams as ‘peer navigators’ to support and track PLHIV in initiating treatment and care services.
* Ensuring supplies of ARVs to dispensing sites from ART sites.
* Developing and implementing a treatment literacy programme, including training for HIV counsellors and CCC/CHBC teams, to ensure that clients, particularly stable patients who are deemed eligible for longer appointment spacing, have a better understanding of their treatment regimen, the importance of monitoring and adherence, and associated health issues.
* Linking (existing) hospital dieticians to each ART team to provide nutrition counselling where needed.
* Addressing gaps in the provision of CD4 testing (required as a baseline measure at ART initiation) to avoid delays in initiation: same-day diagnosis and treatment should be provided where possible. This may entail the purchase of new equipment as well as training for lab staff and the repair/maintenance of existing facilities.
* Treatment interventions will be supported by activities to address discrimination and rights to health issues in health care settings which will be supported by catalytic funding.

Pharmaceutical and health products

Global Fund support is requested for 20% of procurement ARVs in 2018-19, as well as costs related to treatment initiation and routine laboratory and clinical monitoring over the funding period. The GoN will cover 100% of ARVs in 2019-20 and 2020-21.

Since the GoN’s fiscal year for the annual budget and program planning does not match with the periods of the new funding application, the actual percentage shown each year in the National Supply Plan does not match with the stated percentage contribution. The quantification and percentage contribution from the Global Fund and the GoN will be finally worked out during grant negotiation period.

Treatment monitoring

The programme is planning to scale up and decentralise VL testing through a more rational use of existing capacity in the country. The GoN has allocated additional funds to purchase new VL machines to supplement the existing VL centres,[[23]](#footnote-23) and the HIV programme will also have access to more than 30 GeneXpert machines managed by the TB programme, to ensure that every ART centre is linked to a local VL testing facility. Global Fund support is proposed for training lab staff on using GeneXpert for VL monitoring. CD4 and EID training will also be provided. Maintenance of CD4, VL and other health equipment is requested from the Global Fund.

Support for the ongoing development and roll-out of the HIV tracker (database) with UIC system in DHIS2 platform (which is also being used by MoH as part of HMIS), is requested as an RSSH intervention. This will include applications for patient tracking, monitoring and adherence.

Treatment adherence, counselling & psychosocial support and other treatment interventions

To enhance treatment adherence and retention in the cascade, outpatient care delivered through the largely PLHIV-led Community Care Centres (CCC) and Community and Home-Based Care (CHBC)[[24]](#footnote-24) will be rationalised as part of the differentiated care approach. CCC/CHBC providers will work closely with ART teams, with HIV counsellors as the focal point, to take on a greater case management role. CCC/CHBC providers will also be trained and supported to provide treatment literacy, as well as psychological support and adherence evaluation, including for stable clients who are having less frequent clinical visits. In addition, CCC/CHBC providers will be trained to carry out CLT for partners/spouses of PLHIV and other key populations, particularly among migrants and their spouses where other service providers are not available. CCC/CHBC providers will also be carrying out a ‘Right to Health’ campaign, supported by catalytic funding, which will be critical in increasing ART uptake. Adherence clubs for key populations who are on treatment will be explored where there is sufficient capacity and demand, and expanded if deemed effective.

Other treatment interventions

Cervical cancer is the most frequent cancer among women in Nepal.[[25]](#footnote-25) Women living with HIV have a higher risk of developing cervical cancer than HIV-negative women, and WHO recommends annual cervical cancer screening for women and girls who are living with HIV.**[[26]](#footnote-26)** A study on Cervical Cancer Screening among women living with HIV is being conducted by the Save the Children. Based on the findings of the study, support may be proposed to Global Fund for initial and annual cervical cancer screening, and referral to treatment where necessary, for women who test positive for HIV. Additionally, GoN has initiated HPV vaccination among adolescent girls with the aim of expanding it to across the country which will also benefit adolescents KPs.

**PMTCT (Elimination of Vertical Transmission - eVT)**

The eVT (PMTCT) programme is now well-established as an integral component of ANC services throughout the country, with HIV screening and counselling for ANC visitors up to the health post level in 55 districts as of July 2016, and by the end of 2017, all health care providers in the country will have been trained on eVT. In line with the NHSP eVT target of 90% coverage by 2020-21, GoN will take over major role of screening among pregnant women from 2018-19. However, Global Fund support is proposed for the following critical activities for comprehensive eVT programme:

* eVT training for service providers
* Transport costs for the collection of DBS for early infant diagnosis (EID) to EID testing.
* Cash incentive to women tested positive for encouraging regular ANC attendance and institutional delivery.
* Cash transfers for children living with HIV for 2018/19 and 2019/20. Every HIV-positive child receives NRs.1000 per month to go towards their education, health, nutrition and livelihood costs. By Year 3, this support will have transitioned to the national social security system under the Ministry of Federal Affairs and Local Development).
* Income generation and livelihood support programmes for eligible women living with HIV.
* eVT orientation for private hospitals.

**Collaboration on TB-HIV Coinfection**

With TB prevalence among PLHIV at 11.2% and HIV prevalence in TB patients at 2.4%,[[27]](#footnote-27) collaborative TB-HIV interventions remain an important component of the programme. All diagnosed HIV cases are currently screened/tested for TB at HIV treatment centres, and all ART centres provide symptom-based TB screening for ART clients every 3 month, and IPT for those who do not have active TB. In addition, with strong cooperation between the eVT and TB programme on access to HIV test kits, 60%[[28]](#footnote-28) of TB patients are now receiving HIV screening, with 100% targeted by 2020. TB-HIV collaborative activities will be fully covered by the GoN from 2018-19. Some Global Fund resources are proposed to support the greater integration of TB and HIV services, such as the provision of TB screening with CLT, and the use of GeneXpert technology for HIV viral load testing.

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| **2.2 RSSH funding request** |
| The Global Fund strongly encourages funding requests for RSSH investments to be submitted within a ***single*** application, and preferably to be requested in the first submission. |
| **Does this funding request include an RSSH component?** | ☑ Yes ☐ No |
| **If yes**, describe the request below and how it is strategically targeted.Referring to the national health strategy, gaps and lessons learned outlined in the previous section, describe the funding request for RSSH and how the investment is strategically targeted to strengthen systems for health and achieve greater impact on the diseases. In your explanation, refer to the Funding Landscape Table on ‘government health spending’, Performance Framework and Budget as appropriate. Note that it is optional to complete a Programmatic Gap Table for RSSH.**(maximum 3 pages)** |

The funding request for RSSH has been discussed jointly by all three disease programmes and with other development partners in the country, as part of the country dialogue.[[29]](#footnote-29) After consulting with the Global Fund country team it was decided that the RSSH request should be spread over all three disease applications. The interventions below have been included here in the expectation that they will not only increase the impact of the HIV programme but also contribute to the broader health system strengthening outcomes specified in the NHSS. They include some of the prioritized critical programmatic and social enablers identified in the NHIP, as well as interventions to address gaps identified through the country dialogue and a recent assessment of laboratory support for the three diseases.[[30]](#footnote-30) Where possible, efforts will be made to leverage synergies with the system strengthening activities of the other disease programmes and the development partners.

**Procurement and supply chain management systems**

Procurement strategy: Whilst there are now almost zero stock outs of ARVs, irregular supplies of OI drug, test kits, reagents and other commodities have been reported at some service delivery sites. These gaps will be addressed, as part of the broader strategy of integrating HIV-related procurement with the national procurement, through capacity building on requisitioning/forecasting at local level (for TB and Malaria as well as HIV), and strengthening LMD capacity to procure HIV products.

Supply chain infrastructure and development of tools: storage facilities, particularly at site level, will be upgraded, and a delivery truck (four-wheel) will be procured for the Logistic Management Division (MoH) to help ensure the cold chain.

National product selection, registration & quality monitoring: Capacity strengthening on pharmacovigilance, including training and mentoring, will be provided at ART centres, as well as to DDA staff as needed.

**Health management information system and M&E**

Routine reporting: Nepal has made substantial investments in updating its HMIS, developing DHIS2, and developing a unique identifier code (UIC) system. These tools will play a vital role in improving the tracking of clients across the prevention-treatment continuum, understanding how the various services interact and where and why clients drop out of the cascade. Global Fund support is therefore requested for the roll-out of the unique identifier code (UIC) system and case-based HIV database to all health facilities, with appropriate hardware and IT support. Where possible, support will be aligned with other development partner-supported activities on DHIS2. Opportunities to link private sector facilities to the tracking system/database will be explored. Reporting forms will be reviewed and updated to align with the IRRTTR approach and SMS2 interventions.

Programme & data quality: To ensure data quality, regular onsite data verification (OSDV) as well as supportive supervision on data collection, recording and reporting will be conducted at facility level.

Analysis, review & transparency: The SI technical working group will continue to plan and oversee the implementation of the annual M&E work plan, address related challenges and to finalise and disseminate the updated SI guidelines (no budget required). Annual reviews of the HIV programme will be conducted at subnational and national level.

Operational research: A risk and vulnerability assessment among the prison population will be conducted to guide interventions that will be implemented with domestic resources.

Surveys: To continue strengthen the evidence base for interventions, estimates and projections, IBBS will be carried out among people who inject drugs (IBBS among other key populations will be funded by domestic resources). The IBBS will include young people and adolescents in each population. Activities will include the updating of tools and protocols, training; data collection; and reporting & dissemination of results.

To enhance the local capacity on estimation and projection, a training on AEM spectrum model for key SI and programme people at Save the Children and NCASC is planned.

Evaluation of treatment outcomes after implementation of Test and Treat Strategy

**Human Resources for Health (HRH), including Community Health**

Capacity building for health workers at community level: The increasing numbers of people on treatment, the expansion of sites providing ART, eVT, testing and other services, and increased demand for HIV-related diagnostic and monitoring services are creating a growing demand for HCW with the relevant competencies. In addition, the frequent turnover and transfer of trained personnel in both the public and community sectors remains a challenge. Competency gaps will be addressed through in-service training (including refresher training) as well as through pre-service training where feasible.

A number of HIV-specific trainings are identified under the prevention, treatment and eVT modules: the training below is expected to have broader impact.

* Training on symptomatic TB assessment and referral for community-led testing (CLT) facilitators (integrated with CLT training);
* Strengthening capacity for the delivery of quality laboratory services. This will be based on the needs identified in the Assessment of Laboratory Support, and may include quality management and monitoring, biosafety, equipment operation and routine maintenance, information systems and data management, HIV drug resistance.
* Infection prevention and control as part of other laboratory related training for HCW; as well as Training on sample collection, transport & storage.

**Integrated service delivery and quality improvement**

The NHSP is predicated on the increasing integration of HIV and STI service delivery with general health services, particularly with MCH, SRH and TB services, in the expectation that this will reduce fragmentation and duplication, thereby reducing inefficiencies and costs and improving programme effectiveness.

Supportive policy and programmatic environment

The increasing integration of the programme and growing emphasis on community-led responses under NHSP 2016-2021 will be supported by strengthening the evidence base, systems and policy framework, including guidelines and SOPs. These activities will be led by NCASC with technical support where necessary. Support is requested for:

* Collaboration with the TB programme on the use of GeneXpert for HIV viral load testing (including cost of cartridges for VL testing).
* Support for finalising the national TB/HIV framework/guidelines in collaboration with the NTC is budgeted in the TB application.

Lab systems for disease prevention, control, treatment & disease surveillance

Nepal’s strategy for fast-tracking the HIV response through initiatives such as community-led HIV testing, test and treat and scaling up viral load testing will significantly increase demand for quality lab services. An assessment of laboratory support to the HIV and TB programmes in Q2 2017 identified an urgent need to strengthen various aspects of laboratory capacity. Activities proposed here are based on the recommendations:

* Strengthening the National Public Health Laboratory (NPHL) as the authority to monitor and support health laboratories to ensure alignment with National Laboratory Policy, National Guidelines and SOPs.
* Support for NPHL on developing an action-oriented and implementable programme based on the National Laboratory Policy
* Training all staff in Infection Prevention and Control (IPC) with emphasis on management of needle stick injury and post-exposure prophylaxis (PEP) as a part of advance clinical management training.
* Coordinate with TB programme for developing integrated training manual and package. This is budgeted in the TB application.

**Community responses and systems**

The IRRTTR strategy is centred on expanding the community’s role in case finding and case management as the programme scales up to achieve the fast-track targets. As reaching these targets will be contingent on reaching vulnerable and/or marginalised populations who for various reasons do not access health services, there is a need for continued investment in strengthening community capacity to carry out these roles. A critical component of this work is dismantling the barriers that impede the uptake and utilisation of HIV-related service: several activities to address this, including community-based monitoring and advocacy, particularly to ensure rights to health, are proposed for catalytic and domestic funding.

Support is proposed for:

* Expanding the community’s role in case finding and case management, including CLT and adherence monitoring through CCC/CHBC.
* Community Support System (CSS): supporting the PLHIV community in districts where there is no formal network or organised group in order to promote test and treat, support access to HIV services and support PLHIV to organise into strong networks/CBOs. Similar activities are proposed for the MSM and TG communities under the Prevention modules.

**If no**.

a) Indicate when the RSSH funding request was/will be submitted; and,

b) **If the RSSH funding request has not yet been submitted**, highlight below the elements of the planned RSSH investment that will directly support the disease program in this

funding request.

**(maximum ½ page)**

[*Applicant response*]:

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| **2.3 Focus of application requirement *1***This question is required for Lower-Middle Income (LMI) and Upper-Middle Income (UMI) countries. It is not applicable for Low-Income (LI) countries.To respond, refer to guidance provided in the *Instructions.* |
| **For LMI countries:**- Does the funding request focus at least 50% of the budget on: disease- specific interventions for key and vulnerable populations; programs that address human rights and gender-related barriers and vulnerabilities; and/or highest impact interventions?- For RSSH, does the funding request primarily focus on improving overall program outcomes for key and vulnerable populations in two or more of the diseases, and is it targeted to support scale-up, efficiency and alignment of interventions? | ☐ Yes ☐ No |
| ☐ Yes ☐ No |
| **For UMI countries:**- Does the funding request focus 100% of the budget on interventions that maintain or scale-up evidence-based approaches for key and vulnerable populations, including programs that address human rights and gender-related barriers and vulnerabilities? | ☐ Yes ☐ No |
| **Ensure that the funding request as described in questions 2.1 and/or 2.2 meets this focus of application requirement.** |

Not applicable for Nepal

1 Refer to the [Global Fund 2017 Eligibility List f](http://www.theglobalfund.org/en/fundingmodel/process/eligibility/)or income level. LMI and UMI countries have specific requirements in terms of the focus of applications as set forth in the Global Fund [Sustainability, Transition and Co-Financing Policy.](http://www.theglobalfund.org/en/fundingmodel/process/cofinancing/)

**SECTION 3: OPERATIONALIZATION AND RISK MITIGATION**

This section describes the planned implementation arrangements and foreseen risks for the proposed program(s). Applicants are encouraged to **attach an updated Implementation Arrangements Map.** To respond, refer to additional guidance provided in the *Instructions.*

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| **3.1 Implementation arrangements summary** |
| Do you propose major changes from past implementation arrangements, e.g. in key implementers, flow of funds or commodities? | ☐ Yes ☑No |
|  If **yes**, provide an overview of the new implementation arrangements and elaborate how these changes affect the operationalization of the grant.If **no**, provide a summary of high-level implementation arrangements focusing only on lessons learned for the next period.In **both cases**, detail how representatives of women's organizations, key populations and people living with the disease(s), as applicable, will actively participate in the implementation.Include a description of procurement mechanisms.**(maximum 1 page)** |

As Save the Children International will remain as the PR and the current implementation arrangements are working well, no major changes are proposed. However, the HIV partners, including the Government of Nepal, have agreed that the Global Fund money will mostly support interventions among key populations, while the GoN will increase domestic funding for procurement of ARVs and other commodities, the operational costs of government sites, and the recruitment of additional human resources at ART centres and OST sites. It will also address other critical gaps that cannot be covered by the Global Fund grant, such as HIV services among migrants and prison inmates, the eVT programme and TB-HIV interventions. This will help to ensure the sustainability of critical HIV services in the country.

The programme has consistently sought to ensure a high level of active, meaningful participation by women’s organizations, key populations and PLHIV in programme implementation, with more than 70% of the SRs currently working under Global Fund grant being either key population-led, PLHIV-led or women-led. Save the Children will give special priority to key population-led, PLHIV-led and women-led organisations when soliciting requests for proposals for the selection of partner NGOs to ensure that this level of participation will be maintained or increased in the coming funding period.

As described in section 2.1, the implementation districts will be grouped into geographically prioritised clusters, each managed by a single SR. This will reduce the overall number of SRs and is therefore expected to rationalise management, improve cost-effectiveness lead to more standardized service delivery.

During the process of making any major decision, be it during the roll-out of a specific intervention (e.g. community-led testing) or developing strategies for increasing the coverage of key populations, the PR consistently holds consultation meetings with key population networks and existing partners. By providing their feedback through such consultations, these organisations play an active role in implementation.

In addition, women’s organisations, key populations and PLHIV are well represented on the CCM and the CCM oversight committee, which continuously monitor the PR’s activities. This gives such organisations a voice in programme implementation.

There will be no change in the current procurement mechanisms with regard to procurement made by Save the Children, as the current PPM is working well. The GoN is proposing to make a significant increase in its procurement budget for ARVs and other commodities; the optimal procurement mechanisms for this are currently being explored, and will be discussed at a forthcoming high level meeting between the CCM and the GoN.

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| **3.2 Key implementation risks** |
| Using the table below, outline key risks foreseen, including those that were provided in the *Key Program Risks* table shared by the Global Fund during the Country Dialogue process. You can also add key operational and implementation risks, which you identified as outstanding over the previous implementation period, and the specific mitigation measures planned to address each of these challenges/risks to ensure effective program performance in the given context.Applicant response in table below. |
| **Risk Category****(Functional area)** | **Key Risk** | **Mitigating actions** | **Timeline** |
| Programme | Delay in roll-out of community-led HIV testing (by lay providers) at national level. | Finish the piloting (phase-wise implementation) of community-led testing as soon as possible and replicate the lessons learned from piloting in the nationwide roll-out. |  July 2018 |
| Programme | Prevention programme and testing coverage of key population does not reach 90%. | Roll out community-led testing throughout the country as soon as possible. | July 2018 |
| Programme | No significant increase in the number of people enrolled in ART, despite the roll-out of the Test and Treat strategy. | Mobilise CHBC and CCC workers in communities effectively, especially in areas with high HIV yield. Mobilize other SRs to link 100% of HIV-positive persons to HIV care. Revise the national estimates of HIV (for example, when estimating infections among the migrant population, including only migrants at high risk in the calculation). | Dec 2018 |
| Programme | Getting Ministry of Home Affairs approval for the expansion of OST sites and satellite dispensing sites takes longer than anticipated, which affects implementation and ability to reach targets. | Submit the expansion plan to MoHA for their approval well in advance, and initiate coordination meetings between MoHA and MoH. |  July 2018 |
| Implementation  | Delay in transfer of funds to government treasury account, resulting in delays in program implementation. | Ensure frequent communication and good cooperation with the Ministry of Finance, Ministry of Health and respective entities. If a tripartite agreement needs to be signed, ensure that the process is initiated early so that there is no delay. | March 2018 |
| Implementation  | Delay in programme implementation due to the transition to the new federal structure. | It is possible that once the new federal structure is fully operational, some reprogramming or adjustment of the working modality may be required. All stakeholders will stay abreast of the latest developments so that any change that may be required can be planned and initiated in good time.  |  Ongoing |
| Procurement, Supply Chain | Delay in procurement of pharmaceuticals and health commodities from Government core fund | A high level decision will be made for timely procurement of life saving ARVs and other health commodities budgeted under the Government Fund and an regular oversight and capacity building initiatives will be made from EDPs Logistics Task Force | Initiate the process by October 2017 |
| *Add rows for additional key risks as necessary* |

**SECTION 4: FUNDING LANDSCAPE, CO-FINANCING AND SUSTAINABILITY**

This section details trends in overall health financing, government commitments to co-financing, and key plans for sustainability. Refer to the **Funding Landscape Table(s)** and supporting documents as applicable. To respond, refer to additional guidance provided in the *Instructions.*

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| **4.1 Funding Landscape and Co-financing** |
| a) Are there any current and/or planned actions or reforms to increase domestic resources for health as well as to enable greater efficiency and effectiveness of health spending? **If yes,** provide details below. | ☑ Yes ☐ No |
| b) Is this current application requesting Global Fund support for developing a health financing strategy and/or implementing health- financing reforms? **If yes,** provide a brief description below. | ☐ Yes ☑ No |
| c) Have previous government commitments for the 2014-16 allocation been realized? **If not**, provide reasons below. | ☑ Yes ☐ No |
| d) Do current co-financing commitments for the 2017-19 allocation meet minimum requirements to fully access the co-financing incentive, as set forth in the Sustainability, Transition and Co-financing Policy? **If not**, provide reasons below. | ☑Yes ☐ No |
| e) Does this application request Global Fund support for the institutionalization of expenditure tracking mechanisms such as National Health Accounts? If yes or no, **specify** below how realization of co-financing commitments will be tracked and reported. | ☐ Yes ☑No |
| **(maximum 2 pages)** |

Government health spending has increased steadily in terms of total volume over the last decade. As a percentage of GDP, it has remained around the 5-6% level over the last 5 years. According to Nepal’s most recent national health accounts (2011/12), household out-of-pocket payments account for more than 50% of all health expenditure, while almost half is spent on medicines and curative care.

During this period, reliance on external funding has declined significantly, with GoN funding increasing from around 50% during the first health sector plan (NHSP-1) from 2005-2009, to some 75% at the start of NHSP-3 (2016) (Figure 1). [[31]](#footnote-31)

In contrast, the HIV programme in Nepal remains heavily dependent on external assistance. GoN financing for the programme comes both through direct sectoral budgets (see below) and through the Pooled Fund, a basket of funds which comprises, from external partners, including the World Bank, DFID, and KfW. The Pooled Fund accounted for around 10% of overall HIV spending in 2014,[[32]](#footnote-32) and was used primarily to support comprehensive HIV prevention programme for key populations (including migrants).

The largest single contributor is the Global Fund, which supported just under half of HIV expenditure in 2014, while bilateral funding—principally from USAID and GIZ—accounted for just over one-fourth of spending in 2014. Several other partners, including UN agencies and INGOs, also continue to support the response (see Financial Gap Table).

Figure 4. Trends in share of domestic and external health spending in Nepal (percentages).



This funding landscape is now in a period of transition, with external resources on a rapid downward trend since 2014—the reduced Global Fund envelope for 2018-2021 will result in a decrease of around 35% in 2018[[33]](#footnote-33)—while the government has taken important steps towards securing the sustainability of the response by stepping up its contribution. For 2017-18, the government has, for the first time, committed significant resources (USD 1.4 million) for the procurement of ARV and has pledged to fund 100% of ARV procurement in 2018-19 and 2020-21. As of 2018-19, the GoN will also assume full financial responsibility for the eVT programme, TB-HIV interventions, and prevention programmes for migrants and in prisons and other closed settings. In addition, it is increasingly taking over support for human resources, commodities and services that have hitherto been supported by the Global Fund.

While an overwhelming proportion of government resources for the health sector comes from the Ministry of Health, other sectors also contribute, notably the Ministry of Home Affairs (MoHA), Ministry of Defence (MoD), Ministry of Finance (MoF), Ministry of Education (MoE), Ministry of Federal Affairs and Local Development (MoFALD) and the Ministry of Supply. These funds are disbursed as follows: prison health care services and police and military hospitals, under the aegis of MoHA and MoD respectively, consume health sector resources. MoE disburses through the health sector in the form of financial support for medical colleges. MoFALD invests resources in delivering health services through local authorities. Meanwhile, MoS is involved in the Goiter Control Program of Nepal.

Ministry of Health in particular has implemented a budget and expenditure tracking system called Transaction Accounting and Budget Control System (TABUCS) which requires all the spending units all over the country within Ministry of Health to upload their expenditure reports in every trimester. This allows expenditure tracking more efficiently and timely. Moreover, NCASC has already initiated a process of collecting and tracking AIDS related expenditure on regular basis which will be an innovative process to track the HIV related expenditure in the country. Besides, periodic exercise (NASA) will further provide information on HIV spending tracking in the country.

**4.2 Sustainability**

Describe below how the government will increasingly take up health program costs, and actions to improve sustainability of Global Fund financed programs. Specifically,

a) Explain the costs, availability of funds and the funding gap for major program areas.

Specify in particular how the government will increasingly take up key costs of national disease plans and/or support health systems; including scaling up investments in programs for key and vulnerable population, removal of human rights and gender-related barriers and enabling environment interventions.

b) Describe actions to improve sustainability of Global Fund financed programs. Specifically, highlight key sustainability challenges of the program(s) covered by the funding request,

and any current and/or planned actions to address them.

**(maximum 1 page)**

Nepal has developed an ambitious national strategy for HIV that envisages fast-tracking the response to reach the 90-90-90 treatment targets by 2020 through innovative, evidence-based approaches implemented through a resilient health system that integrates public, community and private sectors. The total cost for the last three years of the plan (which coincide with the implementation period of the forthcoming grant) is USD 110,190,629. As shown in the HIV Gap Overview, the total funds anticipated from domestic and external sources, including the Global Fund, fall considerably short of this target.

Recognizing the urgency of accelerated investment if the national goal of ending AIDS is to be achieved by 2030, the GoN has committed to a very significant increase in resources for the HIV programme, and will contribute an average 9.4 million for each of the three years (Figure 5).

Figure 5: GoN allocation for HIV Response



This includes covering 100% of the country’s procurement of ARVs in 2019-20 and 2020-21, as well as the salaries of health staff hired specifically for the programme, such as HIV counsellors, who have to date been supported by the Global Fund. In addition, through this commitment, the GoN has assured regular budget allocations for core programme components, including treatment, eVT, TB-HIV, STI and strategic information that previously received significant Global Fund support. Many of the remaining costs associated with these programmes that are proposed for funding in this application will be absorbed by the GoN by the end of the implementation period. One example is the cash transfer programme for children living with HIV, which will undergo a phased transition to the national social security programme. Given the upward trend in overall GoN health expenditures (Figure 6) over the last decade, there is reasonable expectation that the adjusted level of domestic investment in the HIV response will be sustained and even increased beyond the end of the implementation period.

Prevention programmes for certain key populations remain largely reliant on Global Fund support; in addition, above allocation funding has been prioritised to address the gaps in programming for FSW, MSM and TG left by the absence of USAID funding after 2018. For the upcoming period, however, the GoN has demonstrated its commitment to supporting prevention programming by assuming responsibility for HIV interventions among the migrant and prison populations. The GoN and other country stakeholders will use the next three years to explore robust mechanisms for mobilising resources and for channelling government resources to the community sector to ensure the sustainability of services for key populations.

Programming related to removing human rights-related barriers to HIV services, including prejudice, discrimination and violence against PLHIV and key populations, have also been predominantly financed by the Global Fund. For the forthcoming implementation period, Global Fund support for these activities is primarily proposed through catalytic funding, which requires a matching contribution from domestic resources for programming to address these issues. As well as indicating the GoN’s commitment, this also provides a platform from which domestic resources for human rights-related programmes can be increased in future.

Figure 6. Trend of GoN health spending (in billions)



**Prioritized Above Allocation Request**

Provide in the table below a prioritized above allocation request which, if deemed technically sound and strategically focused by the TRP, could be funded using savings or efficiencies identified during grant-making, or put on the Register of Unfunded Quality Demand to be financed should additional resources become available from the Global Fund or other actors (e.g. private donors and approved public mechanisms such as UNITAID and Debt2Health). This above allocation request should include clear rationale and should be aligned with the programming of the allocation for maximum impact. The request should reflect the order in which interventions will be funded if additional resources become available. In line with the Global Fund’s Strategy to maximize impact and end the epidemics, the prioritized above allocation request should be ambitious (for example, representing at least 30-50 percent of the allocation amount).

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| **[C*omponent* ]** *– Copy the table as needed, if your funding request includes more than one**component* |
| **Module** | **Interventions** | **Amount requested** | **Brief Rationale, including expected outcomes and impact**(how the request builds on the allocation) |
| **Priority - High**Prevention programmes for female sex workers and their clients | Core IRRT package for key populations as outlined in Section 2.1 | $4,000,000 | FSW are one of the key populations in the NSP and ongoing coverage is essential in meeting Nepal’s goal of fast-tracking the response to end AIDS by 2030. To date, FSW have been covered USAID-FHI360 (80% coverage). USAID-FHI360 has not committed any funding for the continuation of the program beyond 2018-19. Support through PAAR would therefore enable the country to meet the NHIP targets of 87% and 90% coverage of FSW in 2019-20 and 2020-21, with prevention programming and HIV testing. This will keep the country on track to meet its national, regional and global commitments on health and HIV.  |
| **Priority - High**Prevention programmes for key populations | Continuation of services for MSM and TG populations | $600,000 | To date, USAID-FHI360 has supported some MSM/TG interventions in 5 non-GF districts but will not commit funding beyond 2018-19, Since there is still a strong need from the community, and other external resources are not envisaged, support is requested for the continuation of services in 2019-201 and 2020-21. |
| **Priority - High**RSSH | Capacity building of medical personnel at ART sites  | $2,000,000 | The GoN commitment to increase resources for treatment, care and support includes capacity strengthening of medical personnel at ART sites. Intermittent short-term technical assistance would augment the GoN efforts and complement the capacity support available from other partners (AHF, WHO, Linkages), as well as maximise Global Fund investments in TCS. |
| **Priority - High**RSSH - Health management information system and M&E | TA to support roll-out of the DHIS2 system | $3,000,000 | DHIS2 is a government priority: the NHSS anticipates its roll-out throughout the country by 2020. GoN resources are available for this, alongside support from DFID, GAVI, KOIKA and GiZ. Intermittent technical assistance is anticipated to accelerate and scale up the process, and ensure quality.  |
| **Priority - Medium**Prevention programmes for PWID | National and international TA to strengthen the Harm Reduction programme in Nepal | $2,000,000 | Harm reduction interventions, including the OST scale up, have often been challenged by issues related to quality of service, coordination, institutionalisation and monitoring. Technical assistance is sought to expedite solutions to the challenges. This will build on the GF investment in OST by informing efforts to increase uptake, retention and quality. |
| **Priority – Medium**Young Key Populations | Engaging young people in prevention-related activities focusing on minimising risk behaviours (unsafe sex, injecting drug use and unsafe migration) as well as improving health-seeking behavior. | $100,000 | Studies have indicated that a number of young people (under the age of 20) engage in sex or sell sex, begin using illicit drugs and ultimately progress to injecting. Likewise, many young people (particularly from rural areas) drop out of school and migrate to India or the Gulf for work. These behaviours increase vulnerability to HIV. Youth groups and youth-led organisations anticipate that engaging young people in prevention and behaviour change can have positive and lasting impacts. This work would complement the in-reach interventions for young key populations in the main allocation. |
| **Priority – Medium**Study and Assessment | (i) Assessment of migration patterns and HIV vulnerability, and (ii) Cascade assessment to assess progress towards 90-90-90 targets. | $100,000 | Migration to India, particularly to states where HIV prevalence among FSW is high, is recognised as source of infection. The main source of information for targeting HIV interventions among migrants is a 2007 study by UNFPA. However, it is likely that changes in health seeking behaviour and migration patterns (e.g. the shift to Gulf countries as the preferred destination) over the last decade have implications for HIV transmission and access to HIV services, which will be explored in the assessment. The findings of this and the cascade assessment are expected to guide a more strategic targeting of resources and make HIV interventions more efficient and effective. |
| **TOTAL AMOUNT** | $11,800,000 |  |

**Relevant Additional Information (optional)**

Provide any additional contextual information relevant to the prioritized above allocation request (e.g. any explanations that further clarify linkages to the allocation funding; any considerations or data that informed the request or updates of the request; etc.)

Prevention programmes for FSW and their clients

To date, interventions for female sex workers and their clients in Nepal have been addressed solely by USAID through FHI360360 (former Saath-Saath and current Linkages programme). Support for the FSW through the Linkages programme has been committed only up to 2018-2019, with a coverage target of 80% of FSW. No further funding is envisaged.

The NHIP has set a target of reaching 90% of FSW in 2020-21 with prevention programming and HIV testing. Even with efficiencies derived from better targeting and more streamlined implementation arrangements (e.g. clustering of NGO partners to provide multiple services within geographical areas), the existing Global Fund-supported key population prevention programme (covering MSM, TG, MSW, PWID and male labour migrants)will be tasked with reaching higher targets with fewer resources. As a result, stretching the Global Fund allocation to cover FSW in addition to the KPs currently supported would be extremely challenging. At the same time, FSW are a key population in Nepal’s HIV epidemic and cannot be left without support for ongoing prevention interventions, STI management, HIIV testing and linkage to other services without adverse impacts both on their own well-being and on the trajectory of the epidemic. Support for FSW interventions is therefore proposed as a prioritized above allocation request.

TA for capacity building of medical personnel at ART sites

As per the MoU between the MoH and Expertise France (EF), EF is providing Technical Assistance to the national HIV programme, under the current country grant for HIV, to strengthen national capacities for HIV care. The current TA includes strengthening health system capacity to improve access and better care for HIV; strengthening capacity for the management and monitoring of HIV care; and paediatric patient management. The experts from EF will have trained a number of clinicians in Nepal by the end of the current grant term, and are also supporting the ongoing Hepatitis C treatment which will be completed by the end of this year. The major objective of the current TA is to transfer skills and knowledge on HIV care to Nepali clinicians so that they can independently manage cases beyond the end of the existing grant.

With the skills transferred from EF, capacity building support from other technical partners such as AHF, Linkages/FHI360360 and WHO, updated guidelines on HIV testing and treatment and the substantially increased government resources for treatment, care and support, it is anticipated that the HIV programme will be able to efficiently manage HIV cases, including paediatric and Hepatitis C cases, and further investment in long-term TA therefore cannot be justified from the main allocation. However, to reinforce continuous learning and strengthening on various aspects of HIV clinical management, short-term TA funded by other partners is anticipated.

TA to support roll-out of the DHIS2 system

Strengthening the health management information system is a government priority and the NHSS envisages that DHIS2 will be rolled out throughout the country by 2020. Government resources are available for this, and development partners like DFID, GAVI, KOIKA and GiZ are also keen to assist the government in this effort. During the current GF grant a pilot was conducted (in 3 districts) to assess whether technical support could have an impact on rolling out DHIS2. The results were positive, and it was strongly recommended that the government and other donors should take the initiative to move this forward in order to accelerate the process and assure quality. This investment would also add value to the investment in the HIV database and tracking system (proposed in the main allocation), which could eventually be linked to DHIS2 when it is fully operational.

1. IBBS 2015, 2016 and 2017. National Centre for AIDS and STD Control. [↑](#footnote-ref-1)
2. Government of Nepal. 2016. AIDS Epidemic Model: Impact Modelling and Analysis for Fast Tracking the HIV Response in Nepal. Kathmandu: Ministry of Health and Population, National Centre for AIDS and STD Control, p22 [↑](#footnote-ref-2)
3. National HIV Infection Estimation, 2016, NCASC, p4,5 [↑](#footnote-ref-3)
4. Ibid, p7 [↑](#footnote-ref-4)
5. NCASC ART data 2017. [↑](#footnote-ref-5)
6. Government of Nepal. 2017. Country Progress Report Nepal (to contribute to the GAM Report 2016). Kathmandu: Ministry of Health and Population, National Centre for AIDS and STD Control, p4 [↑](#footnote-ref-6)
7. Ibid, p4 [↑](#footnote-ref-7)
8. Ibid, p5 [↑](#footnote-ref-8)
9. National HIV Strategic Plan 2016-2021, p1 [↑](#footnote-ref-9)
10. Ibid. [↑](#footnote-ref-10)
11. Nepal Health Sector Strategy 2015-2020, Gender Assessment of the National Responses to HIV and TB in Nepal 2016, p16 [↑](#footnote-ref-11)
12. Assessment of the Legal and Policy Environment in Response to HIV in Nepal, p8 [↑](#footnote-ref-12)
13. Gender Assessment of the National Responses to HIV and TB in Nepal 2016, p16 [↑](#footnote-ref-13)
14. Assessment of the Legal and Policy Environment in Response to HIV in Nepal, p9 [↑](#footnote-ref-14)
15. National HIV Strategic Plan 2016-2021, p3. [↑](#footnote-ref-15)
16. Investment Plans for the Implementation of the National HIV Strategic Plan 2016-2021. [↑](#footnote-ref-16)
17. Joint Global Fund and USAID/PEPFAR Key Population HIV Cascade Assessment, Nepal, July 17-24 2017 (Presentation) [↑](#footnote-ref-17)
18. As reported during the country dialogue process; see also Government of Nepal 2015: Gender Assessment of the National Responses to HIV and TB in Nepal 2016; Government of Nepal 2015: An Assessment of the Legal and Policy Environment in Response to HIV in Nepal. [↑](#footnote-ref-18)
19. Up to 38% among PWID in the Eastern Terai (IBBS 2017) and 21% among female injectors in Kathmandu (IBBS 2016). [↑](#footnote-ref-19)
20. AEM-Spectrum modelling, 2016. [↑](#footnote-ref-20)
21. As of March 2017, NCASC data. [↑](#footnote-ref-21)
22. Government of Nepal. 2017. National HIV Testing and Treatment Guidelines. [↑](#footnote-ref-22)
23. Three sites (NPHL, Bir, Dhangadhi) are currently operational, with two more (Eastern and Western Regional Hospitals) expected to be added in the current financial year. [↑](#footnote-ref-23)
24. CCCs are short-term care facilities, run by and catering to the needs of PLHIV as a link between the hospital and home/community. The CHBC package includes adherence support; education on nutrition, hygiene and sanitation; family planning; referral & linkage to other clinical and social services; emotional/spiritual support and counselling; infection prevention; and end of life care (National Guidelines on CHBC and Standard Operating Procedures, NCASC, 2011). [↑](#footnote-ref-24)
25. Family Health Division, Ministry of Health and Population Nepal. 2010. National Guidelines for Cervical Cancer Screening and Prevention in Nepal. [↑](#footnote-ref-25)
26. UNAIDS. 2016. HPV, HIV and cervical cancer. [↑](#footnote-ref-26)
27. Status Report on TB-HIV, SEARO 2013, reported in GAM Report, NCASC, 2017. [↑](#footnote-ref-27)
28. NPT programme data. [↑](#footnote-ref-28)
29. 11 June (TB-HIV), 16 June and 28 June (TB, HIV, Malaria, and development partners). [↑](#footnote-ref-29)
30. Save the Children International. 2017. Assessment of Laboratory Support to HIV, TB and Malaria Programmes in Nepal. [↑](#footnote-ref-30)
31. Brief Overview of the Health Sector Funding. WHO/Susheel Lekhak [↑](#footnote-ref-31)
32. NCASC: NASA 2015 (quoted in the Nepal Country Progress Report 2016). [↑](#footnote-ref-32)
33. NHIP [↑](#footnote-ref-33)