Funding Request Form

Allocation Period 2020-2022

Refer to the "Full Review" Instructions to complete this form.

Summary Information

Country(s)	Nepal
Component(s)	HIV
Planned grant(s) start date(s)	16 March 2021
Planned grant(s) end date(s)	31 July 2024
Principal Recipient(s)	Save the Children International
Currency	USD
Allocation Funding Request Amount	USD 26,926,654
Prioritized Above Allocation Request (PAAR) Amount[1]	USD 17,140,000
Matching Funds Request Amount[2] (if applicable)	USD 1,100,000

Full Review

The Global Fund

[1] PAARs can only be submitted with the Funding Request. To complete a PAAR, fill-in the Excel template that you will receive from the Global Fund Secretariat.
[2] This is only relevant for applicants with designated matching funds as indicated in the allocation letter.

Section 1: Context Related to the Funding Request

To respond to the questions below, refer to the *Instructions* and **Essential Data Table(s).**

1.1 Key References on Country Context

List key reference documents referred to in this funding request that provide the country's contextual cross-cutting and disease-specific information. A list of which types of documents can be used is included in the *Instructions*.

Reference document	Link/Attachment reference	Relevant section(s) and/or page(s)
Nepal Health Sector Strategy 2015-2020	Annex 1	8, 10, 21
Department of Health Services Annual Report 2017-2018	Annex 2	193
Nepal Demographic and Health Survey Key Findings 2016	Annex 3	2-3, 12,13
Multiple Indicator Cluster Survey 2019	Annex 4	11
Policy Note for the Federalism Transition in Nepal	Annex 5	Section II, p 26
Nepal National AIDS Spending Assessment (NASA) 2016-2017	Annex 6	4-6
National HIV Strategic Plan 2016-2021	Annex 7	17
Factsheet 2019 National HIV Estimates	Annex 8	all
Subnational HIV Estimates of Nepal, 2018	Annex 9	all
Factsheet Epidemic Update of Nepal	Annex 10	all
Death, loss to follow-up and missing details of PLHIV reported in National HIV Program	Annex 11	13
Final Report 2016 IBBS Survey Street involved children and youth Kathmandu	Annex 12a	Chapter III, IV
Final Report 2016 IBBS Survey FIDU Kathmandu Valley	Annex 12b	Chapter III, IV, V, VIII
IBBS among Female Injecting Drug Users in Pokhara Valley 2017	Annex 12c	x, Chapter III
IBBS among Male Labour migrants in Western. Midwestern and Farwestern region, 2017	Annex 12d	x, Chapter III
Report IBBS MLM Eastern 2018	Annex 12e	13, Chapter III
Report Wives of Migrants Farwest 2018	Annex 12f	17, Chapter III
IBBS among PWID in Eastern Terai 2017	Annex 12g	9, Chapter III

IBBS among PWID in Kathmandu Valley 2017	Annex 12h	Chapter III-IV
IBBS among PWID in Pokhara Valley 2017	Annex 12i	Chapters III-IX
IBBS among PWID in Western to Farwestern Terai 2017	Annex 12j	xi, Chapter III-IV
Mapping and size estimation of FSW, MSM, MSW, TG and PWID in Nepal, 2017	Annex 13	27
Country Progress Report GAM 2018	Annex 14	
Key Populations in Nepal: A Joint HIV Cascade Assessment by PEPFAR/USAID and The Global Fund	Annex 15	18-24, 27
National HIV Testing and Treatment Guidelines 2020	Annex 16	3-6, 16, 40, 67-8, Ch.6, 81, 91
National Consolidated Guidelines on Strategic Information of HIV Response in Nepal	Annex 17	Chapters 4 and 6
Public-Private Partnership Guidelines for HIV Response in Nepal	Annex 18	29
Piloting of GeneXpert technology for HIV Viral Load Testing May 22_2020	Annex 19	4
Community-based Quality Monitoring (CBQM) Study of key Harm Reduction service for people who use drugs in Cambodia, India, Indonesia, Nepal and Vietnam. Nepal	Annex 20	all
2019 Research on the Health Vulnerabilities of Cross Border Migrants from Nepal.	Annex 21	11
Migration Profile Nepal 2019	Annex 22	36
Report on the Rapid assessment of available information on adolescents living with and/or at an increased risk of HIV in Nepal	Annex 23	7-11, Chapter 6
Report of the Joint Monitoring Mission for Tuberculosis	Annex 24	49
Scaling up Programs to Reduce Human Rights-Related Barriers to HIV and TB Services (Baseline Assessment June 2018)	Annex 25	6, 42
Five-Year Implementation Plan for a Comprehensive Response to Human Rights-related Barriers to HIV and TB Services in Nepal	Annex 26	1-7
Gender Assessment of the National Responses to HIV and TB in Nepal 2016	Annex 27	Chapters 1 and 3
OIG Audit Report Global Fund Grants in Nepal	Annex 28	14-17

Report on HIV Viral Load Testing Optimization Workshop	Annex 29	4, 9

1.2 Summary of Country Context

Explain critical elements of the **country context** that informed the development of this funding request. The following points should be addressed in the response:

- The epidemiological context and other relevant disease-specific information;
- Information on disease-specific and the overall health systems, along with the linkages between them;
- Relevant key and/or vulnerable populations;
- Human rights, gender and age-related barriers and inequities in access to services;
- Socio-economic, geographic, and other barriers and inequities in access to health services;
- Community responses and engagement; and
- The role of the private sector.

Refer to information provided in the key reference documents listed in **Section 1.1**.

The HIV epidemic in Nepal remains concentrated in key populations.[3] HIV prevalence, as measured by IBBS surveys in different regions of the country between 2016 and 2018, is highest among men who have sex with men and transgender people (8.2% in Terai Highway districts and 6.2% in Kathmandu Valley)[4] and people who inject drugs (8.5% in Kathmandu Valley and 4.9% in Pokhara),[5] and relatively lower among female sex workers (2.2% in Kathmandu Valley and 0.7% in Terai Highway districts)[6] and male labour migrants who travel to India (0.3% in western hilly districts and eastern Terai districts, and 0.6% in mid-western hills).[7] Other priority populations at high risk include their respective sexual partners/clients, and people in prisons.

Out of a total population of approximately 30 million, there were an estimated 29,503 people living with HIV in Nepal in 2019.[8] National HIV prevalence peaked in around 2006 and has been declining incrementally since then, to 0.13% in 2019,[9] corresponding with the growing number of people on ART.

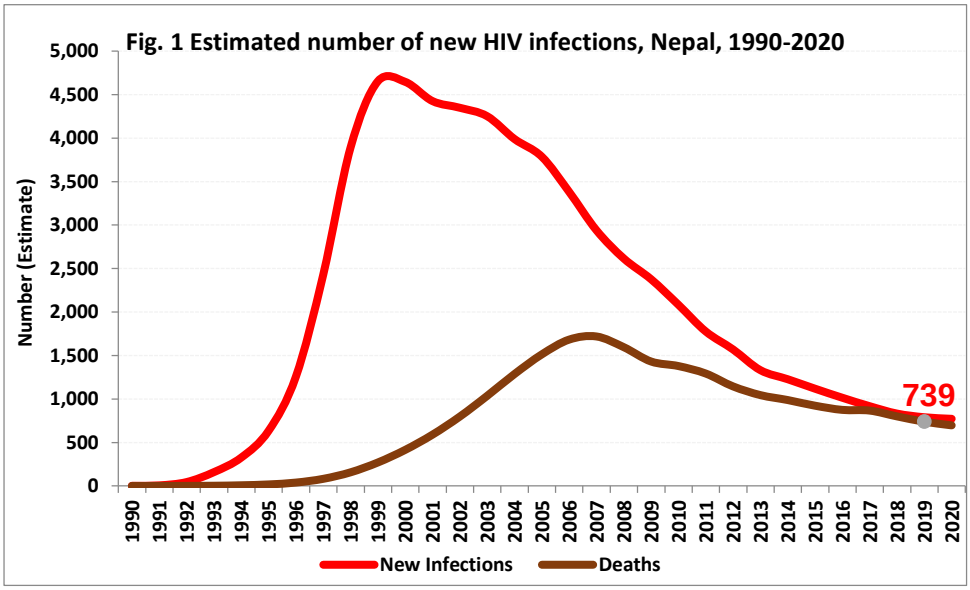
HIV incidence per 1000 population is estimated to have declined dramatically from a peak of 0.20% in 1999 to 0.028% in 2019, while the growing number of people on treatment has contributed to this as well as to a significant decline in AIDS-related mortality (Fig. 1). Estimated annual new infections have fallen from around 2,083 in 2010 to 790 in 2019. Approximately 2,000 HIV cases are reported per year.[10] The magnitude of reported cases in each province has been roughly proportional to the estimated number of infections in those provinces over time, suggesting that testing across provinces is consistent with need.[11]

Of the estimated 790 new HIV infections in 2019, 85% occurred among adults aged 15-49 and 8.8% among children aged 0-14.[12] An estimated 17.2% of new infections were among young people aged 15-24.

Key populations (including migrants)[13] account for some 62% of new HIV infections.[14] Despite low prevalence among migrants, due to their high numbers they account for 22% of new HIV infections.[15] The National Health

[3] See Essential Data Tables for population size estimates.
[4] IBBS among MSM and TG in Terai Highway Districts (2018) and Kathmandu Valley (2017)
[5] IBBS among People who Inject Drugs in Kathmandu Valley (2017) and Pokhara (2017) (Annexes 12h and 12i)
[6] IBBS among Female Sex Workers in Kathmandu Valley (2017) and Terai Highway Districts (2018)
[7] IBBS among Male Labor Migrants in Western & Mid to Far Western Districts (2017), Eastern Districts (2018) (Annexes 12d and 12e)
[8] NCASC: Factsheet: 2019 National HIV Estimates (Annex 8)
[9] Ibid
[10] Ibid.
[11] NCASC, Subnational HIV Estimates of Nepal, 2018. (Annex 9)
[12] NCASC, National HIV Estimates 2019 (modelled data using Spectrum)
[13] 20% of 'low risk Males' are migrants: AEM 2018.

Sector Strategy 2015-2020 acknowledges the increasing trend of migration and the vulnerability of migrants to certain health risks, including HIV.[16] Some 26% of new infections are occurring among so-called 'low risk' women,[17] a significant proportion of whom are assumed to include wives of migrants, sexual partners of other key populations, and those who do not self-identify as members of key populations (such as former sex workers).



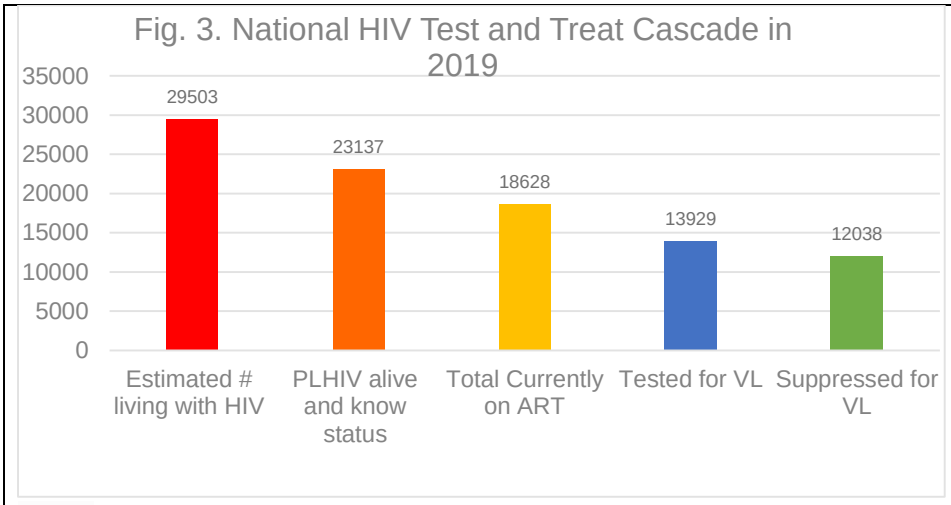
The response to HIV and AIDS in Nepal, led by the Ministry of Health and Population (MoHP) through the National Centre for AIDS and STD Control (NCASC), is highly collaborative, with the NCASC working in close coordination with key INGO implementing partners, USAID/PEPFAR, technical agencies such as UNAIDS and WHO, and national networks of key populations and people living with HIV.

Source: NCASC: 2019 National HIV Estimates

In particular, Nepal is considered as a model in the Asia region for the current coordination between PEPFAR and the Global Fund, and the longstanding collaboration between these two agencies and NCASC has made a significant contribution, through the adaptation and implementation of evidence-based programs, towards accelerating the achievement of the global targets on HIV and AIDS in Nepal.

The National HIV Strategic Plan 2016-2021 established *identify, reach, test, treat, and retain* (IRTTR) as the country's strategy for achieving the 90-90-90 targets and ending AIDS as a public health threat by 2030.[18] To support the effective delivery of this strategy, the key country partners collaborated intensively on the development of national standard service packages for HIV service delivery,[19] which specify innovative and effective approaches that are to be followed by all stakeholders in Nepal, whether government, community or development partner. These standard service packages, which are in the process of being endorsed, form the basis of the interventions proposed in this funding request.

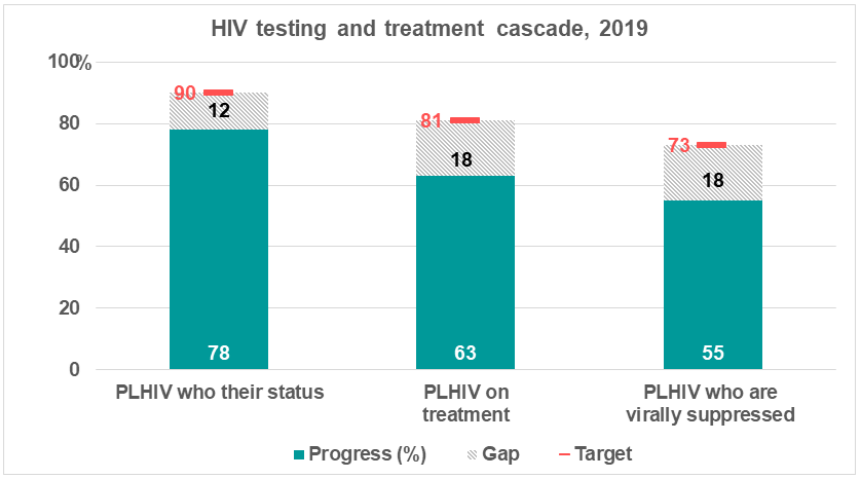
[14] AEM 2018.
[15] Ibid.
[16] MoHP (2015), National Health Sector Strategy 2015-2020, 10. (Annex 1)
[17] AEM 2018.
[18] NCASC (2017), National HIV Strategic Plan 2016-2021 (Annex 7)
[19] Expected to be endorsed in the near future.



Source: Factsheet: 2019 National HIV Estimates

Since adopting the IRTTR strategy, and particularly community-led testing (CLT) and the policy of 'test and treat', Nepal has made significant strides in finding people living with HIV and getting them on treatment (Fig 3). Fig. 4 shows the country's achievement and remaining gaps against the 90-81-73 targets, which are all based on the denominator of estimated number of people living with HIV.

Fig. 4. HIV testing and treatment cascade in Nepal, 2019



Source: https://aidsinfo.unaids.org/

The cascade indicates that critical gaps remain in terms of case-finding, timely linkage to treatment, access to viral load testing and retention in care. Persistent stigma and discrimination towards people living with HIV and key populations, particularly women and young key populations in health care settings; service accessibility issues (including inconvenient locations and service hours); a lack of regular targeted interventions among certain key and priority populations including migrants, wives of migrants and, women who inject drugs; illegal police practices against key populations; and a lack of gender- and youth-responsive interventions, particularly for those with overlapping vulnerabilities, have been identified as barriers to accessing vital HIV services.[20] The National Health Sector Strategy notes the barriers experienced by women, sexual and gender minorities, and confirms that mitigating them to ensure that citizens have greater access to health services is a major thrust for the NHSS.[21] In the upcoming period, strategic interventions supported by catalytic funding and matching domestic investments will build on and sharpen the focus of the work begun under the 5-year plan.[22]

[20] The Global Fund (2018), Scaling Up Programs to Reduce Human Rights-Related Barriers to HIV and TB Services, 6 (Annex 25); Nepal Country Dialogue 2020

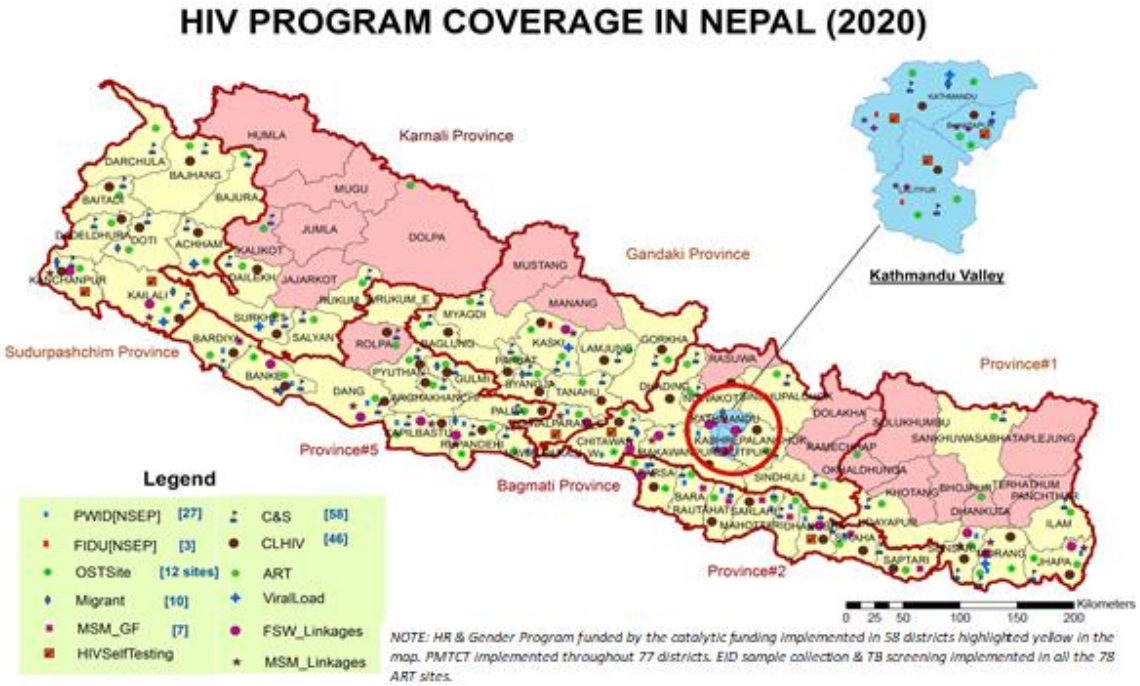
[21] MoHP (2015), National Health Sector Strategy 2015-2020, 21. (Annex 1)

[22] The Global Fund (2018), Five-year implementation plan for a comprehensive response to human rights-related barriers to HIV and TB services in Nepal (Annex 26)

HIV prevention interventions are focused on the key and priority populations noted above, in certain districts selected on the basis of key population estimates, hotspot mapping and the annual HIV prevalence estimates (Fig. 5). The service packages include community-led prevention and behaviour change communication, condom programming, harm reduction (for PWID), community-led and facility-based testing and counselling, and linkage to treatment, PMTCT, STI management and other services. Program data indicate high coverage of people who inject drugs and more variable coverage of female sex workers, men who have sex with men and transgender people. NCASC data indicate that 112,393 migrants and their spouses were reached in 2018/2019,[23] compared to an estimated 300,000 migrants who are considered to be at high risk[24] (seasonal migrants to high-HIV prevalence states in India). These gaps will be addressed going forward with more tailored approaches.

Community-led testing (CLT) has played a catalytic role in enhancing HIV testing coverage across the country. IBBS surveys indicate that the majority of FSW, PWID and MSM and TG know their HIV status,[25] although (due to interruptions in service coverage in 2018 and 2019) testing among migrants has been much lower; less than 25% of migrants[26] and 33% of migrants' wives[27] in the areas surveyed by the IBBS had been tested and knew their status.

Fig. 5. HIV Program Coverage in Nepal



Source: Save the Children International

The next step is to increase positive yields, and communities will play a crucial role in designing and implementing more differentiated approaches to cover the most at risk and hardest to reach segments of their respective populations, including women and young people. Over the last two years, high yield strategies such as index testing and partner notification, enhanced peer outreach approach (EPOA), online to offline (O2O) and self-testing that have been implemented through USAID/PEPFAR support in selected areas have shown considerable promise, achieving positive yields of 15.2%, 17.4%, 8.5% and 4% respectively.[28] This will be backed up by more effective data reporting and management, including the use of biometric data, to eliminate duplicates.

By the end of 2019 more than 80% of diagnosed people living with HIV had been linked to treatment, which is

[23] NCASC (2019), Factsheet 1: HIV Epidemic Update of Nepal (Annex 10)
[24] NSP Review draft (unpublished), June 2020
[25] IBBS studies.
[26] IBBS among Male Labor Migrants: Western & Mid to Far Western Districts (2017), Eastern Districts (2018) (Annexes 12d and 12e)
[27] IBBS among Wives of Migrants: Far Western Districts (2018) (Annex 12f)
[28] USAID/PEPFAR Nepal program data October 2019-June 2020

being delivered free of charge from 78 ART centres (including 2 community-based sites) and 22 dispensing sites around the country (shown in Fig. 5). PLHIV networks have been instrumental in facilitating this linkage to treatment, and work alongside with ART centres to deliver differentiated levels of care and support, both facility-based and in the community.

Communities will continue to play a leading role in ensuring linkage to and retention in HIV care. A major focus of this grant will be addressing the barriers noted above by strengthening community capacity to provide a comprehensive package of services, engage effectively with counterparts in the health system and local government and advocate for equitable, human rights-based services and a greater role in decision making, as well as to improve accountability through the activation of community-based monitoring mechanisms. Much of this work will be supported by the catalytic funding and matching domestic investments.

The PMTCT program is increasingly well integrated with ANC services. Coverage at the national level in 2018 was 66%.[29] One of the main challenges to increasing access to PMTCT is the relatively low level of institutional deliveries and attended births. Despite the considerable success of the Aama Programme (RMNCH)[30] in encouraging women to give birth at health facilities,[31] only 77.5% of women have institutional deliveries and 79.3% of births are attended by skilled birth attendants.[32]

Nepal's health system

Government health spending has almost doubled from USD 0.54 billion in 2017/2018 to USD 0.96 billion in 2020/2021. As a share of GDP, it has increased marginally from 1.4% to 1.8% over the same period. Health expenditure as a share of the national budget reached 7.8% in 2020/2021, increasing from 5% in 2015/2016.

Per capita government health spending has increased from USD 10.8 in FY 2014/2015 to USD 20.2 in 2018/2019. However, in constant terms (base year fixed to FY 2000/01), per capita government health spending has increased very little, from USD 4 to USD 5.8 within the same period.

Total per capita health expenditure (public and private) in Nepal in 2017 was USD 48 USD, increasing from USD 41 in 2014. Out-of-pocket expenditure as a share of current health expenditure dropped to 57.8 % in 2017 from 60% in 2014 but fluctuated in between.

Nepal has undertaken numerous social health protection initiatives over the years and in 2016 launched a national health insurance system as an important step towards achieving universal health coverage. However, limited geographical and health coverage have contributed to low enrolment.[33] In the forthcoming implementation period, national insurance will be further considered in efforts to link people living with HIV and key populations to existing social support initiatives at national, provincial and local levels, as is already being done with support for children living with HIV.

Nepal's shift to a three-tiered federal form of governance, which was mandated by Constitution of Nepal 2015 and set in motion following local elections held in late 2017, marks a major departure from the country's long tradition of unitary governance. Under the new system, the health sector will be functioning under the Ministry of Health and Population (MoHP) at the central level, the Ministry of Social Development (MoSD) at the provincial level and the health section or health department under 753 newly-created local level governments, which will oversee more than 4,000 health facilities.

Accountability, budgetary decisions and program implementation have also been divided among the three tiers, with the local level bearing the bulk of the responsibilities[34]. Although the new governance structure has great

[29] NCASC Factsheet: Epidemic Update of Nepal 2019. (Annex 10)
[30] A GoN programme, launched in 2009, to reduce financial barriers to women seeking institutional delivery.
[31] MoHP (2015), National Health Sector Strategy 2015-2020, 8. (Annex 1)
[32] Nepal Multiple Indicator Cluster Survey 2019: Percentage of women age 15-49 years with a live birth in the last 2 years whose most recent live birth was delivered in a health facility; and Percentage of women age 15-49 years with a live birth in the last 2 years whose most recent live birth was attended by skilled health personnel, 11. (Annex 4)
[33] Health Insurance Plan Yet to Cover 38 Districts in Nepal." *The Kathmandu Post*, The Kathmandu Post, 4 Sept. 2019, kathmandupost.com/national/2018/06/07/health-insurance-plan-yet-to-cover-38-districts-in-nepal, cited in BDS (2020), National Report: Community-Based Survey Nepal
[34] Heem Shakya Monday, June 8, 2020 The Kathmandu Post https://tkpo.st/2suTIQJ

significance for the ongoing health sector reform agenda,[35] inherited structural challenges from the previous highly centralized governance may lead to conflicting priorities at the local level, with local officials showing more interest in infrastructure development than health[36]. Within the first two years of their operation, provincial and local governments have accounted for about 34% of the national budget.[37]

Of special concern is the lack of clarity in the delineation of authority between jurisdictions in the different layers of government.[38] Several acts and regulations that further clarify the roles, responsibilities and authorities of all three levels of government are currently being proposed. Other key challenges under the new structure include health financing, inadequate capacity at all levels including limited human resources, and inter-ministerial and inter-governmental coordination. These challenges are already impacting the delivery of the HIV program, as described in the 2019 OIG Report.[39] This grant proposes strategic investments in human resources at all three levels of government to support capacity building of existing staff as well as the development of robust and sustainable systems for program management, data management, financial management, procurement and supply chain and quality assurance. These will benefit health system delivery, particularly at the provincial and local levels, beyond the three disease programs.

Issues with the procurement of life-saving ARVs and HIV commodities have posed particular challenges in the current implementation period. A priority under this grant will be to strengthen Government-led procurement processes—in alignment with investments in the same area by GIZ, USAID and DFID—to enable the timely and efficient procurement of health products. As an interim measure it is proposed that the government procure ARVs through one of the Global Fund's platforms, such as Wambo, to ensure timely procurement and value for money.

1.3 Lessons Learned from Global Fund and Other Partner Investments

Describe how Global Fund and domestic investments, as well as those of other partners, supported national health targets during the current allocation period. Include the main **lessons learned** that are relevant to this funding request (for example, innovations or bottlenecks in service delivery).

All the lessons learned from efforts to address bottlenecks and the adoption of innovative practices were derived through the strong, longstanding collaboration and coordination between the NCASC, the Global Fund and USAID/PEPFAR on all aspects of the HIV response.

Addressing a bottleneck (case-finding); innovative service delivery: Since the adoption of the IRTTR strategy in 2017, community-led testing (CLT), where clients can get tested in a familiar, secure environment by someone they trust, has driven a significant increase in HIV testing, and is now an integral part of prevention programming and CHBC. However, closing the gap of 12% to reach the first 90 (see Fig. 4 in Section 1.2 above), has proved to be a bottleneck, with positive yields remaining low (1.8%, USAID/PEPFAR program data). Several innovative approaches have been piloted and partially rolled out among key populations assessed to be at higher risk in the last two years and are achieving high yields, such as index testing (11% yield reported by SCI, 15.2% by USAID/PEPFAR), self-testing (4%, USAID/PEPFAR), enhanced peer outreach approach (EPOA) (17.4%, USAID/PEPFAR), online to offline (8.6%, USAID/PEPFAR) and risk network referral.
Lesson learned: intensified case finding using the approaches above in combination with risk categorization can significantly increase positive testing yields. This funding request proposes a scale-up

[35] Rajshree Thapa, Kiran Bam, Pravin Tiwari, Tirtha Kumar Sinha, Sagar Dahal: Implementing Federalism in the Health System of Nepal: Opportunities and Challenges. http://ijhpm.com, Int J Health Policy Manag 2019, 8(4), 195–198
[36] Pratik Khanal, Shiv Raj Mishra (2019), Federal governance and the undying parade for universal health coverage in Nepal. https://www.nepjol.info/index.php/HPROSPECT/article/view/22856
[37] MoHP (2020). Budget Analysis of Ministry of Health and Population. MoHP, Kathmandu, Nepal.
[38] R Thapa, K Bam, P Tiwari, TK Sinha (2019) Op.cit.
[39] The Global Fund Office of the Inspector General (2019), Audit Report: Global Fund Grants in Nepal, 14-17 (Annex 28)

of these approaches through the prevention and CHBC components, together with immediate linkage to confirmatory testing and treatment for positive clients, in the upcoming implementation period.

Addressing a bottleneck (viral load testing): Viral load (VL) is the recommended means for monitoring the progress of PLHIV on ART towards viral suppression (the third 90). VL testing is currently available at 8 sites in Nepal. VL suppression among clients tested was above 90% in 2018 (NCASC program data), but in 2019, some 25% of ART patients did not have access to VL testing services. Moreover, those that did had to wait an average 24.1 days from sample collection to the receipt of VL test results (NSP Review). The GeneXpert platform is used for TB screening in Nepal but has not been optimized for HIV VL testing. A pilot study of GeneXpert for HIV VL testing in Achham and Surkhet in 2019 indicated that HIV VL testing on the GeneXPert platform could be rolled out but would require strong coordination between NCASC, the NTCC, NHPL and stakeholders, as well as training, adequate monitoring and supervision, and attention to maintenance issues. A USAID/PEPFAR-funded workshop on optimizing HIV viral load services in Nepal in February 2020 recommended that GeneXPert should be used effectively and efficiently to maximize the impact of ART, based on scale-up plans developed jointly by NCASC, NPHL, NTCC and SC/GF.
Lesson learned: optimising existing GeneXpert capacity is a feasible way forward for expanding access to VL testing in Nepal, and is proposed in this funding request.

Innovative service delivery: WHO recommends that pre-exposure prophylaxis (PrEP) should be offered to people at high risk of HIV infection as part of a comprehensive prevention package. A demonstration study conducted by USAID/PEPFAR among female and male sex workers, men who have sex with men and transgender people in the Kathmandu Valley in 2019 indicated a high level of acceptance of PrEP (93%), and demonstrated that the use of PrEP is not increasing the risk of sexually transmitted infection and not decreasing condom use. However, Adequate treatment literacy and counselling would be needed to improve adherence.
Lesson learned: PrEP is feasible and potentially high impact prevention intervention for key populations at increased risk in Nepal. Based on the learnings from the study, support for a rollout of PrEP among FSW, MSW, MSM and TG in high prevalence settings is requested in PAAR.

Section 2: Funding Request and Prioritization

To respond to the questions below, refer to the *Instructions,* as well as national strategy documents, **Programmatic Gap Table(s), Funding Landscape Table(s), Performance Framework, Budget and Essential Data Table(s)**.

2.1 Overview of Funding Priorities

Summarize the **approach used for prioritization** of modules and interventions (or in the case of Payment for Results, the performance indicators and/or milestones). The response should include:

- How these prioritized modules ensure the highest possible impact with a view to ending the epidemics of HIV, TB and malaria; and
- How challenges, barriers and inequities, including those related to human rights and gender, are being addressed through the modules prioritized within this funding request.

Priorities in this Funding Request

- Increase the quality and coverage of differentiated HIV prevention interventions for all key populations and other high-risk individuals, and increase HIV case-finding.
- Increase access to differentiated HIV care, treatment and support for all diagnosed PLHIV, with particular attention to bridging the gap between diagnosis and treatment, and the gap between treatment and retention., and achieving viral suppression.
- Contribute to building sustainable capacity and systems within the health sector, in the newly federalized context, to effectively lead, manage and deliver HIV services as an integral part of the broader national health system.
- Address human rights and gender-related barriers to accessing services, including the reduction of stigma and discrimination in the community and the health sector, as a critical enabler for all the above.

Nepal has committed to the ambitious goal of ending AIDS as a public health threat by 2030. By then, 95% of people living with HIV will know their HIV status, of whom 95% will be on ARV treatment; and of these, 95% will be virally suppressed. The forthcoming National HIV Strategic Plan (NHSP) 2021-2026 will set an interim goal of achieving the 92.5-92.5-92.5 by 2026.

The investments proposed in this funding request are an integral part of the broader country program to achieve these goals. The prioritization of modules and interventions has therefore taken into account the national funding landscape and the programmatic coverage of all the partners, as well as their respective strengths in covering specific aspects of the program.

The priorities above address the programmatic gaps identified through the recent review of the NHSP and extensive consultations with communities, government, implementing partners and other key stakeholders conducted over the first half of this year in preparation for this funding request, as well as the baseline assessment of human rights-related barriers to HIV and TB services conducted in 2018.[40] These included a need for an intensified focus on getting to the first and second 90s with a more strategic approach to case finding and linkage to treatment; a more client-centred approach to help retain people in treatment and achieve viral suppression; strengthened and better aligned reporting, surveillance and data use, including cascade analysis, to monitor and track progress; capacitating the health workforce, particularly at the provincial level; integrating HIV procurement and supply chains with the general health logistics system at all three levels of government; and strengthening community responses, including community-led

[40] The Global Fund (2018), Scaling Up Programs to Reduce Human Rights-Related Barriers to HIV and TB Services (Annex 25)

monitoring to complement joint monitoring by other stakeholders to verify progress and strengthen accountability at all levels of service delivery.

The support from this grant will address these gaps by strengthening interventions and linkages across the full continuum of HIV prevention, testing and case finding, care, support and treatment with a much greater emphasis (through capacity building and sensitization) on gender- and youth-responsive services across the continuum. More efficient and effective modalities for case finding and retention, including online-to-offline reach and mHealth, will be supported by strengthening recording, reporting and monitoring through the One National HIV Information System and ensuring the use of unique identifier codes and biometric data to track clients throughout the continuum. This will also facilitate better linkages between services and help to prevent the loss of clients at critical points in the HIV cascade. To enable this, key populations and people living with HIV will be further empowered to manage community-based and community-led service delivery through training, onsite supervision and mentoring, and ensuring that they have a structural in local and national planning and review mechanisms (including facility-based ART Committees).

The catalytic funding allocated to Nepal to address human rights-related barriers to HIV and TB services has been divided proportionally between HIV (60%) and TB (40%),[41] and matched by a total of USD 1.1 million allocated from domestic resources for the same purpose. All three disease programs, in collaboration with the communities, coordinated on the planning of cross-cutting and disease-specific interventions that will be supported by these funds, including training for service providers in facilities and in the community on human rights, medical ethics and addressing stigma and discrimination against key populations, PLHIV, women and young people; legal literacy for key populations and people affected by HIV and TB as well as training for legal professionals on HIV and TB-related human rights issues; sensitization for law enforcement and criminal justice personnel (including police and prison staff) on HIV and TB-related human rights and gender issues, including responding to GBV; advocacy to government, parliament and the public for supportive laws and policies and monitoring their implementation; training for community workers on addressing gender discrimination and GBV; and mobilising and strengthening communities to enhance their role in program planning and design, resource allocation, and advocacy, including patient advocacy.

Human rights-related barriers are not only addressed through the catalytic funding activities, but are a strong focus throughout the proposal and across the prevention-care continuum. High impact community-led activities such as community-led testing and community-based care including accompanied referrals to facility-based services, and a gender- and youth- responsive approaches all contribute to increasing access to essential HIV-related services.

As indicated in the Financial Gap overview, Nepal's HIV response has historically been implemented through a small number of primary implementers, namely the government, the Global Fund through Save the Children International (SCI), USAID/PEPFAR through Family Health International (FHI 360), and the AIDS Healthcare Foundation (AHF), who work collaboratively under the leadership and coordination of the NCASC to support prevention, testing, care and support in selected districts.

Key population	Current implementing partner	Implementing partner 2021-2024
Female sex workers	USAID/PEPFAR (FHI 360)	USAID/PEPFAR (FHI 360)
Men who have sex with men and transgender people	SCI, USAID/PEPFAR (FHI 360)	USAID/PEPFAR (FHI 360)
People who inject drugs, and their partners	SCI	SCI
Migrants and their spouses	SCI and provincial governments	SCI
People in prison	NCASC and provincial governments	SCI

[41] The full amount is budgeted under HIV and all TB-related activities have been included in this Funding Request.

People living with HIV	NCASC, SCI, AHF, USAID/PEPFAR (FHI 360)	NCASC, SCI, AHF, USAID/PEPFAR (FHI 360)

Taking into account the scope of the national program and the funding landscape for the period 2021 to 2024, including definite and provisional commitments from the respective partners, and based on intensive consultation between the MoHP, the NCASC, the CCM, the three non-government implementing partners and people living with HIV and key populations, it is envisaged that during this implementation period, the Global Fund program, through SCI, will continue to support HIV prevention and testing interventions in selected districts among people who inject drugs and their partners, migrants and their spouses (with co-funding from provincial governments), and people in prisons (with co-funding from provincial governments and the NCASC). Interventions among female sex workers and their clients, men who have sex with men and transgender people will continue to be supported by USAID/PEPFAR (through FHI 360), extending their coverage to all current MSM and TG program districts. A rollout of pre-exposure prophylaxis (PrEP) among female and male sex workers, men who have sex with men and transgender people, which showed high acceptability in a demonstration study conducted by USAID/PEPFAR in 2019, is proposed in the Priority Above Allocation Request (PAAR). Treatment, care and support interventions for people living with HIV will be supported by the NCASC, SCI and AHF.

At the time of writing, USAID/PEPFAR has committed to funding the FHI 360 program until September 2021. This potentially leaves a gap in the coverage of three priority populations (FSW, MSM and TG) in Years 2 and 3 of the implementation period. However, there is a strong expectation, backed up by the funding history indicated in the FGA, that USAID/PEPFAR support will be maintained at least at the current level over the following three years. The CCM is currently seeking confirmation to this effect from USAID/PEPFAR. As a safeguarding measure, funding for prevention and testing among FSW, MSM and TG for Years 2 and 3 is proposed in the PAAR.

There is inherent flexibility to this approach. Should additional funding become available—as has happened in the past through USAID/PEPFAR—there is scope to address emerging specificities among sub-groups of key populations that put them at higher risk. Studies are planned under this grant (main allocation and PAAR) to investigate such risk factors among migrant populations, prison populations and trans men. Such initiatives may lead to reprogramming among the key implementers; however, given the highly collaborative nature of the partnership, the ongoing dialogue among partners and community networks, and the defined service packages that have been developed by all stakeholders,[42] it is expected that this would be accomplished with minimal disruption to service delivery.

This strong coordination and collaboration among all the major partners at both national and implementation levels will continue to be critical in maximizing the impact of the proposed investments. All partners will be involved in regular joint planning, implementation, monitoring and review of the program and particularly the cascade from prevention to treatment, care and support services.

The proposed health system strengthening investments are designed to address the critical weaknesses that have affected the achievement of the 90-90-90 goals.

The selection of RSSH inputs in this funding request was made after extensive consultation not only among the three disease programs, UNAIDS, WHO and the communities, but also with GIZ, USAID and DFID Nepal. This has ensured that the proposed activities complement and build on, rather than overlap with, the health sector investments by these agencies, particularly in the areas of governance and planning, financial management, procurement and supply chain management, HMIS, laboratory systems, human resource

[42] Currently in the process of being endorsed.

development, community systems strengthening and infrastructure. On this basis, support is proposed, on a cost-sharing basis by the grants for all three diseases, for technical assistance at the federal level to coordinate the implementation of capacity building and RSSH plans, financial management, policy harmonization, and alignment with other EDP support, to ensure that there is no duplication of resources. This technical assistance will also support the government's plans to establish a Centre for Disease Control that will bring all the disease components together under a single agency.

The federalization and devolution of responsibilities so far exercised by central level ministries has created enormous opportunities as well as challenges in program design and implementation. This funding request, following intensive consultations with provincial authorities, has taken into consideration the opportunity, expectations and capacity in the provinces. Strengthening of the overall functioning of provincial health directorates is envisioned through additional human resource support, which will be supported on a cost-sharing basis, and realigning the implementation arrangements.

2.2 Funding Priorities

a) Based on the Global Fund Modular Framework, use the table below to detail **each prioritized module** proposed for Global Fund investment for the relevant disease component(s) and/or Resilient and Sustainable Systems for Health (RSSH).

COMPONENT: HIV

Module 1.1	**Prevention: People who inject drugs, and their partners**
Intervention(s) & Key Activities	The following interventions will be implemented as part of a comprehensive package of services for people who inject drugs that includes the differentiated HIV testing services detailed in Module 2.1. These prevention, testing and case finding activities are designed, through the linkage and referral activities in the respective modules, to link seamlessly to the full continuum of treatment, care and support, thereby minimizing leakage across the cascade of HIV services. Needle and syringe programming (NSP) in 28 districts, which will include: • Procurement of needles, syringes and alcohol swabs. • Differentiated NSP service delivery, catering to the needs of men, women female and male sex workers, young people and transgender people who inject drugs: distribution through fixed sites (including OST Social Support Units) and community outreach, EPOA, online to offline approaches, including all HIV testing services. • Dedicated NSP services for women who inject drugs to be expanded from the current two (Kathmandu Valley and Pokhara) to two more provinces, Province 1 and Province 5 (total 7 districts). • Emphasis on gender- and youth-responsive services through training for service providers on responding to the needs of people who inject drugs who have overlapping vulnerabilities (including women, young people, MSM, transgender people, FSW and MSW) and by engaging women who inject drugs and young people who inject drugs as peer and outreach workers. • Implementation of the existing government protocol for safe disposal of needles and syringes. • Basic injection-related health care, including referral for abscess management, with transportation cost. • Psychosocial and family counselling. • Provision of PEP and PPE (taking into consideration the possible continuation of the COVID-19 pandemic) for community workers/field staff. • Referral to OST, HTC and STI services, including detox referral with cost.

	• HIV prevention training for service providers as per the OST guidelines. • Local level advocacy meetings between stakeholders and local authorities, local law enforcement, and the public. <u>Opioid substitution therapy and other medically assisted drug dependence treatment</u> Where OST and NSP are provided in the same district, both NSP and social support for OST will be managed by the same SR in order to reduce overhead costs and facilitate demand generation for OST, as well as easy referral. • Distribution of OST through 12 existing medical care units (government-based and NGO-based) and 1 new medical care unit (government-based) with community-led management and support provided through a Social Support Unit (SSU) (co-located with or close to the medical care unit). Five additional OST sites are proposed in the PAAR for districts where there are high numbers of PWID but no OST services. • Interventions to increase service uptake by adjusting/extending service hours, dispensing through satellite and/or mobile units (2 existing satellite dispensing units; 8 additional satellite dispensing units are planned), ensuring gender- and youth-responsive services, as well as community-led demand generation through the SR. • High-level advocacy for mobile/satellite dispensing and take-home doses (including an impact assessment of take-home doses for needy and stable clients implemented during the lockdown period, and the revision of the OST guidelines). • Emphasis on women-friendly OST services by engaging female staff in SSU and in medical units. • Expansion of OST sites in the far west, based on the recommendations of the OST review (forthcoming from NHRC). • Engaging private hospitals in current OST districts to improve access to OST services. In Year 1, this will include exploration, preparation and roll out at least in two private hospitals in areas with high numbers of PWIDs. OST drugs, dispensing machines and training will be supported by the grant. • Procurement of OST drugs and dispensing equipment. • Training for SSU staff on providing gender- and youth-responsive psychosocial support through the SSU, including peer support and referral to mental health services. • Quarterly coordination meetings between MOHP, MOHA, stakeholders (in a neutral location). • Periodic coordination meetings of local OST committees that include law enforcement agencies and local leaders. • Training, onsite coaching and mentoring of service providers. <u>Overdose prevention and management</u> • Education on overdosing and strategies to reduce risk, linking it to NSP and OST. • Naloxone (including nasal spray) distribution through medical settings and available through community settings. <u>Condom and lubricant programming</u> • Supply, distribution and promotion of condoms to prevent HIV, STI and unwanted pregnancy, together with guidance on correct and consistent use, through interventions including BCC, NSP and community-led testing (CLT). <u>Behaviour change interventions</u> • HIV prevention education, counselling, mobilization for CLT, self-testing and index testing, IEC and strategic behaviour change communication (including positive prevention and U=U messaging), referral and follow-up, aimed at informing, educating and motivating people who injects drugs and their partners, and building their skills to

	recognize and reduce their risk of HIV, HCV and HBV infection/transmission. • Use of innovative online to offline (O2O) approaches, including online appointment booking, to mobilize PWID for HIV testing (including training, website hosting, devices and communication costs) designed specifically to reach hard-to-reach populations, including women who inject drugs and young people who inject drugs. • Gender- and youth-responsive BCC and IEC on HIV literacy, harm reduction, HIV prevention strategies, mobilization for CLT/index testing/risk referral network/self-testing (oral); peer support, including WWID-led and youth-led peer support. • Targeted IEC and BCC for FSW, MSW, MSM and TG who inject drugs. COVID-19 information and education will be included in all BCC packages while the pandemic is ongoing. <u>Community coordination</u> • Strengthening of PWID-led networks to promote increased uptake of NSP, OST and other harm reduction activities as well as HIV testing. • Inter- and intra- -network coordination meetings. • Periodic meetings of clients of NSP, OST and other harm reduction services facilitated by networks. • Family counselling and psychosocial support, particularly to the family members of new OST clients. Capacity building for harm reduction and OST staff and OW on respecting the rights and needs of women who inject drugs and other PWID with intersecting vulnerabilities (e.g. female and male sex workers, men who have sex with men and transgender people). Community/network mobilisation and strengthening, advocacy, and community-based monitoring will be an integral component of interventions among people who inject drugs. These activities are detailed and budgeted in the RSSH-Community Systems Strengthening and Reducing Human Rights-Related Barriers modules. <u>Sexual and reproductive health services, including STIs</u> • STI management for the prevention, diagnosis and treatment of STIs among people who inject drugs as well as their partners, provided through referral to government hospitals, SRH and PHC sites or at selected community-based clinics. • Referral to SRH and ANC services, including accompanied referral to PMTCT for PWID/partners who are pregnant. <u>Interventions for young Key Populations</u> • Capacity building for harm reduction and OST staff and OW on respecting the rights and needs of young people who use drugs. • Development and delivery of youth-appropriate IEC and BCC; counselling, peer support and mentoring. • Family counselling. <u>Prevention and management of co-infections and co-morbidities</u> • BCC/IEC on preventing HCV and HBV infection. • Screening, diagnosis and treatment of HCV for PWID who are co-infected with HIV • Screening for TB. • Referral to: HPV/HBV screening, mental health screening, interventions to address harmful alcohol use. <u>Addressing stigma, discrimination and violence: see under Reducing human rights-related barriers to HIV and TB services.</u>
Priority Population(s)	Men and women who inject drugs, and their partners

Barriers and Inequities	High levels of stigma around drug use, particularly against women and young people; discriminatory treatment at health facilities and in the community. This contributes to significant challenges in reaching women who inject drugs (WWID) as well as new entrants. Insufficient geographical coverage of OST has made it hard to achieve enrolments targets. Lack of government support for more user-friendly OST modalities. Legal restrictions on reaching PWID under the age of 18 with prevention and harm reduction interventions (reported by service providers during the country dialogue/NSP Review). Mitigating measures: Capacity building and sensitisation for service providers to address barriers, particularly to reach women and young people who inject drugs, and to strengthen linkage to testing, OST, treatment and other services. High-impact, cost-efficient prevention interventions through innovative digital approaches to increase reach and mobilise clients for testing. Increased coverage of OST and high-level advocacy for more client-centred service delivery.
Rationale	There are an estimated 33,023 people who inject drugs in Nepal, of whom approximately 11% are women.[43] Despite a significant decline in HIV prevalence since the early 2000s, it is still above 8% among PWID in some areas. High coverage of PWID with harm reduction interventions (including needle and syringe programming) has contributed to high, consistent use of sterile injecting equipment, as indicated by recent IBBS (above 90%). IBBS data also show that over 90% of men and women who inject drugs are able to access clean needles whenever required, despite the current NSP provision of 115 needles/syringes per PWID per year; some prefer not to access needles through the NSP and more than half of those surveyed are buying them out-of-pocket. While the proposed increase to 130 needles/syringes per PWID per year by the end of the implementing period is lower than the number recommended by WHO, it is deemed sufficient in Nepal's context in view of the positive behaviour demonstrated by people who inject drugs (safe injecting and taking responsibility for own needle/syringe purchasing). The OST program, considered a key component of effective harm reduction, has been challenged by low enrolment and retention; inadequate geographical coverage of OST sites and the need for daily visits are key barriers. A differentiated service delivery model, with satellite or mobile units to bring services closer to clients and take-home doses for stable clients (in line with WHO guidelines) are therefore planned, as well as to address this but will require strong coordination and support from all stakeholders. One additional government hospital-based site is planned, as well as 8 new satellite dispensing sites (2 are already in place). A further two full OST sites are proposed in private hospitals as an innovative approach to increase coverage and uptake through a public-private partnership. A further barrier to OST enrolment, as identified by the NSP Review, was the fragmented implementation of the harm reduction program, with NSP providers, OST sites and rehabilitation centres all competing for clients. In an effort to improve coordination and improve uptake and retention in both NSP and OST, both services will be managed by the same SR in districts where both are offered. Women who inject drugs have cited stigma and discrimination as major deterrents to accessing both NSP and OST services as well as services at government health facilities. Out of 804 OST clients in 2019, only 37 (4.6%) were women. No transgender people have accessed OST in the last 2 years. Younger people who inject drugs have also reported a

[43] NCASC (2017), Mapping and Size Estimation of FSW, MSM, MSW, TG and PWID in Nepal, 27. (Annex 13)

	lack of youth-friendly services as a barrier. Recent IBBS indicate that some 10% of men who inject drugs[44] and 55% of women who inject drugs are below the age of 20. This proposal therefore emphasises gender- and youth- responsive interventions, including sensitising both health-facility and community-based providers to the needs of women, young people and other people with intersecting vulnerabilities who inject drugs. To scale up prevention and testing reach there will be strong digital engagement of all people who inject drugs using innovative online-to-offline (O2O) strategies, particularly to reach 'hidden' populations (such as WWID and young people) who wish to maintain anonymity. O2O approaches that have already been implemented successfully and will be scaled up include online dissemination of IEC, one-on-one communication online with clients, online risk assessments and online booking of appointments for tests, while offline approaches will be used for the distribution of commodities, accompanied referral to HIV testing, STI clinics and other services, and regular outreach. Aside from their proven effectiveness in improving yields, as indicated by SCI and USAID/PEPFAR program data, digital approaches are more cost-efficient, allowing the same number of staff to reach potentially much greater numbers of the key population. Education on preventing viral hepatitis is a priority: people who inject drugs in Nepal show high prevalence of hepatitis C (38.1% in Eastern Terai, 18.8% in Kathmandu, 21.2% in Pokhara and 23% in Western region: IBBS) and hepatitis B. PWID who are co-infected with HIV and hepatitis are at higher risk of premature death due to cirrhosis and other liver-related complications.(NSP Review). HIV and HCV co-infection was reported at 3.7% among male PWID (IBBS Mid-Western to Far-Western districts, 2017) and 5.6% among women who inject drugs (IBBS 2016). To address this risk, hepatitis C treatment will be provided for PWID with HIV-HCV co-infection.
Expected Outcome	91% of people who inject drugs will have received a defined package of HIV prevention services, including NSP, by 2024 (KP-1d); 92% of people who inject drugs will be reporting the use of sterile injecting equipment the last time they injected. Subject to the extent of OST site expansion, 18.3% of PWID will be enrolled in OST by 2024.
Expected Investment	USD 5,537,910 (Total investment for Module 1.1: Prevention and Module 2.1: Differentiated HIV Testing Services for PWID)

Module 1.2	**Prevention: Male labour migrants and their spouses**
Intervention(s) & Key Activities	The following interventions will be implemented as part of a comprehensive package of services for male labour migrants and their spouses that includes the differentiated HIV testing services detailed in Module 2.2. These prevention, testing and case finding activities are designed, through the linkage and referral activities in the respective modules, to link seamlessly to the full continuum of treatment, care and support, thereby minimizing leakage across the cascade of HIV services. Community-led prevention (and HIV testing) interventions for the migrant population will be delivered in 10 existing districts as well as an additional 10 districts, based on prioritization, in a phased manner from Year 2 (please see the scale-up plan in the Performance Framework folder in the Dropbox). A further 20 districts are proposed in the PAAR. Migrants will be reached predominantly at source (with their spouses) as well as in transit, including as part of a joint initiative with TB and Malaria to provide comprehensive services

[44] IBBS among Men who Inject Drugs, Western to Far Western Terai Highway Districts, 2017; IBBS among Women who Inject Drugs, Pokhara Valley, 2017. (Annexes 12j and 12c)

	for departing and returning migrants at 9 border crossing checkpoints. In migrant districts, outreach workers will also provide TB and malaria-related prevention information and screening using standard checklists. Presumptive cases will be referred to the relevant service centres. Laboratory staff mobilized for HIV testing may also use malaria RDTs in accordance with malaria program guidelines. <u>Condom programming</u> • Supply, distribution and promotion of condoms to prevent HIV, STI and unwanted pregnancy, together with guidance on correct and consistent use, through interventions including BCC and community-led testing (CLT). <u>Behaviour change interventions</u> • HIV prevention education, counselling, risk categorisation and mobilization for CLT, self-testing and index testing, IEC and behaviour change communication (including positive prevention and U=U messaging), referral and follow-up, aimed at informing, educating and motivating migrant populations and building their skills to recognize and reduce their risk of HIV infection/transmission. Activities will be guided by a planned IBBS (funded by GoN) on sexual behaviour and HIV prevalence among returning migrants. • Innovative approaches using mass and digital media and e-reach/online-to-offline (O2O) approaches, including internet-based outreach to raise awareness about safe sex, HIV services, ART and testing. This will include training, website hosting, devices and communication costs for outreach workers. Specific online approaches will be designed to effectively engage young people and women. • Ensuring gender- and youth-responsive services through training for service providers on responding to the needs of people who have overlapping vulnerabilities (including women, young people, MSM, transgender people, FSW and MSW among the migrant community) and by engaging women and young people as peer and outreach workers. • Targeted IEC for young migrants, MSM, MSW and TG (including younger members of those populations) among the migrant population. <u>Sexual and reproductive health services, including STIs referral</u> • STI management for the prevention, diagnosis and treatment of STIs among migrants and their spouses, provided through referral to hospitals, SRH and PHC sites. • Referral to SRH and ANC services, including accompanied referral to PMTCT for spouses who are pregnant. Community/network mobilisation and strengthening, advocacy, and engagement with the community-based monitoring system will be an integral component of interventions among migrants and their spouses. These activities are detailed and budgeted in the RSSH and Reducing human rights-related barriers modules.
Priority Population(s)	Male labour migrants and their spouses
Barriers and Inequities	Difficulties accessing health services in India due to high costs, language barriers, and lack of information (IOM p46). Low literacy and cultural practices, including gender discrimination, mediate against safe sex practices among migrants' wives (IOM p 49). Stigma and discrimination against PLHIV in the community is a barrier to accessing services for both men and women. HIV prevention and testing service delivery to migrants and their spouses has experienced significant disruption in the last 2 years, largely due to delays in procuring services through government processes. The large population of migrants and their absence for much of the year pose challenges for implementation.

	Mitigating measures: Capacity building and sensitisation for service providers to address barriers, particularly to reach women and migrants with intersecting vulnerabilities, such as young migrants, and migrants who also inject drugs and/or are men who have sex with men or transgender people. High-impact, cost-efficient prevention interventions through innovative digital approaches to increase reach and mobilise clients for testing. Strengthened linkage to testing, treatment and other services. The challenges related to contracting NGO service providers through government mechanisms will be addressed jointly by the Global Fund and USAID/PEPFAR as one of the components of a sustainable HIV response.
Rationale	An estimated 3.5 million Nepalis work abroad. Out of these, some 330,000 seasonal migrants who travel to certain high-HIV prevalence states in India, and their wives, are considered as a key population at high risk of HIV. More than 76 per cent are between 15 and 34 years of age[45] In a 2018 study of the health vulnerabilities of cross-border migrants from Nepal, 81.6% of male migrants were married.[46] HIV prevalence among male labour migrants is low (0.3% in 6 eastern districts, IBBS 2018; 0.6% in the Mid and Far-West Hills, IBBS 2018; and 0.4% in the Western and Mid- to Far West region, IBBS 2017); and similarly low among their wives (0.5% in Far-Western Nepal, IBBS 2018) However, due to their high number, migrants are estimated to account for over 22% of HIV infections in Nepal. Given the disruption of services over the last two years, an intensified focus is needed to scale up high-impact interventions aimed at maintaining low levels of prevalence by addressing risk behaviours, finding and treating cases in the community by mobilizing migrants for testing, and preventing onward transmission, with an emphasis on 'U=U' messaging. An ambitious scale-up plan is proposed for 20 districts with a further 20 districts (with smaller migrant populations) proposed in the PAAR. All of these districts, except Kathmandu, are source districts for seasonal migrants who travel to certain states in India where HIV prevalence is high, As Kathmandu is a major pre-departure and arrival hub for migrants from all over the country who are travelling to and from destinations other than India, prevention and testing interventions will also be implemented for migrants who are temporarily in the city. Over half of migrants from Eastern Terai districts and 25% from Western districts had a history of sex with a female sex worker; less than half used condoms with their wives (IBBS 2017 and 2018). This, coupled with low levels of comprehensive knowledge of HIV prevention and access to prevention services among both migrants and their wives, indicates a need for increased coverage and better targeted interventions. To scale up prevention and testing interventions among the migrant community, there will be an emphasis on strong, continued digital engagement through innovative O2O strategies, including popular internet-based applications, particularly to reach those who wish to maintain anonymity, women and young people, and migrants with other intersecting vulnerabilities. O2O approaches that have already been implemented successfully and will be scaled up include online dissemination of IEC, one-on-one communication online with clients, online risk assessments and online booking of appointments for tests, while offline approaches will be used for the distribution of commodities, accompanied referral to HIV testing, STI clinics and other services, and regular outreach. To address the stigma and discrimination around HIV, particularly for women and young

[45] IOM (2019), Migration in Nepal: A Country Profile 2019. 2011 Census data, 36 (Annex 22)
[46] IOM (2019), Research on the Health Vulnerabilities .of Cross Border Migrants from Nepal, 11. (Annex 21)

	people, community-based providers will be trained on responding to the needs of women, young people and other people in the migrant community with intersecting vulnerabilities. This will complement similar training for health-facility providers (see the Treatment, care and support module).
Expected Outcome	90% of migrants in selected districts who work in selected high-HIV risk states in India, and their spouses, will have received a defined package of HIV prevention services by 2024 (KP-1e). 90% of migrants will be reporting the use of a condom at last sexual intercourse.
Expected Investment	USD 3,315,889 (Total investment for Module 1.2: Prevention and Module 2.2: Differentiated HIV Testing Services for Migrants and their Spouses)

Module 1.3	**Prevention: People in prisons and other closed settings**
Intervention(s) & Key Activities	In selected prisons with a population of more than 500: • CLT/periodic HIV screening (index testing/family testing). • BCC, psychosocial counselling, and linkage to ART services. • Sensitization and enabling support to prison authority/staff. • Post-release support to ensure continuation of ART. • Synergy (and integration) in implementation with the National Tuberculosis Control Center (NTCC) for TB screening and BCC. In each prison, both HIV and TB interventions will be implemented by a single SR; the modality for this is currently being worked out. • Referral to PMTCT for pregnant women in prison Support for an additional 10 sites (prisons with 300-500 inmates) is requested in the PAAR.
Priority Population(s)	Prison inmates in selected prisons (male and female)
Barriers and Inequities	The prison program was due to be funded in the current implementation period through domestic resources. However, it was stalled due to insufficient budget release. As the program will be supported by the GF grant in the upcoming program, it is expected that funds will be disbursed in a timely manner. Condom distribution and other harm reduction services inside prisons are currently prohibited.
Rationale	There are some 23,800 men and women in prison in Nepal. The NHSP identifies people in prisons as a key population: they assumed to be at risk of HIV and STI transmission due to unsafe sex practices, and inadequate information regarding HIV risk factors. However, currently available data and anecdotal information do not indicate that prisons in Nepal are high risk settings. A recent analysis in 74 prisons in Nepal[47] indicated HIV prevalence of 0.6% and HIV/TB coinfection of 0.1%. Program data indicate that there are approximately 60 prison inmates in the country who are currently on ART, and all were infected prior to their incarceration. Nevertheless, in view of the potential risks, people in prisons need access to prevention, HIV testing and counselling, and linkage to treatment. Given the restrictions on implementing interventions in prisons (see above), this package is designed to ensure that men and women in prisons have access to the information they need to reduce their HIV risk, find cases of HIV in prisons and ensure that they are linked to ART. Approximately 6% of the targeted population are women.
Expected Outcome	57% of the total prison population in Nepal will be reached with BCC and 51% tested for HIV (KP-1f, HTS-3f). The program will cover the 13 largest prisons in the country, each of which has over 500 inmates.
Expected Investment	USD 318,729

[47] MoHA/Nepal Health Society/FHI 360: Presentation given at the Sharing Meeting on National Level Situation Analysis on HIV, TB, TB/HIV, Hepatitis and Mental Illness in Prison Setting (August-September 2019)

Module 2.1	Differentiated HIV Testing Services: People who inject drugs, and their partners
Intervention(s) & Key Activities	Differentiated testing approaches will be implemented to improve HIV yield and ensure achievement of the 'first 90'. Testing will be done as per the national HIV testing and treatment guidelines: all people who inject drugs who are reached will be offered a test upon first contact and subsequent testing will be based on risk categorization, with subsequent testing based on an assessment of the individual's risk. Self-testing will be available to clients as an option and will be gradually rolled out as per demand. In additional to the community-led testing approaches described here, HIV testing and counselling, linkage to ART and referral to other services will continue to be available free of charge at government facilities. • Procurement of test kits, including self-test kits (test kits will also be procured through GoN resources). • Procurement of Hepatitis C test kits in initial years. <u>Facility-based testing</u> • HIV testing and counselling at a health facility or lab setting (SRH, ANC, TB, PHC). Counselling will be tailored to the needs of women, specific KPs and young people • For people who are HIV positive, accompanied referral to ART. Index testing, assisted partner notification and risk network referral will be offered. • HCV screening, TB screening. • Linkage to comprehensive prevention services, including NSP/OST and STI services as appropriate for people who are HIV negative. <u>Community-based testing</u> • HIV testing at a community-based site or mobile facility. Approaches include online and social media, self-testing, index testing, EPOA, risk network referral. Counselling will be tailored to the needs of women, specific KPs and young people. • Community-led HIV screening using a single RDT by lay community providers, including Community Home-Based Care (CHBC) and drop-in centre (DIC) workers, in a community setting. • For people with a reactive result, accompanied referral to confirmatory HIV testing, and, if positive, to ART and TB screening. Index testing, assisted partner notification and risk network referral will be offered. • Linkage to comprehensive prevention services, including NSP/OST and STI services for people who are HIV negative. • Training and mentoring of providers, particularly on partner/index testing, online approaches, addressing fear of testing and disclosure, risk assessment and treatment literacy. <u>Self-testing</u> • Supervised/assisted or unsupervised/unassisted HIV self-testing. • Distribution of and guidance on HIV self-test kits by community service providers, including assessment of suitability of self-testing, contacts for online and offline help in taking the test and follow-up to interpret the results and link the client to confirmatory testing in case of a positive result. • Accompanied referral to confirmatory testing for people with a reactive result, and to treatment if confirmed. • Procurement of test kits. • Training and mentoring of providers.
Priority Population(s)	People who inject drugs, and their partners; women who use drugs
Barriers and	High levels of stigma around drug use, particularly against women and young people;

Inequities	discriminatory treatment at health facilities and in the community. Reluctance to attend confirmatory testing due to fear of disclosure. Fear of testing/blood. Low self-awareness of risk. Low positivity yield of HIV testing. Mitigating measures: Differentiated high-yield testing approaches; skilled counselling to address fear of testing/disclosure, conduct risk assessments and mobilize index testing, partner notification and risk referral; accompanied referral for confirmatory testing and treatment initiation.
Rationale	Some 67% of PWID were tested for HIV between 2016 and 2019 (almost 80% in 2019 alone), but positivity yield has remained low (0.002% in 2019), largely due to a lack of differentiation in targeting (NSP Review). This has made reaching the first 90 in Nepal a challenge. Various strategies are planned for reaching and case finding among the remaining hardest-to-reach people at high risk, particularly women and younger people who inject drugs, using approaches recommended in the Joint HIV Cascade Assessment, including index testing (11% yield reported by SCI, 15.2% by USAID/PEPFAR)[48] to reach partners and other family members, risk referral networks, digital approaches and self-testing, which have shown promising yields in initial implementation in Nepal. USAID/PEPFAR has begun to roll out HIV self-testing in collaboration with the GF, NCASC and NPHL based on the finding of their pilot study. All these approaches are recognized as part of the differentiated HTS delivery approach in Nepal's 2020 National HIV Testing and Treatment Guidelines and will be significantly scaled up through this proposal. In line with the Guidelines and the Global Fund coverage indicator, all people who in inject drugs who are reached will be offered testing and counselling at the first contact. Community-led testing (CLT) will be done by trained lay providers as an integral component of prevention, harm reduction and CHBC and CCC services. CLT has made a major contribution to the scale-up of testing coverage in Nepal by directly addressing key human rights-related barriers to facility-based services including stigma and discrimination and perceived lack of confidentiality, as well as other deterrents such as inconvenient service hours, distance from service, and lengthy turnaround times for test results. Very high testing yields (9.4%) have been reported among 'Other high risk populations'[49] This suggests that intensified efforts may be needed to identify people with previous high-risk behaviours who no longer self-identify as KPs (such as former PWID, ex-partners, former FSW who injected drugs, etc.) Accompanied referral both to confirmatory testing and to ART centres for initiation for positive people will be crucial in ensuring that all positive cases are linked to treatment. Ensuring that all positive cases are reported to NCASC and linked to the biometric tracking system will also be a priority.
Expected Outcome	86% of people who inject drugs, and their partners will have had an HIV test and know their HIV status by 2024 (HTS-3d); this is approximately 94% of the people who inject drugs who will have been reached by prevention interventions. Testing coverage is expected to achieve 95% of the estimated PWID population by 2030. Differentiated testing will also lead to increased case finding, driving an increase in number of PLIHV on treatment and virally suppressed.
Expected Investment	Please see total for prevention and differentiated testing services in Module 1.1 above

[48] SCI and USAID/PEPFAR program data.
[49] USAID/PEPFAR program data Q1 2020.

Module 2.2	Differentiated HIV Testing Services: Male labour migrants and their spouses
Intervention(s) & Key Activities	Differentiated testing approaches will be implemented to improve HIV yield and ensure achievement of the 'first 90'. Testing will be done as per the national HIV testing and treatment guidelines: all migrants who are reached will be offered a test upon first contact and subsequent testing will be based on risk categorization, with subsequent testing based on an assessment of the individual's risk. Self-testing will be available to clients as an option and will be gradually rolled out as per demand. In additional to the community-led testing approaches described here, HIV testing and counselling, linkage to ART and referral to other services will continue to be available free of charge at government facilities. Differentiated HIV testing services for migrants and their spouses will be implemented in the same districts and sites as prevention services (see Module 1.2). • Procurement of test kits, including self-test kits (test kits will also be procured through GoN resources). <u>Facility-based testing</u> • HIV testing and counselling at a health facility or lab setting (SRH, ANC, TB, PHC). Counselling will be tailored to the needs of women, specific KPs and young people. • For people who are HIV positive, accompanied referral to ART, TB screening; index testing, assisted partner notification, risk network referral will be offered. • Linkage to comprehensive prevention services, including STI, SRH, PMTCT services, for people who are HIV negative. <u>Community-based testing</u> • HIV testing at a community-based/led site or mobile facility. Approaches include online and social media, self-testing, index testing, EPOA and risk network referral. Counselling will be tailored to the needs of women, specific KPs and young people. • Community-led HIV screening using a single RDT by lay community providers, including CHBC, in a community setting. • For people with a reactive result, accompanied referral to confirmatory HIV testing, and, if positive, to ART, TB screening; offer of index testing, assisted partner notification, risk network referral. Regional platforms such as SAARC and R-CCM will be leveraged to improve access to ART for migrants while they are in India. • Linkage to comprehensive prevention services, including STI and SRH services for people who are HIV negative. • Training and mentoring of providers, particularly for partner/index testing. <u>Self-testing</u> • Supervised/assisted or unsupervised/unassisted HIV self-testing. • Distribution of and guidance on HIV self-test kits by community service providers, including assessment of suitability of self-testing, contacts for online and offline help in taking the test and follow-up to interpret the results and link the client to confirmatory testing in case of a positive result. • Accompanied referral to confirmatory testing for people with a reactive result, and to treatment if confirmed. • Training and mentoring of providers.
Priority Population(s)	Male labour migrants who work in selected high-HIV risk states in India, and their spouses
Barriers and Inequities	Stigma and discrimination against PLHIV in the community is a barrier to accessing services for both men and women. Low self-awareness of risk is a barrier to uptake. HIV prevention and testing service delivery to migrants and their spouses has experienced significant disruption in the last 2 years, largely due to delays in procuring services through government processes.

	Low positivity yield of HIV testing. Mitigating measures: Differentiated high-yield testing approaches; skilled counselling to address fear of testing/disclosure, conduct risk assessments and mobilize index testing and risk referral; accompanied referral for confirmatory testing and treatment initiation.
Rationale	Due to program implementation disruptions, HIV testing among the migrant community has been inconsistent, ranging from 103,667 tested in 2015/16 to just 6752 in 2018/19 (NSP Review). As for PWID, more targeted strategies are planned for case finding, including index testing (11% yield reported by SCI, 15.2% by USAID/PEPFAR)[50] to reach partners and other family members at risk, risk referral networks, digital approaches and self-testing, which have shown promising yields in initial implementation in Nepal. USAID/PEPFAR has begun to roll out HIV self-testing in collaboration with the GF, NCASC and NPHL based on the finding of their pilot study. All these approaches are recognized as part of the differentiated HTS delivery approach in Nepal's 2020 National HIV Testing and Treatment Guidelines and will be significantly scaled up through this proposal. In line with the Guidelines and the Global Fund coverage indicator, all migrants reached will be offered testing and counselling at the first contact. Community-led testing (CLT) will be done by trained lay providers as an integral component of prevention and CHBC and CCC services. CLT has made a major contribution to the scale-up of testing coverage in Nepal by directly addressing key human rights-related barriers to facility-based services including stigma and discrimination and perceived lack of confidentiality, as well as other deterrents such as inconvenient service hours, distance from service, and lengthy turnaround times for test results. Accompanied referral both to confirmatory testing and to ART centres for initiation for positive people will be crucial in ensuring that all positive cases are linked to treatment. Ensuring that all positive cases are reported to NCASC and linked to the biometric tracking system will also be a priority.
Expected Outcome	81% of labour migrants who work in selected high-HIV risk states in India, and their spouses, will have had an HIV test and know their HIV status by 2024 (HTS-3e); increased HIV case finding driving an increase in number of PLIHV on treatment and virally suppressed.
Expected Investment	Please see total for prevention and differentiated testing services in Module 1.2 above

Module 3	**Module: Treatment, care and support**
Intervention(s) & Key Activities	**<u>Scale up access to client-centred treatment for adults and children</u>** Activities will be focused on retaining clients throughout the prevention-care continuum by expanding coverage of high quality, client-centred treatment, care and support that meets the needs of people living with HIV and ensures a more effective sharing of tasks between facility-based and community based services. This will include addressing human rights-related barriers such as stigma and discrimination at health facilities and in the community, • Establishment support for 15 new facility-based ART centres (5 each in Years 1, 2 and 3) based on current case load and projected need. • Mobilizing CHBC teams with a mix of women and men community mobilizers, and other networks to support the enrolment of all ART clients into the HIV Care/ART tracking/biometric system. • CD4 rapid tests (optional) will be piloted in selected sites: procurement cost of 500 kits.

[50] SCI and USAID/PEPFAR program data.

	• Procurement of a 6-month buffer stock of ARV *(OI and STI drugs to be procured through GoN)* **Prevention-care continuum through 60 CHBC services and 47 CCCs:** • Community-led HIV care and support will be provided using a differentiated service delivery approach, including short-term residential care at CCCs, home-based care (CHBC) at all ART centres, and mobile/online reach for stable clients. CCC and/or CHBC staff provide adherence support and psychosocial support for PLHIV, index testing, counselling on side-effects, treatment literacy (including viral load literacy – see below), delivery of ARV drugs, support for navigation at ART centres and linkage with other facility-based and community-based services, positive prevention and promotion of U=U, index testing, collection of VL samples, organization of peer support. The provision of CCCs with an attached CHBC team will be rationalized; they will be provided only where the ART centre has a caseload of more than 60 clients. Through this rationalization process, the number of combined CCC/CHBCs will decrease from the current total of 56 to 45 or less. In districts/sites where there is no fully-fledged CCC/CHBC team, support to ART clients will be made available by CHBC workers attached to ART centres in adjoining districts. Some CCC/CHBSs are led by women; women-led services will be prioritised in expansion districts when selecting CCC/CHBC SRs. • Support to clients initiating ART at ART centres by CHBC or CCC staff/peer navigators. Specific KP/youth peer support will be provided where needed (with transportation costs for accompanied referral). Efforts will be made to trace and enrol known PLHIV who are not already on treatment as well as those who are newly diagnosed PLHIV • Transport costs for accompanied referral to ART centres for clients initiating ART and for cases of treatment failure (transition from 1st to 2nd line) that require repeated visits and VL tests. • Increased structural coordination between ART centres and CCC/CHBC, including a role for a CCC/CHBC staff member on the ART Management Committee at each ART centre. To facilitate this, CCC/CHBC coordination meetings with the ART management committee will be held. • Baseline clinical assessment costs for people starting ART (viral load and CD4 – others to be covered by GoN). • Multi-month dispensing (3-6 months) for clients who are stable on ART, with regular online/phone-based follow-up and support by CHBC teams in close collaboration with the ART centre. • Updating of national CCC/CHBC guidelines. • E-health and m-health approaches, including online adherence support, auto push SMS alerts for ART clients to collect drug refills. • Designing and implementing a comprehensive strategy for adherence/retention and reducing loss to follow up (LTFU) before and after initiation on ART at both facility and community level. This will include development/updating of tools and IEC on treatment literacy and preparedness (including VL literacy – see below); positive prevention and promotion of U=U; disclosure support; reminder/alert systems/app, pre-loss intervention to maintain contact with clients and consistent implementation of biometric tracking and eHealth/mHealth approaches.. • Linkage to diagnosis and management of advanced HIV disease (including CD4 testing) as well as free NCD treatment and other health services available in the government system. • Advocacy at the provincial level to improve access to existing social services support units at hospitals (up to 50 bed hospitals). • Regional platforms (e.g. SAARC, R-CCM)will be used to improve access to ART in India. Community/network mobilisation and strengthening, patient advocacy, and engagement with the community-based monitoring system will be an integral

component of interventions among PLHIV. These activities are detailed and budgeted in the RSSH and Reducing Human-rights-related barriers modules.

Training and supervision for physicians, nurses, health assistants, ART counsellors/case managers, CCC/CHBC staff, lab staff, M&E staff, logistics staff, local/provincial government health officers

→ Clinical training and refresher training, including rollout/training on the 2020 updated treatment guidelines, will be supported by GoN and other partners.

- Regular, supportive onsite coaching and supervision focusing on guidelines implementation (including same-day or at least 7-day ART initiation); respectful, non-judgmental treatment of PLHIV/KPs, youth and CLHIV; proper recording and reporting.
- Training and refresher training for CCC/CHBC staff on community-based HIV care and support, including service package/guidelines; counselling skills; psychosocial support; use of biometric system; prioritization of clients; addressing the needs of aging PLHIV; and KP-friendly, youth-friendly and CLHIV-friendly services. (2 batches per year).
- Regular, supportive onsite coaching and supervision for CCC/CHBC staff jointly by NCASC/PR and other stakeholders.

Coordination

- Coordination meetings (ART Management Committee: hospital, ART centre, local authority, CCC/CHBC) and Provincial HD (under SR management).
- CCC/CHBC review meetings with provincial authorities (2 meetings/year). This will include coordination on linkages to locally available livelihood/income/nutrition/ CLHIV/education support programs and subsidies at the provincial level.
- Regular coordination with other implementing partners on the joint planning, review and monitoring of the prevention to care continuum to ensure timely linkage to treatment and support for all people living with HIV (newly diagnosed or known) as well as community-based follow-up for adherence, retention and viral load testing.

Treatment monitoring - Viral load

Expand coverage of viral load testing as the standard approach for routine monitoring of people on ART in line with the updated 2020 Testing and Treatment Guidelines, and reduce turnaround times for test results, by:

- Utilizing existing capacity for point-of-care VL testing by implementing the recommendations and learnings from the 2019 piloting of the GeneXpert platform for HIV VL testing in Nepal, including:
  - Collaborating with the NTP on the utilisation of GeneXpert machines procured for TB diagnosis.
  - Updating the National HIV laboratory plan and SOPs for sample collection and transfer and notification of results.
- Exploring and piloting alternative specimens for VL testing (such as dried plasma spot which has been prequalified by WHO for use with some VL platforms available in Nepal).
- Procurement of dried plasma spot cards (also known as plasma separation cards).
- Training, supervision and on-site coaching of lab personnel; VL literacy for health workers and the clients.
- Procurement of sufficient reagents/GeneXpert cartridges.
- Maintenance contracts (detailed in the RSSH/Laboratory systems module). Minor maintenance costs will be borne by the province/hospital.
- Ensuring systems for external quality assurance, engaging and equipping (HR) provincial lab (detailed in the RSSH/Lab module).

Prevention and management of co-infections and comorbidities

- Management of OIs and co-infections as per 2020 National HIV Testing and Treatment Guidelines (including CTX prophylaxis; TB counselling, screening and preventive

	therapy; prevention of common fungal infections, STI prevention and treatment; cervical cancer prevention and screening; • Treatment of HCV co-infection; • Routine screening for depression and referral to mental health services. • Linkage to social security units and other available free health services for the management of complications associated with aging and long-term HIV infection. **Counselling and psychosocial support** • Development and implementation of a community-based psychosocial support program for PLHIV, including peer support, disclosure support, assisted partner notification, support for people aging with HIV, specific support for young PLHIV, and referral to mental health services. • Nutrition counselling (integrated with CHBC). • Livelihood and nutrition support for ultra-poor PLHIV, through linkage to livelihood programs (government budgets for nutrition have been allocated to provinces). • Linkage to livelihood support through CCC/CHBC, including linkages to local financial institutions, rural entrepreneurship and agriculture initiatives, cooperatives, and educational support for adults, including adult former CABA. **Orphans and vulnerable children package** • CABA cash transfer. This will be maintained at NPR 1000/month. It will be discontinued in provinces/palika that are providing support, based on a forthcoming assessment (below). CSOs will advocate for the inclusion of CABA support in the Government's social protection framework from Year 3. • Conduct an internal assessment and mapping to determine which provinces/local authorities are providing support for CABA. • Support for absorption (fully or partially) of cash transfer into sustainable frameworks such as local (palika) child rights committee mechanisms and/or local/provincial/national subsidies and support programs. • Child-centred psychosocial support, including online/offline peer support, treatment literacy, therapies to address self-stigma, anxiety etc., and a preparedness program for children transitioning to adulthood, covering life choices, career counselling, relationships etc. • Linkage to educational support (vocational training, other technical education) programs for CABA/CLHIV over 18 years of age. • Facilitated access to birth/citizenship registration. • Empowerment of CABA/CLHIV: training, counselling and community strengthening activities, including organizing for peer support and advocacy. **Treatment monitoring - drug resistance** • At least one DRS survey to be budgeted during the implementation period, in collaboration with WHO. **Treatment monitoring - ARV toxicity** • Strengthening the existing ARV toxicity monitoring system at health facility level (training, supervision, response mechanism).
Priority Population(s)	People living with HIV
Barriers and Inequities	Stigma and discrimination in health care settings and the community Insufficient coverage of differentiated services (multi-month dispensing for stable clients, conveniently located ART centres and dispensing centres, effective peer navigation in health facilities). Inadequate access to viral load testing and timely results.
Rationale	HIV treatment is provided through 78 ART centres and 22 ART dispensing centres in 60 districts. Since adopting the Test and Treat approach in early 2017, the number of people

	on ART has increased significantly. As of June 2019, 18,628 people were receiving ART. As of May 2020, 88 CHBC teams operating in 57 districts had cared for 10,547 PLHIV while 56 CCCs in 52 districts had cared for 8,400 PLHIV (SCI data). These services provide a vital bridge between health settings and the community. Nevertheless, there is a need to update and rationalize service modalities in order to ensure that 'missing' diagnosed PLHIV are linked to treatment and more clients are retained in care and virally suppressed. With an increasing number of PLHIV who are virally suppressed as well as a smaller number of PLHIV who are newly initiating treatment, there is a need for a differentiated service delivery approach to ART. Multi-month (3-6 month) dispensing of ARV drugs to stable clients through PLHIV-led CHBC services can help to reduce LTFU (reduced transport costs/time away from work) and death, improve their quality of life while allowing ART centres to focus on clients in need of closer monitoring and support. Regular coordination meetings between ART centres and community service providers, as well as more robust and effective linkage among and between communities/CBOs, NGO, INGOs with local health authorities and new administrative mechanisms will be needed to make services more client-centred and sustainable. This will include stronger linkages with local authority provision of social support (including livelihood and nutrition programs). Quality improvements will be ensured by increased onsite supervision and mentoring of both clinical and CHBC services. The procurement of a 6-month buffer stock of ARV using GF funds will mitigate the risk of disrupted delivery due to stock outs and ensure sufficient supplies for multi-month dispensing. Unique identifier codes along with biometric information registration have been successfully rolled out over the last 3 years (as part of the DHIS2 tracker system) to track individuals along the treatment and care continuum. They are playing a role in identifying and preventing LTFU and facilitating continued access to treatment for people who are mobile. However, not all PLHIV are in the system and data is not being collected from all sites on a regular basis. More consistent use of biometric data tracking across the continuum of care in conjunction with mHealth approaches will help to eliminate duplicates, ensure better management of individual clients and better retention in care, and minimize LTFU. CCC/CHBC teams will be trained to mobilize biometric enrolment and some equipment support will be provided for this, while ART centre staff will be trained on stabilising and consistently using an effective systems for tracking LTFU. Viral load (VL) and CD4 monitoring are necessary for quality continuum of care and retention. VL testing in Nepal was expanded from 1 site in 2015 to 8 sites in 2018, and viral suppression among those tested is above 90%. However, in 2019, some 25% (4,667/18,628) of ART patients did not have access to VL testing services and those that did waited an average of 24.1 days from sample collection to the receipt of VL test results (NSP Review). Existing GeneXpert capacity in the TB program has not yet been optimized for HIV viral load testing. Planning and phasing in GeneXpert in collaboration with the NTP, strengthening equipment maintenance strategies and implementing EQA for VL testing are envisaged to expand access to high quality VL testing. This will be implemented through strong collaboration with the NTP, based on the recommendations of the Comprehensive Analysis of GeneXpert-focused Viral Load and TB Diagnostics Services in Nepal conducted by KIT in 2019;[51] the pilot study of GeneXpert for HIV viral load testing in Achham and Surkhet in 2019; and the USAID/PEPFAR workshop on the optimization of HIV viral load services in Nepal in February 2020. To facilitate VL sample collection from hard-to-reach areas, alternative specimens for VL testing such as dried plasma spot will be explored. The use of dried plasma spots has been prequalified by WHO for use with some VL platforms available in Nepal, and will minimize

[51] KIT (2019), Final Report: Comprehensive Analysis of GeneXpert-focused Viral Load and TB Diagnostics Services

	the need for cold chain while ensuring biosafety. Support for an assessment of needs with regard to a structured national sample transportation system, which would benefit all three diseases, is requested in the PAAR. Discriminatory attitudes and practices experienced by PLHIV in health care settings remain major barriers to accessing treatment; meanwhile, training for HCW on human rights and medical ethics is not being implemented consistently.[52] This will be addressed in the upcoming implementation period supported by GF catalytic funding and matching domestic resources. Community health service providers will be trained on responding to the specific needs of key populations, women and young people. In addition, community-based monitoring mechanisms will be established to monitor PLHIV client satisfaction and the results will be shared with hospital administrators and used to advocate for better service quality. Mental health was identified through the country dialogue as key concern for people living with HIV, and mental illness is one of the leading non-HIV related causes of death among PLHIV.[53] Investments will be made in improving the quality of psychosocial care and strengthening access to mental health screening and services for PLHIV, including young people and children living with HIV. As of 2019, 1,320 children affected by AIDS are receiving cash transfers under the CABA program administered by NAP+N. A Youth Lead-funded impact assessment of the CABA cash transfer has been approved and will begin once the COVID-19 situation eases. Consultations with CABA beneficiaries and caregivers indicate that the current support is vital for their wellbeing. However, there are growing opportunities to transition this support to local authorities. It is government policy to provide cash transfers to disadvantaged children (including orphans, children with disabilities, and children affected by AIDS) but the allocated budgets are often inadequate. Nevertheless, several local authorities are taking the initiative: Biratnagar Municipality has committed NPR 2000 for CLHIV; Koshi/Province 1 has committed NPR 1000 for CLHIV; and Damak Municipality has committed to provide educational support for CLHIV, although these activities have not yet been implemented. Networks and NGOs will advocate to local authorities (e.g. through regular coordination meetings) to ensuring that CABA receive sufficient support through government resources. Drug resistance monitoring: This has not been started yet, though a study on ADR and PDR was conducted in 2016.
Expected Outcome	91% of people living with HIV will be enrolled in ART by 2024 (TCS-1.1); reduced LTFU, increased viral load testing and 91% of people on ART virally suppressed by the end of the implementation period.
Expected Investment	USD 9,273,076

Module 4	**PMTCT**
Intervention(s) & Key Activities	<u>Prong 1</u> • eVT training (pre-service and in-service) and supportive supervision for ANC service providers, including training on data recording. This will complement the ongoing training from the Aama programme (RMNCH) by the Family Welfare Division. • Increased coverage of syphilis screening at ANC (dual HIV/syphilis RDTs – combo

[52] The Global Fund (2018), Scaling Up Programs to Reduce Human Rights-Related Barriers to HIV and TB Services, 6, 42 (Annex 25)

[53] NCASC, Death, loss to follow-up and missing details of PLHIV reported in National HIV Program, June 2020 (Annex 11)

	pack), including monitoring of syphilis testing. Kits to be procured by NCASC starting from 2nd year of the grant cycle. • CLT and/or linking pregnant women (KPs/partners of KPs) to ANC; for women who test positive, accompanied referral to confirmatory testing and enrolment in PMTCT. • PMTCT orientation/mobilization of CLT providers and NGO staff to increase testing of pregnant women and encourage them to enrol in ANC. • Orientation to PMTCT (including national testing protocol, recoding and reporting) for private health facilities. Protocol development for the private sector engagement/partnership. Pilot case reporting program from selected private health facilities. • Pregnant women in prison – referral to PMTCT (detailed under Prevention: People in prisons) <u>Prong 4</u> • Collection of DBS for EID (transport costs) and use of GeneXpert at provincial level.
Priority Population(s)	Pregnant women, babies born to women infected with HIV
Barriers and Inequities	Low levels of institutional delivery (77.5%) and births attended by skilled birth attendants (79.3%)[54] are key challenges to increasing PMTCT coverage. EID testing is currently conducted only at the NHPL.
Rationale	Elimination of vertical transmission (eVT) is increasingly well integrated with ANC services across the country, with PMTCT services available at 78 ANC sites in all 77 districts as well as at remote birthing sites and health posts up to district and regional hospitals. HIV testing has been incorporated into maternal and child health care in the form of PITC. However, HIV testing coverage of pregnant women in 2018 was only 58%, with considerable regional variation (from 30% in Province 2 to 74% in Gandaki Province). 66% of HIV-positive pregnant women received ART in 2018,[55] provided through 78 ART sites and 22 ART dispensing centres across the country. These gaps in testing at ANC visits and linkage to treatment will be addressed through training and onsite supervision of service providers, in collaboration with the Family Welfare Division. To address the more than 20% of women who do not deliver in health facilities or with skilled birth attendants present, support is also proposed for mobilizing CLT providers and NGO staff to promote testing and ANC enrolment among pregnant women. An unknown number of women access ANC services in private hospitals. Efforts will be made to bring them into the eVT program by developing protocols for engagement with the private sector and piloting in selected facilities. This will be guided by the Public-Private Partnership Guidelines developed in 2016[56] as part of the effort to achieve universal access to HIV prevention, treatment, care and support. Early Infant Diagnosis (EID) coverage of infants up to 18 months of age is 93% (UNAIDS). Dried blood spot samples are collected from all ART sites. Access to timely EID testing and results, which has previously only been available at the central NPHL, will be increased by expanding services to the provincial level.
Expected Outcome	92% of HIV-positive pregnant women will be receiving ART to reduce the risk of mother-to-child transmission (PMTCT-2.1) and to keep mothers alive and well; increased identification and treatment of congenital syphilis.
Expected Investment	USD 304,866

[54] Nepal Multiple Indicator Cluster Survey 2019, 11 (Annex 4)
[55] NCASC 2019, Factsheet 1: Epidemic Update of Nepal (Annex 10)
[56] NCASC (2016),Public-Private Partnership Guidelines for the HIV Response in Nepal, 29 (Annex 18)

Module 5	TB/HIV
Intervention(s) & Key Activities	<u>TB/HIV collaborative activities</u> • Quarterly TB/HIV coordination meetings at provincial level (central level meetings to be under the TB grant) to plan and coordinate delivery, recording and reporting (including reporting and sharing data from both TB sites and HIV testing sites), joint monitoring and supervision. • Roll out the TB/HIV collaboration guidelines (developed under TB grant) at provincial level, including training for ART centre staff. • Collaboration on the use of GeneXpert capacity in the NTP for HIV viral load testing (see Treatment, Care and Support module). • HIV testing among people with TB (test kits from HIV budget; implemented by NTP) • Screening of PLHIV for TB as part of CLT package (diagnosis of TB in PLHIV using GeneXpert will be budgeted under TB). <u>Treatment</u> • Provision of support and follow-up during treatment for both HIV and TB. <u>Prevention:</u> TB preventive therapy (TPT) • Procurement of Isoniazid for 6-month Isoniazid for PLHIV without active TB disease. • Begin to transition to 3-month 3HP regimen (drugs will be procured by the TB program). • Treatment literacy, follow-up and support for people on TPT (including via digital technology) through CHBC. <u>Engaging all care providers</u> • Support for TB-instigated PPM (Public-Private Mix) working committees at federal and provincial level as well as activities with Nepal Medical Association. (Cost share with the TB programme: budgeted under the TB programme). • CME for selected private sector institutions/facilities, particularly on TB and HIV case finding and notification (budgeted under the TB programme). <u>Community TB/HIV care delivery</u> • Adherence support to PLHIV for DOTs as well as for TPT through CHBC. <u>Key populations</u> • Collaborate with the TB and Malaria programs on providing prevention and screening services for all three diseases for migrants at 9 major transit check points, as well as providing IEC and referral to ART sites as appropriate. These sites will be supported on a cost-share basis by the TB, Malaria and HIV grants. • Collaborate with the TB and Malaria programs on providing TB and Malaria prevention information and screening through HIV outreach activities in 20 migrant districts (see Module 1.2), in accordance with respective TB and Malaria quality standards and guidelines, • Collaborate with the TB program on providing HIV and TB prevention and testing services for people in 13 of Nepal's largest prisons (see Module 1.3)
Priority Population(s)	People living with HIV and people living with TB
Barriers and Inequities	People living with HIV and TB patients are treated at separate facilities, leading sometimes to inadequate coordination, recording and reporting on screening for both diseases and follow-up of people who are co-infected. Efforts will be made to overcome this by strengthening the coordination between both programs at central and provincial level, particularly on joint monitoring and supervision, and by initiating collaboration on case-

	finding from private health facilities.
Rationale	The prevalence of HIV infection among TB patients in Nepal is 0.7%, while TB prevalence among people living with HIV is 9.9%.[57] After advanced HIV disease, tuberculosis is the 2nd leading cause of HIV-related death in Nepal (NCASC, Death, loss to follow-up and missing details of PLHIV reported in National HIV Program, June 2020). It is therefore critical to ensure that active TB among people living with HIV is detected and treated, and that cases of HIV among people with TB are diagnosed and liked to treatment. Effective collaboration between NCASC and the National Tuberculosis Control Center (NTCC) has ensured that most TB patients receive HIV screening and most HIV-infected TB patients receive ART[58]: A total of 22,029 (69%) of registered TB cases were tested for HIV in 2018/19 and 159 (0.7%) were positive, of whom 155 were initiated on ART.[59] In 2017/18, a total of 15,260 PLHIV were screened for TB.[60] To reach 100% coverage, stronger collaboration between the two programs is proposed, particularly on joint monitoring and supervision, optimizing GeneXpert capacity for HIV viral load testing (see under Treatment Care and Support) and the rollout of the new TB/HIV guidelines. With a view to increasing resource efficiency, coverage and impact, joint TB/HIV/malaria community approaches are planned among migrants at 9 transit check points (2 already established by the NTP). People living with HIV are at significantly increased risk for active TB. TB preventive therapy (TPT) is provided for PLHIV without active TB. The current recommended TPT regimen in Nepal is 6-month Isoniazid preventive therapy (IPT). A cumulative 43% of those on ART have been put on IPT since 2014, of which 2,026 were initiated in 2018 itself.[61] Anecdotal evidence suggests low uptake/completion due to lack of information/treatment literacy and perceived side effects. More consistent counselling and follow-up (including treatment literacy) of people on TPT, through online as well as offline approaches, is proposed to increase retention, as well as a transition (over the implementation period) to the shorter course 3HP regimen. An unknown number of clients are tested and treated for both diseases at private facilities, To increase HIV and TB case-finding the two programs will coordinate with selected private sector institutions through regular meetings of the PPM committee and by developing continuing medical education on screening protocols and case reporting.
Expected Outcome	100% of newly initiated ART clients will have been screened for TB by 2024 (TB/HIV-3.1a); increased initiation and completion of TPT.
Expected Investment	USD 80,231

Module 6	**Reducing human rights-related barriers to HIV/TB services**
Intervention(s) & Key Activities	**Stigma and discrimination reduction** Implementation modality: Through engaging KP and PLHIV-led networks, and other organizations. • Train master trainers on the application of the stigma reduction toolkit (which covers addressing stigma and discrimination related to HIV, TB and Malaria, non-discrimination, violence, ethics and human rights, including attention to all key populations, women and young people and people with intersecting vulnerabilities

[57] NTCC (2020), NTP Annual Report, 2018-2019, 12
[58] NTC (2019), Report of the Joint Monitoring Mission for Tuberculosis, 49 (Annex 24)
[59] NTCC (2020), NTP Annual Report, 2018-2019, 27
[60] MOHP (2018), Department of Health Services Annual Report 2017/18, 193 (Annex 2)
[61] NTC (2019). Op.cit., 49 (Annex 24)

	(source: GF). • Conduct mass media and social media campaigns to reduce stigma and discrimination based on HIV and TB status, with particular attention to discrimination against women, young people and key populations (source: GF). • Run regular support groups of HIV key populations and TB-affected populations, with attention to women and young people, to foster resilience through community mobilization, participation in governance, and addressing stigma and self-stigma. These activities will include programs to address harmful gender norms aimed at men and boys (source: GF). • Training for NGO staff, ORW on delivering services that are responsive to the needs of key populations and particularly women, youth and people with intersecting vulnerabilities (source: GF). • Sensitization programs for key populations, particularly those who are older/male, on stigma and discrimination faced by women and young people in the same key population (source: GoN). • Training for women (including trans women, FSW) and MSW focusing on empowering them to be vocal and seek help and services, particularly when facing violence (source: GF). • Scale up an online or mobile phone-based monitoring system of stigma and discrimination experienced in health services. This will include agreed indicators for reporting, mechanisms for a timely response and accountability by health authorities or service providers, and regular review, at all levels, of follow up. Women affected by HIV and TB, women in key populations and young people, alongside other PLHIV and KPs, will be actively involved in the design, implementation and review of the system (source: GF). • Institutionalize in teacher education a module of training on facts of HIV, TB and STI prevention and care and human rights issues related to HIV and TB (source: GoN). • Provide education on facts of HIV, TB and STI prevention and care and human rights issues related to HIV, TB and Malaria for out-of-school young people (source: GoN). The NTCC will invest in a rights-based and gender-responsive approach to strengthen the existing TB delivery system in Nepal to facilitate marginalized and vulnerable people to access services without any discrimination. In addition, by sensitizing the health workers and making them responsive to needs of KPs. • Assessment on TB community rights, gender, and TB stigma using STOP TB partnership tools on Stigma assessment & CRG (community rights & gender) assessment. • Conduct workshop on developing social media plan. • Provide technical assistance to develop concept and plan for TB free initiative. • Conduct workshop for discussion on the road map of "TB free" Palika (local level) to be shared by technical assistance. • Organize MTOT on human rights and medical ethics related to HIV and TB. • Training for health care workers on human rights and medical ethics related to HIV and TB. **Legal literacy ("Know Your Rights")** • Update positive prevention materials to ensure legal literacy content appropriate for all HIV key populations and people affected by TB. • "Know your rights" campaign days organized by key population groups. **Human rights and medical ethics related to HIV and HIV/TB for health care providers** • Using revised curriculum, in-service training of master trainers on HIV- and TB-related human rights issues for health facility staff. (source: GoN).Training roll-out across service providers will also be supported by GoN resources. • Develop PLHIV/KP/PMTCT-friendly check list for hospitals and implement in selected

	hospital periodically by NCASC (source: GoN). **HIV and HIV/TB-related legal services** • Roll out package for training legal aid professionals in HIV-related human rights issues. Establish/support legal advice helpline (online) with referral to legal aid organizations/pro bono lawyers in provinces (on an MOU basis). **Sensitization of lawmakers and law enforcement agents** • Advocacy workshops for law enforcement agents at provinces (source: GoN). • training roll out up to province and local level (source: GoN). • Integrate sessions on stigma in all HIV-related trainings. • Discussion/advocacy with high-level police and Ministry of Home Affairs with participation of key populations to inform them and seek support for new curriculum for both pre-service and in-service training. • Orientation to Gender, GBV and Human Rights for law enforcement/criminal justice personnel on responding to GBV and IPV, • Using revised curriculum noted above, training on HIV- and TB-related human rights issues in prison settings, especially TB-related and HIV-related stigma, for prison staff and prison hospital staff (source: GoN). **Improving laws, regulations and policies relating to HIV and HIV/TB** (joint activity with TB) • Gender audit/assessment for the HIV, TB and Malaria programmes in Year 3 (source: GF) • Based on the findings of the assessment, advocacy to government, parliament and the public for supportive laws and policies and monitoring their implementation (e.g. TB Act, drug law and policy including the legal grounding of harm reduction and the rights of women who use drugs, amendment of the Legal Aid Act, age of consent, citizenship, intimate partner violence, policies that allow for criminalization of sex workers, barriers to HIV and SRH services for young people). • Coordination meetings with the National Human Rights Council (collaborative activity between HIV and TB). TB: • Meeting with Prime Minister and other relevant Ministers • TA for coordination and facilitation to form high level End TB Committee • Workshop to define role and function of high-level End TB committee • Meeting with parliamentary committees (Health and Education) and other relevant Ministries • Engagement with parliamentarians, religious and community leaders, among others, for advocacy and sensitization including the training of parliamentarians on human rights, patient-centered care, and the role of protective legal frameworks in the TB response • Advocate for ultra-poor patients with TB to be included in poverty alleviation programme • Advocate with the Ministry of Labor to make a provision for health unit in the big factories and industries and include TB as an integral component. • Conduct coordination meetings with National Human Rights Council in collaboration with HIV programme **Reducing HIV-related gender discrimination, harmful gender norms and violence against women and girls in all their diversity** • Access to PEP, emergency contraception and STI treatment. • Raise awareness of TB, HIV and Malaria-related services among mothers' groups

	• Include training on screening for GBV and IPV in training/capacity building for NGO staff, ORW.
	
	Community mobilization and advocacy
	• Mobilization of patient advocacy group (local health facility management committee, FCHVs) to address human rights challenges faced by people living with TB, HIV and Malaria. (Joint activity with TB and Malaria)
	• Build capacity of communities, including women and young PLHIV and KPs,
	  • to play an active role in program planning and design, advocacy for resource allocation, advocacy to reduce stigma and discrimination and advocacy for more supportive laws and policies;
	  • to coordinate with other communities, CSOs and partners on the above.
	• This intervention will include the development of training modules and a training manual on the above, and training of trainers. Train community groups to respond in times of emergencies/pandemic.
	
	TB:
	• Meeting with youth to identify their role and responsibility in community TB care.
	• Conduct workshop to develop IEC /BCC materials for different platforms.
	• Printing IEC materials, posters, pamphlets, forms, guidelines, and other documents.
	• Conduct workshops to identify and record the hard to reach and vulnerable populations.
	• Establish survival group network at national and provincial levels and organize TB orientation to network.
	• Organize regular meetings of survival groups at Provincial level.
	• Organize advocacy meetings at local levels with service providers, local leaders, & patients.
	• Deliver messages broadcasting through Television, Radio, and other social media.
	• Develop TB documentary for broadcasting.
	• Set up community-based monitoring of service delivery quality, including stigma, discrimination, and confidentiality.
	
	Community-led monitoring of HIV services, including the use of online feedback tools, is detailed and budgeted under RSS: Community systems strengthening.

Priority Population(s)	Key and vulnerable populations such as mobile and migrant populations, people affected by TB, people living with HIV, people who use drugs, prisoners, socially marginalized communities, refugees, transgender and women, who are stigmatized or denied care because of their social or legal status.
Barriers and Inequities	Among the most significant challenges in achieving Nepal's 90-90-90 targets are the human rights and gender-related barriers that make it difficult for key and vulnerable populations and people living with AIDS to access essential health and social services. A baseline assessment of human rights-related barriers to accessing HIV and TB services conducted in June 2018[62] identified the most significant barriers as: 1) stigma and discrimination, experienced in the community and at health facilities, based on HIV status, gender and/or perceived or actual behaviours associated with key populations; 2) gender inequality, including gender-based violence and lack of decision-making power; 3) outdated laws that hinder KP access to HIV services; 4) illegal police practices against key populations - specifically men who have sex with men and transgender people and female sex workers; and 5) poverty and geographical barriers, as both time and financial resources

[62] The Global Fund (2018), Scaling Up Programs to Reduce Human Rights-Related Barriers to HIV and TB Services (Annex 25)

	are needed to access HIV services. Barriers to TB services are related to hierarchical caste-based and gender-based discrimination, social stigma, cultural and logistical barriers with poverty being an overarching structural barrier, financial barriers due to transport costs and loss of wages and time constraints. Mitigating measures: High level advocacy and sensitization of policy-makers to bring about protective legal frameworks; reinforce patient-centred HIV and TB care through training of frontline health workers on human rights and community-based monitoring of health services.
Rationale	A rights-based and gender-responsive approach to HIV and TB prevention and care would strengthen the existing delivery systems of HIV and TB services, Although significant progress has been made in reducing inequities in the provision of and access to HIV (and TB and Malaria services) in recent years, critical human rights-related barriers remain (see above). A more gender-responsive, human rights-based response is needed to increase uptake of services, improve the health and well-being of vulnerable people, and accelerate the achievement of national and global targets on eliminating AIDS. Implementation of a 5-year plan to address these barriers, supported by GF catalytic funding, has recently begun. An HIV stigma index survey is in progress, the stigma and discrimination toolkit has been updated and training for police as well as training on medical ethics for health care workers have been included in provincial budgets through domestic resources. A review of the alignment of laws and policies with GESI is also underway. The activities in this proposal are planned to build on these activities, informed by extensive consultation with communities, service providers, program managers and government representatives during the country dialogue/NSP Review process. These interventions will have an increased focus on addressing the specific and overlapping vulnerabilities faced by women, gender minorities and young people, as well as empowering communities to play a more central role in program design and review as well as implementation, and making community-based monitoring a central platform for making health care providers and law enforcement more accountable.
Expected Outcome	Increased HIV and TB case finding, increased access to prevention, treatment and related health and social services; reduced incidence of HIV and TB; and improved health outcomes and quality of life for key and vulnerable populations including people living with HIV and TB .
Expected Investment	USD 1,100,000 A matrix showing both Global Fund and GoN-funded activities is attached (in the HIV budget folder).

Module 7	**RSSH: Health products management systems**
Intervention(s) & Key Activities	**Storage and distribution capacity** • A procurement advisor will be assigned at the PR in Years 1 and 2 to support the Logistics Management Division and subnational procurement staff as well as the PR on timely and cost-efficient procurement of drugs and other health products for all three disease programs. This TA will include strengthening capacity for quantifying and forecasting, monitoring stock status and logistics management, including LMIS and eLMIS. • Training of trainers on logistics management (for eventual cascading to provincial and local levels).

	To escalate the support to a higher level for the benefit of the wider health system and the sustained operation of eLMIS and PSM at both provincial and central levels, international TA and associated activities have been proposed in the PAAR.
Priority Population(s)	Key populations and people living with HIV who need timely access to quality drugs and health commodities.
Barriers and Inequities	Gaps in planning and managing procurement and supply chain management increase the risk of stock outs of lifesaving drugs and essential commodities.
Rationale	Despite progress in procurement and supply chain management in recent years, persistent bottlenecks continue to pose a risk to grant implementation, In coordination with the MoHP and the three disease programs, the procurement advisor will oversee the procurement for grant purposes while advising on the strengthening of PSM systems and human resources at the national and subnational levels. The support will contribute to the establishment of resilient and sustainable procurement and supply management systems under the federalized structure. These activities will be coordinated with USAID, GIZ and DFID support for PSM, including USAID's support for eLMIS.
Expected Outcome	Improved planning and governance of procurement and supply chain management for HIV-related health products, leading to zero stock outs at all levels.
Expected Investment	USD 192,654

Module 8	**RSSH: Health Management Information Systems and M&E**
Intervention(s) & Key Activities	**Routine reporting** • Strengthening online reporting and recording from all health facilities to ensure that IHMIS/DHIS2 coverage is above 90% for all disease reporting including for timeliness and completeness: HR support; internet costs (15 new ART sites), computers (15 sites) training; monitoring, supervision and mentoring (Years 1, 2, 3). This will include finalisation and implementation of the One National HIV Information System (ONHIS) across the entire prevention, treatment, care and support system and across all partners/implementers to allow for tracking of clients across the entire prevention-care continuum and the generation of disaggregated data for comprehensive monitoring. • Technical assistance at HMIS (central level) to support the integration and interoperability of TB, HIV and Malaria reporting systems (including DHIS2 tracker, One National HIV Information System and e-TB register) with HMIS (cost share between the HIV, TB and Malaria grants). ➔ CME for recording/reporting from the private sector is planned under TB/HIV: Engaging all care providers **Program and data quality** • Supervision and monitoring for improved data quality, including onsite supervision, coaching and mentoring, taking into account the federalized context. Tools such SCI's RDQA protocol will be deployed. • Training and mentoring to local level data entry coordinator (by provinces) • Annual data quality audit and analysis to feed into the program review and quality assessment (cost sharing with FHI 360). **Analysis, evaluations, reviews and transparency** • Joint HIV program review (all partners), coinciding with a midterm program review of the NSP or after Year 2 of grant implementation (to provide input for the next funding cycle). • Regular joint monitoring, review, and planning among partners at the federal, provincial and local level, using ONHIS data to analyse program performance and identify gaps across the HIV cascade.

	• Simple epidemiological analysis (annual) of key indicators to ensure timely assessment of programmatic progress and the trajectory towards desired impact. This will be linked with the GAM reporting cycle.
	  • TA (Year 1)
	• Develop and implement a comprehensive, fully costed HIV program evaluation plan (funded by GoN and other donors as well as GF).
	• Update the M&E plan and develop a detailed costed M&E action plan (as a follow-up to the 2018 MESST and as part of the national processes to update the HIV NSP):
	  • MESST recommendation review/workshop (Year 2).
	
	Surveys
	IBBS for MSM and TG (Year 2). Other IBBS for other key populations (Migrants, female sex workers, men who have sex with men and transgender people), as well as mapping and size estimation of key populations, are proposed in the PAAR.
	
	Administrative and finance data sources
	A NASA is planned for 2021 but the cost will be covered by UNAIDS.

Priority Population(s)	Key populations and people living with HIV, as comprehensive, high quality strategic information will directly contribute to the effectiveness of the response.
Barriers and Inequities	Gaps in availability and quality of data; fragmented reporting systems across implementers; gaps in support to staff (not all personnel/sites trained on electronic reporting; inadequate supervision). Mitigating measures: Capacity building; nationwide rollout of a unified HIV information systems (ONHIS) with interoperability with national HMIS; consistent, strengthened supervision and monitoring to improve data quality and analysis; regular joint monitoring planning and review to address gaps across the cascade.
Rationale	A greater focus is needed on generating and using timely, high quality information to monitor and evaluate progress towards national and global commitments on HIV and AIDS, to identify gaps and bottlenecks and to guide program improvement and alignment that will maximize the impact of investments in HIV and lead to improved health outcomes for key populations and people living with HIV. The proposed technical assistance for HMIS will also support the TB and Malaria programs. The One National HIV Information System (ONHIS) was developed by NCASC on the basis of its ART tracker system through a joint effort with the GF, UNAIDS/PEPFAR, UNAIDS and AHF, and will be used by all implementers and all HIV-related services in Nepal to record, report and track individuals along the continuum of HIV prevention, testing and case finding, care, support and treatment services. Support for finalizing ONHIS and ensuring its interoperability with IHMIS will enhance cascade analysis and the tracking of progress towards the three 90s as all implementers across the prevention-care continuum will, for the first time, be reporting into a single coherent system. This is will make a significant contribution towards address barriers and inequities in HIV-related services and ensuring that individuals receive the service they need and are retained in the prevention-care continuum.
Expected Outcome	More than 90% of routine reporting units submitting complete, timely reports according to national guidelines.
Expected Investment	USD 1,197,076

Module 9	**RSSH: Integrated service delivery and quality improvement**
Intervention(s) & Key Activities	**Service organisation and facility management** • Technical assistance (national): to be based at MoHP.

	This TA will provide overall coordination support to MoHP for system support, RSSH facilitation, coordination, financial management and policy harmonisation. This TA will also support the proposed establishment of a Centre for Disease Control (CDC) responsible for all the disease components. The TA will also coordinate possible alignment with DFID/USAID/GIZ support for improving overall procurement systems, including budget execution, procurement practices and absorptive capacity. The TA will help develop the capacity development plan and coordinate with other development partner and TA agencies on its implementation. The TA will also be tasked with assessing opportunities in the expanding fiscal space at local and provisional levels to support the HIV program, including social support programs and initiatives and available funding for social contracting. USAID/PEPFAR will provide joint support for this work. • Deployment of existing human resources at SCI's regional offices to Provincial Health Directorates (PHD), where they will be responsible for supporting GF grant implementation and building capacity for the overall functioning of the PHD under the leadership and guidance of the Provincial Health Director. (Cost-share by the 3 Diseases). • Regular coordination meetings/interaction, led by MoHP, with provincial heath ministries/health directorates for streamlining overall health interventions alongside GF and other donor interventions (three coordination meetings with provincial authorities, two meetings with federal ministries including Ministry of Home and other ministries. This will support better policy coordination on issues like OST, social security, One-Stop Crisis Management Centres (OCMC), young people and gender, and addressing legal barriers. • Assessment of the HIV supply system at federal, provincial and local levels towards integrating HIV supply systems with the broader health system at all levels (Year 1). Based on findings and needs, further activities, HR and resource allocation will be initiated in Year 2 onwards.
Priority Population(s)	Key populations and people living with and affected by HIV, TB and Malaria, as effective leadership and coordination will directly contribute to the effectiveness of the respective disease responses.
Barriers and Inequities	Lack of full ownership of the three disease programs, leading to gaps in political and resource commitment; gaps in capacities needed to effectively coordinate the three disease programs at the national level; gaps in capacities needed to exercise the increased authority and responsibility for health at the provincial level under the federalised structure; g aps in capacity assessment and planning.
Rationale	As well as supporting the coordination of the disease programs within the health system, this TA is intended to build general and specific capacities within the MoHP to lead and manage the HIV, TB and Malaria response, in view of the Ministry's intention to assume the role of PR after 2024. An assessment of capacity needs and preparatory work will be conducted in Year 1, with implementation in Year 2. The staff assigned to the PHDs will coordinate closely with the TA at the central MoHP on overall coordination strengthening systems, including financial management, and facilitating RSSH at the provincial level. As provincial and local governments under the federal structure now have authority to allocate adequate resources for HIV, they will also support strategic planning for human resources for the HIV program as well as sustainability plan for HIV services. The NSP Review found that better integration of the HIV supply chain with the national

	system could potentially not only save costs and ensure reliable distribution of HIV commodities and services, but also strengthen overall procurement and supply management in the country's health system. Consultations with stakeholders in the provinces also indicated that, particularly under the federalized structure, provincial involvement in, and ownership of, HIV procurement, storage and distribution would be crucial for the sustained implementation and continuation of services. The proposed assessment will be contribute to the initial planning for this transition.
Expected Outcome	Increased national ownership, political commitment and domestic resource mobilization for an effective and sustained response to HIV, TB and Malaria at all levels. PHDs able to deliver effective coordination and management of health services in provinces, including coordination and oversight of Global Fund grants.
Expected Investment	USD 479,477

Module 10	**RSSH: Community systems strengthening**
Intervention(s) & Key Activities	Implementation modality: Through KP and PHIV led networks and other organizations **Community-based monitoring** • Development of a community-based monitoring (CBM) Manual and training of NGOs/CBOs on the application of CBM, including the adaptation of existing tools developed by USAID/PEPFAR. • Community-led mapping of human rights-related (and other) barriers. • Technical assistance to strengthen the CBM platform, build local capacity for CBM, mentoring and quality assurance. **Community-led advocacy and research** • Use of community-led monitoring data for advocacy for improving service quality and accessibility (regular interactive meeting at local/provincial authorities). • Regular community led advocacy to improve service quality, accessibility, policy reform, local resource mobilization for universal health coverage, among others. • Capacity building of community for advocacy skills • Coordination activities at provincial level with provincial authority, local authority (i.e. setting up Provincial AIDS Coordination Committee, provincial AIDS focal point). **Institutional capacity building, planning and leadership development** • Capacity building and mentorship of PLHIV and key population community organizations and networks (support governance, financial management system, leadership development). • Development of online communication platforms for PLHIV and key populations and sub-populations, including young KPs, for peer support and information sharing. • Develop technical capacity to respond to human rights, gender and legal and policy barriers to services.
Priority Population(s)	Key populations and people living with HIV, TB and Malaria
Barriers and Inequities	Gaps in the resources, systems and capacity for communities of key populations and people living with HIV to effectively manage, deliver and advocate for quality HIV services.
Rationale	The active engagement of CSOs in the HIV response in Nepal has played a critical role in creating demand for HIV testing and related treatment, promoting and delivering community health services, advocating for more equitable service delivery and resource allocation, and demanding accountability from service providers and implementers in the response. In view of the goal of ending AIDS as a public health threat by 2030, community capacity

	now needs to be further strengthened to scale up coverage, quality and sustainability of client-centred services. The proposed community-led monitoring platforms will facilitate the flow of feedback on equity and quality in health service delivery and be an integral component of joint monitoring of the HIV response. This will a key role in ensuring progress towards the three 90s. The CBM manual will include key indicators and participatory, inclusive processes for collecting and analysing data, disseminating the results and preparing reports. USAID/PEPFAR is developing a scorecard for the FHI 360 programme that could be adapted for the national programme. Communities will be trained in the use of the scorecards to collect and analyse data and use it, in coordination with other stakeholders, to guide planning and implementation.
Expected Outcome	Communities are empowered to monitor service delivery and use data to participate actively in planning and advocating for a more effective and accountable HIV response.
Expected Investment	USD 317,115

Module 11	**RSSH: Laboratory systems**
Intervention(s) & Key Activities	**National laboratory governance and management structures** • Strengthening of the National Public Health Laboratory (NPHL) through support for human resources, training, monitoring and supervision (Year 1). (Cost-share by the 3 diseases). • Development of laboratory information system (LIS) for HIV viral load testing services and its integration with national reporting system (DHIS 2 tracker). This will minimize the turnaround time (TAT) for the VL test results which has been a long-standing issue. **Infrastructure and equipment management systems** • Strengthening of the provincial public health laboratories (PPHL) through support for a staff member at each PPHL. • Provision of some basic equipment for PPHLs (Cost-share by the 3 diseases) • Equipment maintenance at PPHLs (Cost-share by the 3 diseases) • Operation costs for PPHLs. **Quality management systems and accreditation** • Strengthening QA and functionality in PPHLs: training, monitoring and supervision (Cost-share by the 3 diseases). Integration will be ensured during implementation. • Rolling out of HIV EQAS through proficiency panel testing, with training and consumables as required. **Avoidance, reduction and management of health care waste** Based on the assessment of Lab waste management and recommendations, the following activities are planned; • SoP for onsite management of lab waste within the broader framework of health waste management. • Develop standard training curriculum and roll out series of training to lab personnel in all seven provinces. • Procure dedicated autoclave for waste management for 3 labs that produce higher volumes of waste. (for other provinces, autoclaves are requested through PAAR by other grants). Coordination support to NPHL to facilitate implementation of other key recommendations made by the lab assessment.
Priority Population(s)	People living with and at risk of HIV, TB and Malaria, as increased coverage of quality

	diagnostic and monitoring services and rigorous quality assurance will contribute to the effectiveness of the respective disease responses.
Barriers and Inequities	Inequitable and inconsistent access to quality diagnostic and monitoring services. Lack of clear guidelines for newly established provincial laboratories on reporting, information sharing, coordination and collaboration.
Rationale	The NPHL strengthening will be a continuation of the support for all 3 diseases under the current grant in Year 1 only; thereafter, the cost will assumed by the government. The support to PPHLs will continue the existing HR (currently funded by the TB grant) but with an expanded job description to cover support to lab services for the HIV and Malaria programmes. This will be supported on a cost-sharing basis by all three diseases. This support is envisaged as part of a broader government initiative to develop a sustainable system of laboratory services to meet both the needs of the population and international standards[63] by building capacity at different levels of the federalised structure. The development and integration of an LIS for HIV VL testing will help to minimize turnaround times for VL test results, which is a long-standing issue. Annual maintenance contracts arranged at provincial rather than national level are expected to increase provincial ownership and help to ensure that equipment is kept fully functional at all times. A recent assessment of the country's laboratory system using the WHO's laboratory Assessment Tool (LAT) found that proper infectious waste management is not practiced consistently, leading to potential biorisks for staff, clients, the community and the environment. This support is envisaged to support the implementation of the forthcoming National Laboratory Strategic Plan. Further support for the development of a quality management system and for the implementation of laboratory waste management systems is requested in the PAAR.
Expected Outcome	Expanded coverage of quality diagnostic and monitoring services contributing to the effectiveness of the HIV, TB and Malaria responses.
Expected Investment	USD 155,680

Module 12	**RSSH: Financial management systems**
Intervention(s) & Key Activities	**Routine grant financial management** • Financial workshop for central and provincial GoN staff. Capacity building for finance managers fiduciary control, timely, transparent reporting and risk management related to the HIV program and grant management
Priority Population(s)	Key populations and people living with HIV, as strong financial management and accountability will directly contribute to the effectiveness of the response.
Barriers and Inequities	Gaps in health-related financial management and planning at central and provincial levels.
Rationale	Gaps in financial management capacity, particularly at subnational levels, have posed challenges in the administration of grant funds. budget absorption and efficiency. The workshop, in Year 1, will provide financial managers with tools to ensure timely disbursement an reporting.
Expected Outcome	Strengthened financial management at central and provincial levels,
Expected Investment	USD 4,960

[63] MoHP, National Laboratory Strengthening Plan 2020-2025

Module 13	Program Management
Intervention(s) & Key Activities	**Coordination and management of national disease control programs** • Monitoring and supervision from national and subnational levels. • Support to GoN, in collaboration with other stakeholders, on the development of HIV-related policy, strategy, governance and strategic information, including sustainability planning and human resource planning. **Grant management** • Oversight and supervision of SRs by the PR. • Annual planning and review meetings with SRs. • Financial management training and financial software for SRs. • Technical support for grant implementation from HQ. • Human resource, operational and overhead costs at the PR. • Routine visits and monitoring by NCASC. • Human resource, operational and overhead costs at NCASC. • Participation in GF and SCI meetings, conferences and training.
Priority Population(s)	Key populations and people living with and affected by HIV, as effective program coordination and grant management will directly contribute to the effectiveness of the response.
Barriers and Inequities	Frequent staff turnover, gaps in program management and financial management capacity
Rationale	Investing in strong, responsive program and grant management facilitates the timely and effective implementation of interventions, enabling them to be implemented at sufficient scale to achieve the intended coverage, outcomes and impact. It also contributes to robust and accountable governance, an essential element of sustainability.
Expected Outcome	Strengthened program management and implementation, contributing to the overall effectiveness of the response and the achievement of targets.
Expected Investment	USD 5,748,991

b) Does any aspect of this funding request use a **Payment for Results** modality?

☐ Yes ☒ No

If yes, in the table below, indicate the relevant performance indicators and rationale for the choice of performance indicators and/or milestones.

Performance indicator or milestone	Target				Rationale for the indicator/milestone selection for Global Fund funding
	Baseline	Y1	Y2	Y3	
Add rows if necessary					
Total amount requested from the Global Fund					

Specify how the accuracy and reliability of the reported results will be ensured.

[Applicant response]

N/A

c) Opportunities for integration: Explain how the proposed investments take into consideration:

- Needs across the three diseases and other related health programs;
- Links with the broader health systems to improve disease outcomes, efficiency and program sustainability.

Needs across the three diseases and other related health programs

Several opportunities have been identified to address needs across the three disease programs that will also contribute to the strengthening of the broader health system. As well as building human resource and systems capacity, these activities will also generate efficiencies by deploying health workers (including community health workers) across the three disease programs as well as designing and implementing integrated training at various levels.

Laboratory strengthening has been identified as a key priority as all three disease programs envisage a stronger role for provincial public health labs (PPHLs), particularly in quality assurance. Job descriptions of the lab technicians in each PPHL currently supported under the TB program will be expanded to cover respective quality assurance systems and overall lab functioning for HIV and Malaria as well, with all three diseases supporting refurbishment, basic equipment and equipment maintenance for the 7 labs. By strengthening diagnostic and quality assurance capacity at the PPHLs, the benefits of this investment will potentially go beyond the three diseases.

The HIV program will continue to collaborate closely with the TB program on addressing co-morbidity through prevention and screening of all PLHIV and presumptive TB patients for both diseases, as well as providing TB prevention information and TB screening (using a standard checklist) for key population through prevention and testing interventions. In migrant areas, HIV SRs will also be mobilised to provide malaria information and education, as well as malaria RDTs in accordance with Malaria program quality standards and guidelines. All presumptive TB and malaria cases will be referred to the relevant service centres The HIV grant will also contribute resources to 9 transit check points where comprehensive HIV, TB and Malaria prevention and screening services will be provided for seasonal migrants,. A closely integrated

approach will also be taken in prisons, where TB and HIV interventions will be implemented by a single SR to increase cost-efficiency and coordination and reduce duplication of effort.

The HIV and TB programs will also collaborate on the utilisation of the GeneXpert platform for HIV viral load testing. Optimizing existing GeneXpert capacity in the country for viral load testing—while ensuring that TB testing is not adversely impacted—could lead to improvements in health outcomes for ART clients by addressing a significant gap in the HIV treatment cascade. The optimization plan will be based on the findings from two pilot sites where the GeneXpert platform has been used to support both disease programs since early 2019. GeneXpert cartridges for viral load testing will be procured through the HIV grant, while the maintenance of GeneXpert machines that are used by both diseases will be supported on a cost-sharing basis between the HIV and TB grants.

Both the NCASC and NTP are moving towards a 'one-door' system for recording and reporting that will integrate data from all reporting units (including non-GF implementers in the case of HIV) and eventually with the IHMIS platform. Technical assistance is proposed at the central level (HMIS) to support the integration and interoperability of TB, HIV and Malaria reporting systems with HMIS. At the provincial health directorates, HR support is proposed to provide overall support for program data and quality as well as specific support for data quality, reporting to HMIS and interoperability for the implementation of all 3 grants. This TA and HR, which will be supported on a cost-share basis by all three grants, will contribute to strengthening national HMIS and surveillance.

Support will be continued for the existing technical assistance at the logistics management division (LMD) to support timely procurement for the TB, HIV and Malaria programs as well as their integration into the national procurement system. It is envisaged that the TA will work closely with other development partners' (GIZ, DFID, USAID) ongoing efforts to update MoHP's procurement systems and component parts (e.g. technical specification, forecasting and costing of health products and supplies, online systems and tracking) including the establishment and updating of related policies, guidelines, frameworks, SOPs and their implementation and monitoring. The TA will also support the transition of HIV procurement (ARV and commodities) to one of the GF procurement systems as an interim measure.

To support the engagement of private sector health care institutions/facilities, particularly on case finding and notification, the HIV program and Malaria program will be integrated into NTP-instigated PPM (Public-Private Mix) working committees at federal and provincial level, which are conducting activities with the Nepal Medical Association as well as private sector providers.

Links with the broader health systems to improve disease outcomes, efficiency and program sustainability

Support for the PMTCT program will be focused on further coordination with RMNCH services under the Family Health Division to ensure that all pregnant women have access to HIV testing at their first ANC visit or during delivery, and immediate linkage to treatment and EID if required. The expansion of the PMTCT program since its inception in 2005 has already contributed significantly to preventing new infections and enabling women living with HIV to remain alive and well. Support for scaled up coverage of dual HIV and syphilis screening during ANC visits is also expected to contribute to improved health outcomes for mothers and their children.

d) Summarize how the funding request complies with the **application focus requirements** specified in the allocation letter.

As Nepal is currently classified as a Low-Income Country, it is not subject to any restrictions on the programmatic scope of the funding request for the HIV program. Nevertheless, the funding request complies with the guidance provided in the allocation letter, namely that it includes investments in health and community systems and addressing human rights and gender-related barriers and inequities in accessing HIV services, as well as maintaining a strong focus on scaling up high-impact, demand-driven interventions focusing on key populations and people living with HIV in order to reach the 95-95-95 targets by 2030. It also addresses the sustainability of programs implemented by and for key populations and people living with HIV by considering opportunities for social contracting through government mechanisms. USAID/PEPFAR and the Global Fund will continue to work jointly to strengthen this area as the country works towards the long-term sustainability of the response. The PR has already started developing the sustainability plan with Government entities, particularly on the procurement of medicines and health commodities from domestic resources, in the current grant.

In line with the guidance from the MoHP on the 'division of labour' among key implementers in light of Nepal's projected funding landscape over the next three years, as explained in Section 2.1, Global Fund-supported HIV prevention and testing interventions will be focused on people who inject drugs and their partners, a defined sub-population of male labour migrants and their wives,[64] and men and women prisoners in selected prisons. Treatment, care and support interventions will target all people living with HIV.

Interventions will be designed to address challenges, including human rights-related barriers, to reaching the 95-95-95 targets. Modalities for outreach and testing will be designed to reach higher risk and hidden individuals and increase HIV testing yield, while the treatment, care and support program will focus on strengthening linkage to and retention in treatment, access to viral load testing and results, access to non-stigmatizing, non-discriminatory services that are responsive to the needs of women, young people, key populations and individuals with intersecting vulnerabilities, and improved tracking of clients through the cascade.

The shift to a federal structure poses significant challenges for health care planning, delivery, reporting, evaluation and oversight, particularly at the provincial and local levels, where the capacity to take on increased responsibilities is not well developed. However, this is also an opportunity for the country to build a more responsive, client-centred and integrated health delivery system. A series of cross-cutting strategies and interventions are proposed that are designed to strengthen capacities at federal, provincial and local levels to lead, manage and deliver the response, and, in the long term, to embed the disease programs more firmly within broader health care delivery and governance structures at all three levels. Given that under the newly federalized system, some of these structures are still evolving, RSSH interventions will be responsive to emerging needs over the course of the implementation period. In planning the RSSH component, strong consideration has been given to integration across the three diseases in the interests of cost efficiency, value for money and more sustainable outcomes for the broader health system as well as the HIV response (see 2.2c above).

Nepal has been offered additional catalytic funding (conditional upon the allocation of matching funds by the government) to address human rights-related barriers and inequities that are impeding the country's progress towards ending HIV and AIDS, TB and Malaria. In response to the priorities identified through the country dialogue process as well as recent reports and assessments[65] and the 2018 Baseline Assessment

[64] Those who migrate to specific high HIV-prevalence states in India.

[65] YKP-Lead, Youth Lead, AHF (2019); BDS (2020), National Report: Community-based Survey Nepal; Gender Assessment of the National Responses to HIV and TB in Nepal 2016.

and 5-Year Plan on Scaling up Programs to Reduce Human Rights-Related Barriers to HIV and TB services, interventions will build on selected priority activities in the Plan (implementation of which began only in 2019). These will be augmented with related strategies and interventions designed to address the drivers of human rights barriers, including stigma and discrimination, with an intensified focus on the needs of women, young people and people with overlapping vulnerabilities.

Interventions to address human rights barriers and inequities will include the training of master trainers on ethics, human rights and the application of the stigma reduction toolkit. The training will then be rolled out through pre-and in-service training (at the government's cost) for health workers, police and prison staff. NGO staff and outreach workers will be trained on delivering services that are responsive to the needs of key populations and particularly women, youth and people with intersecting vulnerabilities. Legal literacy programs and campaigns will be rolled out for key populations and people living with HIV to raise awareness of their rights to health and non-discriminatory and non-stigmatising treatment in health, community and criminal justice settings. At the same time, legal professionals will be sensitised to HIV-related human rights and linkages established with legal aid services and helplines for key populations. 'Knowing your rights' will also be a critical first step towards empowering vulnerable populations to participate actively in the proposed advocacy for resource allocation, equitable services and more supportive laws and policies, as well as for monitoring the response through the community-based monitoring mechanisms proposed under RSSH.

e) Explain how this funding request reflects **value for money**, including examples of improvement in value for money compared to the current allocation period. To respond, refer to the *Instructions* for the aspects of value for money that should be considered.

The key value for money (VfM) dimensions of economy, effectiveness, efficiency, equity and sustainability have guided the development of this funding request. Examples of how economy, efficiency and equity have been applied are outlined below.

Economy: Both the PR (SCI) and the lead entity for HIV (NCASC) will be involved in the procurement of HIV-related drugs and commodities. Challenges in procuring life-saving ARVs and HIV test kits through GoN-led mechanisms necessitated emergency procurements at high cost during the current implementation period. To ensure timely procurement and value for money in the coming period, a two-fold strategy is proposed: in the short term, pooling GoN and Global Fund resources and procuring ARVs through one of the recommended Global Fund platforms, such as Wambo; at the same time, the Global Fund will continue to work with the GoN to develop sustainable processes for the timely and efficient procurement of health products. This work will be coordinated and aligned with investments by GIZ, USAID and DFID to strengthen national procurement systems.

Achieving the 'third 90' in Nepal will require a considerable scale up of viral load testing and a reduction in turnaround times for results. Proposed interventions for optimising the country's existing GeneXpert platform in collaboration with the NTP could bring HIV viral load testing to scale without a significant investment in new equipment.

In each program district, a single SR will be managing all interventions for people who inject drugs, including both needle and syringe programs (NSP) and OST. This will reduce operational costs as well as increasing efficiency and coordination.

Efficiency: To maximize the impact of the available resources, differentiated service delivery (DSD) models will be applied for HIV testing/case finding and treatment, care and support. Nepal has had considerable success in leveraging community-led organisations and networks to increase access to testing, improve

initiation and adherence on ART and reduce loss to follow up through a mix of client-centred delivery models. Further efficiencies will be achieved by scaling up high yield testing approaches such as online to offline, index testing, self-testing; using risk categorization to determine the need for follow up testing; and scaling up multi-month ART dispensing.

Investments in strengthening health systems and capacity (including technical assistance and the redeployment of PMU staff at the MoHP, provincial health directorates, HMIS and national and provincial public health laboratories) are intended to deliver stronger management, coordination, governance and accountability in each of these areas. This will contribute to more efficient resource use as well as the impact and sustainability of the response.

The One National HIV Information System (ONHIS), developed by NCASC in collaboration with the GF, UNAIDS/PEPFAR, UNAIDS and AHF, will incorporate data from all implementers and sites in a single coherent system, thus minimizing duplication and supporting the tracking of individuals within the prevention-care continuum. The increased availability of disaggregated routine data will facilitate regular joint cascade review and planning processes, which can contribute to gains in resource allocation efficiency.

Task sharing will contribute to implementation quality and efficiency in several areas of the program. Outreach workers are empowered to perform multiple tasks, including BCC reach, testing, data entry and linkages to treatment. This helps them to build a strong rapport with, and provide a seamless service for clients. Similarly, a triple role is planned for CHBC teams: initiation of ART, treatment adherence and collection of samples for viral load testing, and index testing, including community-based testing for pregnant women who cannot access hospital services. As mentioned above, NSP and OST outreach workers will be working under the coordination of the same SR to provide joint outreach and referral to the relevant services.

Equity: The needs and concerns of key populations and people living with HIV were clearly articulated during the inclusive country dialogue process, adding to the knowledge base already documented in a baseline assessment of human rights-related barriers to HIV and TB services in 2018. These included persistent stigmatization and discrimination; insufficiently gender-responsive and youth-responsive services; a lack of inclusion in program and policy planning; gender inequality; harassment and physical violence by police; and the time and cost involved in accessing services. To promote more equitable access to services, resources and justice, these and barriers will be addressed through both main allocation and catalytic fund investments in, for example, training on human rights, stigma and discrimination for health care workers and community service providers, law enforcement and lawmakers; creating greater space for women-led prevention, care and support services; ensuring a more structural role for community care workers in local planning and review mechanisms, and capacity building to ensure a stronger voice for communities in advocacy and accountability mechanisms.

2.3 Matching Funds (if applicable)

This question should only be answered by applicants with designated matching funds, as indicated in the allocation letter.

Describe how the **programmatic and financial conditions**, as outlined in the allocation letter, have been met.

The catalytic funding allocation of USD 1,100,000 is conditional upon matching funds allocated by the GoN for the same programmatic area (addressing human rights-related barriers to HIV and TB services). The GoN has committed to allocating a total of USD 1,100,000 in matching funds to support activities addressing human rights and gender-related barriers to all three diseases over the implementation period. 100% of these funds have been allocated to the specified programmatic area. Activities are detailed and budgeted under Module 6: Reducing human rights-related barriers to HIV/TB services, indicating which relate specifically to HIV and which to TB. Activities to increase access to TB services are explained in detail in the TB Funding Request.

The HIV-related interventions cover the seven key areas that are recognized as effective in removing human rights-related barriers to HIV services, namely (i) Stigma and discrimination reduction, (ii) Legal literacy, (iii) Training on human rights and medical ethics related to HIV and HIV/TB for health care providers, (iv) HIV and HIV/TB-related legal services, (v) Sensitization of lawmakers and law enforcement agents; (vi) Improving laws, regulations and policies relating to HIV and HIV/TB, and (vii) Reducing HIV-related gender discrimination, harmful gender norms and violence against women and girls, as well as community mobilization and advocacy interventions intended to empower key populations and people living with HIV to play an active role in designing and implementing programs and advocacy towards dismantling human-rights related barriers to HIV services.

These activities are expected to increase uptake of prevention and treatment services as follows. Demand for HIV testing, STI treatment, ART and other facility-based services will increase if members of key populations and people living with HIV are (i) aware of their rights (through legal literacy and community empowerment interventions) and (ii) confident that they will be treated respectfully by service providers who have been trained to understand their healthcare rights and specific needs. Sensitization of police and lawmakers at all levels, as well as the general public through mass and social media campaigns, to human rights and the objectives of the HIV program will help to create an environment in which people who inject drugs, people who sell sex and transgender people can access services without fear of harassment, discrimination or arrest. Specific advocacy to address policies and laws that currently restrict access to certain services, such as harm reduction services and sexual and reproductive health services for young people, will help to ensure that more people in need of such services can access them safely in future.

The proposed interventions are based on the five-year implementation plan for a comprehensive response to human rights-related barriers to HIV and TB services in Nepal,[66] developed following the baseline assessment carried out in 2018,[67] and represent a scale-up of the interventions currently being implemented through catalytic funding allocated under the existing grant, taking into account the lessons learned through implementation. Where possible, efforts have been made to ensure that the activities will address barriers to accessing services for all three diseases, specifically in the areas of human rights-related training for health care workers, advocacy to lawmakers and mobilizing patient advocacy groups. To fully illustrate the scope of the program, Module 6 indicates not only the grant-supported activities but also those that will be supported by the matching domestic funding. The interventions will be implemented

[66] The Global Fund (2018), Five-year implementation plan for a comprehensive response to human rights-related barriers to HIV and TB services in Nepal (Annex 26)

[67] The Global Fund (2018), Scaling Up Programs to Reduce Human Rights-Related Barriers to HIV and TB Services (Annex 25)

across 60 districts.

In addition to the interventions proposed in Module 6, several interventions are proposed in other modules to increase access to HIV services, particularly by addressing stigma and discrimination against women and young people. These include support for women-led services for women who inject drugs; women-led CHBC services; engaging more women and young people as outreach and peer workers; and interventions designed specifically to reach more key populations with intersecting vulnerabilities.

Progress towards removing human rights-related barriers will be measured, as now, through programme level indicators, including the increase in numbers of key populations and people living with HIV accessing prevention, treatment and care services, and ultimately through the reduced incidence of HIV. Findings from IBBS surveys on stigma and discrimination will also be used to track progress, as will data collected through the Demographic and Health Survey on discriminatory attitudes towards people living with HIV. In addition, the community-based monitoring mechanism proposed in Module 10 will play an important role in monitoring the effectiveness of efforts to reduce human rights and gender-related barriers to services.

Section 3: Operationalization and Implementation Arrangements

To respond to the questions below, refer to the *Instructions* and an updated **Implementation Arrangement Map**[68].

a) Describe how the proposed **implementation arrangements** will ensure efficient program delivery.

The Government of Nepal and the Global Fund have agreed that Save the Children International should remain in place as the Principal Recipient, while the Government will continue to play an integral role in leading and coordinating the response. This decision takes into account the successful delivery of the grant-funded program by the current PR and, crucially, the remaining capacity gaps in Nepal's public health system as the country continues to manage the ambitious transition to a federalized structure. These gaps have been outlined in the letter dated 28 May 2020 from the Global Fund to the Minister of Health and Population.

The PR, the Global Fund and the GoN are working closely together to address these issues within the context of the evolving federalized arrangements, and an assessment of human resource and other capacity gaps at the MoHP is currently in progress. It is envisaged that the findings of this assessment will inform some of the capacity strengthening activities proposed under the RSSH modules in this grant. To oversee and coordinate these efforts and to support the implementation of all three grants, it is proposed that, under this grant, both new and existing human resources will be deployed at both national and subnational levels. There, they will focus on the strengthening of government counterparts to lead, manage and implement the program, including procurement and supply chain management; reporting, managing and using strategic information; and laboratory systems management (including quality management), with a view to building the GoN's capacity to assume responsibility for managing the Global Fund grants in future. The Global Fund and USAID/PEPFAR will be jointly supporting the Government on the sustainability of the response, particularly through strengthening NGO contracting through Government mechanisms. The PR will also seek to align with USAID, GIZ and DFID support on health system strengthening.

[68] An updated implementation arrangement map is mandatory if the program is continuing with the same PR(s). In cases where the PR is changing, the implementation arrangement map may be submitted at the grant-making stage.

As PR, SCI will continue to manage the grant through the Program Management Unit (PMU) in close coordination with the NCASC as the lead entity for the HIV program, as well as key technical partners such as WHO, UNAIDS, UNICEF and others; and key implementing partners USAID/PEPFAR and AHF. There will be strong collaboration between these agencies on the joint planning, review and monitoring of cascade of HIV prevention, treatment, care and support services.

As well as working directly with government counterparts at the MoHP, NCASC and subnational health directorates and offices, Save the Children International will continue to work through sub-recipients in the designated program districts. No major changes to the current implementation arrangements are envisaged. The SRs will be responsible for managing major aspects of the prevention, harm reduction, HIV testing, treatment, care and support and community strengthening components, including outreach work, community-based HIV testing and counselling, community-based care and support, and community-based monitoring, network development, advocacy and research. They will also be responsible for ensuring the recording and reporting of program data through the One National HIV Information System.

In line with the program's strong emphasis on the engagement of the people who are most impacted by the disease as they are best positioned to understand and respond to the needs of their peers, over 70% of the SRs engaged to implement the Global Fund grant are led by key populations, people living with HIV and women. Save the Children International will continue to prioritise key population-led, PLHIV-led and women-led organisations when contracting with partner NGOs to implement the upcoming grant. However, taking into account proven program delivery capacity and need to step up program efficiency, it is envisaged that in certain districts, interventions among some priority populations—specifically, migrants and their spouses—could be implemented by existing organisations led by other key populations rather than only by migrant-led organisations. Building SR capacity for program and financial planning, management and implementation will be a focus in the upcoming implementation period.

The GoN has committed to increasing its domestic financial commitments to the HIV program, including for the operational costs of government health facilities, (some) human resources and systems, the eVT programme and TB-HIV interventions, and the procurement of ARVs and other drugs and commodities. However, to avoid a recurrence of the procurement issues experienced during the current implementation period, it is proposed that in the upcoming period, the government allocation for ARV procurement should be pooled with the grant fund allocation (for the procurement of ARV buffer stocks) to procure the drugs through one of the Global Fund-approved mechanisms, i.e. PPM, Wambo, or GDF. This is envisaged as a temporary measure to ensure timely, value-for-money procurement of life-saving drugs while the country invests in strengthening procurement mechanisms (with support from GIZ, DFID and USAID) and clarifies responsibilities and mechanisms for HIV-related procurement.

b) Describe the role that **community-based organizations** will play under the implementation arrangements.

During the current funding period, a range of community-based organisations have played a key role in planning, designing, implementing and monitoring key aspects of the response. This task-sharing between government and non-government actors is recognized in the NSP as being essential to ensuring that key and priority populations are effectively reached with prevention interventions and testing, as well as linked to and retained in the continuum of care.

The forthcoming program will invest in strengthening community capacity for case finding, focusing on high yield community-led approaches, and for providing high quality care and support through community and home-based care (CHBC). This will include establishing more structured partnerships between community-based and facility-based care providers to ensure that people living with HIV have seamless access to human rights- and gender-responsive services in all health care settings, to address

the gap in the HIV cascade between diagnosis and treatment, and to improve retention in treatment. These activities will be almost entirely managed and delivered by organisations led by key populations and people living with HIV. As an example, this proposal envisages the participation of a CCC/CHBC staff member on the ART Management Committee at each ART centre so that they can fully realise their critical role in the continuum of care and ensure that clients' interests are represented. They will also participate in regular review meetings with provincial authorities to facilitate linkage to social/educational services and support.

The findings from the country dialogue process indicate that women and young people in these populations have been insufficiently included in the design and delivery of strategies and interventions, resulting in their needs being inadequately addressed; their inclusion will be a specific focus of the forthcoming program. For example, dedicated needle/syringe and prevention services for women will be provided through drop-in centres managed by women who are current or former drug injectors in several districts, and female staff will be engaged for OST social support and medical units. A number of CCCs and CHBSs are currently led by women, and women-led CCC/CHBCs will be prioritised when selecting SRs to manage these services in the scale-up districts.

A critical enabler for the effective implementation and sustained impact of these interventions is the dismantling of human rights and gender-related barriers to HIV services. A comprehensive response using evidence-based interventions to address identified barriers, and the factors that drive them, is planned (supported by matching funds from the GoN and GF). Communities will be instrumental in planning, delivering and monitoring this response. One priority is the development of a community-based monitoring system, which will complement existing DHIS2 tracking and program monitoring systems by collecting data from the community perspective on, for example, service quality, including stigma, discrimination and human rights violations experienced by clients; availability of drugs and commodities; and staff capacity at health facilities, as well as barriers to adherence. In addition, it will monitor the meaningful inclusion of key populations and people living with HIV, and particularly women and young people, in policy decisions as well as in program planning, development and evaluation. This will help to ensure greater accountability of service providers and facilitate the integration of human rights and gender considerations into prevention, treatment and care programs for key populations and people living with HIV.

Investments in strengthening and empowering community organisations and networks are planned in order to build the technical capacities to implement these programs at scale.

Given the substantial role played by community-based organisations in delivering critical aspects of the prevention and care and support programs, consideration will be given to improving the mechanisms available to the government for contracting such organisations to deliver services at scale as part of the effort to build a sustainable response. Social contracting has been problematic for the NCASC; however, lessons were learned during the current implementation period and an assessment is planned (possibly using the Global Fund's diagnostic tool on public financing of CSOs) of capacity and opportunities, at both national and subnational levels, to use public funding to support service delivery by CSOs while ensuring both financial accountability and accountability for results. The Global Fund will work jointly with USAID/PEPFAR to strengthen this critical area as part of the long-term planning for sustainability.

Summary of key areas of work for community-based activities in the proposed program:

- Implementing HIV prevention and harm reduction activities among key populations.
- Increasing case finding by mobilizing and conducting community-led HIV testing and counselling (including self-testing and index testing).
- Ensuring linkage to treatment by providing accompanied referral to confirmatory testing and ART

initiation, and providing referral to STI, PMTCT, TB screening, hepatitis C screening and other services.

- Promoting ART adherence/retention in care and viral suppression by providing comprehensive HIV care and support to PLHIV, including through eHealth and mHealth approaches.
- Coordinating within and between community networks, NCASC, implementing agencies, health facilities, local authorities, on increasing service uptake, retention and quality (planning and review).
- Improving livelihoods of KPs and PLHIV by coordinating with local authorities on linkage of KPs and PLHIV to available social/educational services and resources.
- Reducing human rights-related barriers to HIV services by planning and implementing a range of activities, including organising mass media and social media campaigns, managing a community-based monitoring mechanisms; coordinating with and advocating to the public, law enforcement agents, lawmakers, government for supportive, non-punitive and non-discriminatory practices, policies and laws.

c) Does the funding request envisage a **joint investment platform** with other institutions?

☐ Yes ☒ No

If **yes**, describe specific arrangements and modalities.

N/A

d) Describe key, **anticipated implementation risks** that might negatively affect **(i)** the delivery of the program objectives supported by the Global Fund, and/or **(ii)** the broader health system. Then, describe the mitigation measures that address these risks, and which entity would be responsible for these mitigation measures.

Key Implementation Risks	Corresponding Mitigation Measures	Entity Responsible
If it is not fully resolved by the start of the next implementation period, the current lack of clarity over roles and responsibilities in the provision of health care post-federalization poses a risk to the leadership, coordination, implementation and oversight of all three disease programs.[69]	The PR is engaging with health staff at provincial level to provide guidance for the continuation of activities, including supply chain and data flows. At the same time, the GF is reviewing the impact of decentralization on the leadership and implementation of the HIV program in order to plan actions to clarify roles and responsibilities for implementation, supervision and M&E as well as funding and supply flows. TA and human resource support is proposed to build on this process to strengthen capacity at provincial and local levels to effectively manage and coordinate the three disease programs within the context of the wider health system.	Global Fund/GoN

[69] As noted in the Global Fund OIG Audit Report, August 2019, 14 (Annex 28)

	The restructuring is also being seen as an opportunity to build capacity and put in place robust systems at provincial and local levels for laboratory systems, logistics management, and information management.	
The GoN may not be able to fulfil 100% of its commitment to procure ARVs, test kits and viral load reagents, posing a risk of delays and possible stock-outs of ARVs and commodities .	The GoN is making efforts to strengthen national procurement systems and capacity, supported by GIZ, DFID and USAID, among others. While these improvements are ongoing, it is proposed that the government allocation for the procurement of ARV drugs and HIV commodities be combined with the GF allocation and considered as a common procurement pool. Using this pool, procurement could them be made using one of the Global Fund-approved mechanisms, i.e. PPM, Wambo, or GDF. As a safeguarding measure, procurement of a 6-month buffer stock of ARC as well as test kits is proposed under this grant to ensure the continuity of treatment in case of future procurement delays.	NCASC/MoHP, CCM and Global Fund agreement needed to pursue this mechanism
Capacity gaps and frequent staff turnover at NCASC and at provincial and local levels (which are responsible for health care delivery) pose a risk to the effective planning, delivery and monitoring of the HIV program objectives.[70]	The GF is working with the PR and MoHP to assess the capacity building and human resource needs at national and subnational levels to ensure the effective implementation of the HIV program. The results will inform a costed capacity building plan, due in Dec 2020 (though COVID-19-related restrictions could potentially delay the assessment and preparation of the plan), which will be implemented during the upcoming grant implementation period. In addition, redeployment of existing human resources at the PR's regional offices to provincial health directorates is proposed to support overall capacity building efforts as well as the implementation of all three grants.	Principal Recipient
With the government priority on	Lobbying of the MoHP and MoF to	NCASC, MoHP

[70] As noted in the OIG report, op.cit., 17 (Annex 28)

addressing COVID-19, there is a risk that all sectoral budgets, including that of the health sector, will be redirected to the COVID-19 response. Although this may not affect the budget for essential drugs (ARV), it could affect other activities like the co-financing commitments and matching funds for the catalytic investments.	retain the budget already allocated for the HIV response, and careful assessment of the situation. In an extreme situation, there may be a need for reprogramming of some of the activities while ensuring minimum impact on the HIV response.	
COVID-19-related restrictions (travel restrictions; group gatherings for training and workshops; closure of meeting venues) could delay or make it impossible to implement some of the proposed field activities.	Careful assessment of the situation and adjustment of operation plan and modalities. During the recent lockdown period, increased spacing of ART doses, home delivery of drugs by CHBC teams, take-home OST doses for stable clients, and adherence monitoring and counselling by mobile phone were among the strategies deployed to ensure continued service delivery. In addition, numerous coordination and consultation meetings, including for the country dialogue process, were held virtually. These strategies will be reviewed and refined if the pandemic continues; strategies for online training, workshops and supervision will also be developed. Procurement of PPE has been budgeted for field staff. All of these strategies will be assessed and further refined in case the pandemic continues.	NCASC, PR, SR
The current policy restrictions on the OST program (restrictions on satellite dispensing sites and take-home doses for stable clients, as recommended by WHO) will remain in place, thereby jeopardizing the achievement of OST enrolment and retention targets.	NCASC, the PR, PWID networks and other stakeholders will advocate to the Ministry of Home to ease the restrictions while proposing strong safeguards to avoid undesirable outcomes. AN impact assessment of the take-home dose permitted for certain clients during lockdown will be conducted to support this advocacy. Further implementation research is proposed under PAAR.	NCASC, PR, SR

Section 4: Co-Financing, Sustainability and Transition

To respond to the questions below, refer to the *Instructions*, the domestic financing section of the **allocation letter**, **the** Sustainability, Transition and Co-Financing Guidance Note**, Funding Landscape Table(s), Programmatic Gap Tables(s)**, **and a sustainability plan and/or transition work-plan**, if available[71].

4.1 Co-Financing

a) Have **co-financing commitments** for the **current** allocation period been realized?

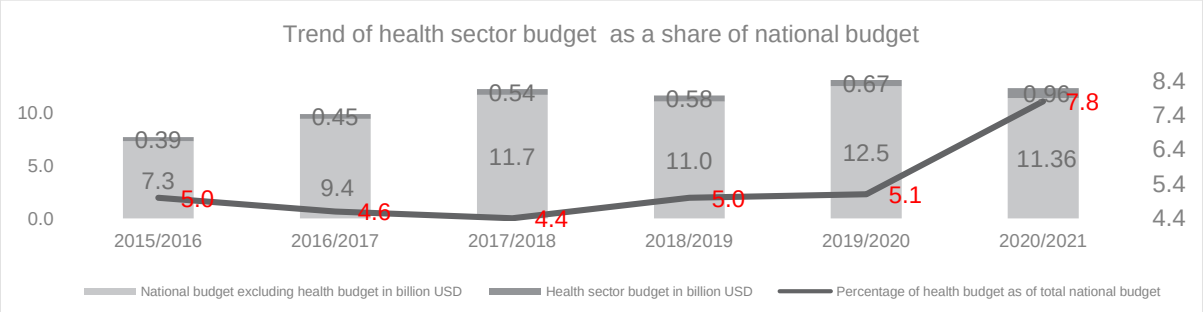
☐ Yes ☒ No

If **yes**, attach supporting documentation demonstrating the extent to which co-financing commitments have been met.

If **no**, explain why and outline the impact of this situation on the program.

	Domestic commitment for HIV for 2017-2019 allocation	Total allocation in Red Book (Budget)	Difference
2020/2021	**9,536,687**	5,524,463	4,012,224
2019/2020	**9,481,409**	5,177,536	4,303,873
2018/2019	**9,431,156**	4,049,437	5,381,719

The above table clearly compares domestic commitment made for HIV for 2017-2019 with the total amounts for HIV budgeted by the federal, provincial and local governments during 2018/2019 to 2020/2021. Investments made for HIV through the social health insurance scheme have not been accounted for in the above table. Premiums for the enrolment of PLHIV into the social health insurance scheme are waived.



It must also be noted that Nepal has increased the health sector budget over the years in actual terms as it jumped from USD 0.54 billion in 2017/18 to USD 0.96 billion in 2020/21. The health sector budget as a share of the national budget reached 7.8% in 2020/2021, increasing from 5% in 2015/2016, but fluctuating in between.

Along with this, the government's share of the Ministry of Health and Population budget has been

[71] Note that information derived from the supporting documentation provided in response to the questions below, including information on funding landscape or domestic commitments, may be made publicly available by the Global Fund.

maintained at over 75% from the period 2016/2017 to 2019/2020 except for the year 2018/2019, when it dropped to 66%. Despite the continuous increase in the health sector budget over the years and the reasonably high government share of health budgets, domestic co-financing commitments for HIV have been only partially realized. This can be attributed to competing agendas, not only over HIV and TB but also among other health issues such as the reconstruction of health infrastructure damaged by the 2015 earthquake, which was the focus of resource allocation in 2017/2018. Moreover, social health insurance has been prevailing over the government health budget between 2016/17 and 2020/21, and the response to COVID-19 has outdone all other national priorities in the current year 2020/21.

Ministry of Health and Population budget by source and absorption rate

	2015/2016	2016/2017	2017/2018	2018/2019	2019/2020
GoN	79	77	77	66	79
EDP	21	23	23	34	21
Absorption rate of the budget %	78.7	93.9	82.1	83.4	NA

Source Budget analysis of Health Sector, MoHP 2019

b) Do **co-financing commitments** for the **next** allocation period meet minimum requirements to fully access the co-financing incentive?

☒ Yes ☐ No

If details on commitments are available, attach supporting documentation demonstrating the extent to which co-financing commitments have been made.

If co-financing commitments do not meet minimum requirements, explain why.

The co-financing commitments for the 2021-2023 implementation period are: USD 5,091,498 million, 5,346,073 million and 5,613,376 million for 2021/22, 2022/23, and 2023/24, respectively. This commitment is confirmed in the letter from MOHP.

c) Summarize the **programmatic areas** to be supported by domestic co-financing in the next allocation period. In particular:

i. The financing of key program costs of national disease plans and/or health systems;
ii. The planned uptake of interventions currently funded by the Global Fund.

Nepal is striving towards 100% domestic resources for the procurement of major commodities required for the HIV response. As such, the government has shown its commitment for the procurement of ARV, condoms and test kits, including for the entire allocation period of 2021-2024, as in the current grant period. For this reason, only the cost of ARV for a period of six months and HIV test kits have been budgeted in the forthcoming HIV grant as buffer stock in case of procurement failure on the government's part. Similarly, for the last couple of years, the government has been shouldering the entire PMTCT program mainly through domestic resources, with near to 100% investment in test kits as well as training the health work force. On a few occasions, test kits were purchased from GFATM in order to address stock outs during the current grant period. Condoms for HIV prevention were procured purely through domestic resources.

In addition, people living with HIV have been covered by the Social Health Insurance Scheme with the provision of a waiver on their premium, and are now even receiving free health care services up to the

district level. The Social Services Unit Implementation Guidelines of 2010 also list people living with HIV as a target population, entitling them to secondary and tertiary services available at hospitals with a Social Services Unit either free of cost or at partial cost.

Through domestic funding, Nepal has allocated funds for a number of activities aimed at removing human rights-related barriers to HIV and TB services, notably through programs to reduce stigma and discrimination among migrants as well as people in prisons, and training for health care workers on medical ethics as they relate to HIV and TB. These activities are expected to continue from domestic funding.

d) Specify how co-financing commitments will be **tracked and reported**. If public financial management systems and/or expenditure tracking mechanisms require strengthening and/or institutionalization, indicate how this funding request will address these needs.

Currently the Ministry of Health and Populations (MoHP) is relying on two systems for tracking budgets and expenditure up to the lowest level of cost centres. The Transaction Accounting and Budget Control System (TABCUS) is specifically developed by the MoHP for tracking funds. This is a very comprehensive system that was developed keeping in view of the detailed fund tracking information required for planning and resource allocation both by the MoHP and the EDPs working in the health sector.

The next system is wider, and was developed by the office of the Financial Controller General (and Public Expenditure and Financial Accountability (PEFA) Secretariat) based on the decision of the Ministry of Finance (MoF). The system is called the Sub-national Treasury Regulatory Application (SUTRA), which is a planning, budgeting and accounting software mandatory for all public institutions' cost centres.

In addition to this, the co-financing commitment from the government for HIV-related activities will be implemented by the NCASC and/or as a conditional grant to the provincial authorities to implement co-financing activities. NCASC will be monitoring and tracking the co-financing activities. The provincial team supported through this funding request will also provide support to strengthen use of these systems for planning, tracking investments and accountability in the programs.

4.2 Sustainability and Transition

a) Based on the analysis in the **Funding Landscape Table(s)**, describe the funding need and anticipated funding, highlighting gaps for major program areas in the next allocation period.

Also, describe how (i) national authorities will work to secure additional funding or new sources of funding, and/or (ii) pursue efficiencies to ensure sufficient support for key interventions, particularly those currently funded by the Global Fund.

The funding need shown below is based on the total estimated cost of the National HIV Strategic Plan for the years corresponding to the grant cycle (2021-2024).

	2021	**2022**	**2023**	**2024**	**Total in USD**
	07/2020 - 06/2021	***07/2021 - 06/2022***	***07/2022 - 06/2023***	***07/2023 - 06/2024***	
Total NSP resource need*	29,475,063	34,347,733	36,057,669	37,737,036	137,617,500
Total domestic (GoN) resources	5,524,463	5,091,498	5,346,073	5,613,376	21,575,410
Total external (non-GF) resources	9,560,981	4,847,271	4,892,738	4,832,544	34,133,534
Total resource gap	14,389,619	24,408,964	25,818,857	27,291,116	91,908,556
Funding request - GF	**6,629,668**	**8,664,807**	**9,188,779**	**3,543,400**	**28,026,654**
Funding gap	7,759,951	15,744,157	16,630,078	23,747,716	63,881,902

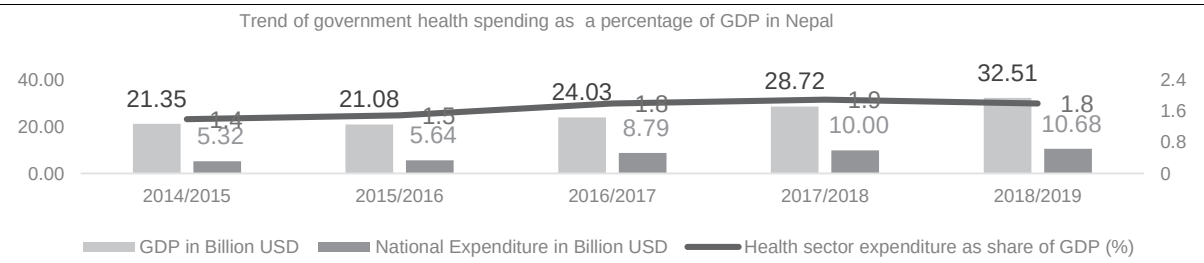
**Preliminary figure from draft NSP; subject to change*

As indicated in Section 4.1c, the Government of Nepal has allocated domestic resources to cover the cost of ARV procurement, condoms and test kits, the majority of PMTCT program costs and the cost of training the health work force as well as several activities to address human rights barriers to accessing HIV (and TB and Malaria) services. The GoN has committed to sustaining and increasing this financial support for the HIV program through resource allocations at the federal level. With support from the technical assistance proposed under this grant (RSSH: Integrated service delivery and quality improvement), the government will also be assessing opportunities to access resources for the HIV program in the expanding fiscal space at local and provisional levels.

b) Highlight challenges related to sustainability (see indicative list in *Instructions*). Explain how these challenges will be addressed either through this funding request or other means. If already described in the national strategy, sustainability and/or transition plan, and/or other documentation submitted with the funding request, refer to relevant sections of those documents.

The budget analysis of the health sector conducted by the Minister of Health and Population in 2019 showed that health expenditure as a share of GDP in Nepal reached 1.8% in 2018/2019, marginally increasing from 1.4% in 2014/2015, while overall national expenditure doubled in this same period to reach USD 10.68 billion in 2018/2019 from USD 5.32 billion in 2014/2015. The Chatham House report issued in 2014 recommended that countries should strive to spend five percent of their GDP to progress towards Universal Health Coverage (UHC).[72] Going by this recommendation, Nepal has been investing less in health as a share of GDP than would be necessary to achieve UHC.

[72] Mcintyre D (2014) 'Shared Responsibilities for Health: A Coherent Global Framework for Health Financing', Final Report of the Centre on Global Health Security Working Group on Health Financing. 2014



Source: Health Sector Budget Analysis MoHP, 2019: USD to NPR conversion rates for FY 2014/2015, 2015/2016, 2017/2018, and 2018/2019 are pegged at 99.79, 106.62, 106.48, 104.69 and 113.16 respectively, taking the conversion rate yearly average of July 16 to July 15 of each fiscal year.

Nonetheless, Nepal has been making strategic efforts to reach the target of UHC by 2030 as envisioned in the Sustainable Development Goals (SDG). Aligning itself to Universal Health Coverage, Nepal has embraced a four-pronged approach comprising of: a) free health services, b) free (disease-targeted) health programs, c) social health insurance program, and; d) social protection program (cash transfer program). The current provision of free health service allows all citizens to access all the services being provided from District Hospitals (DH) and Primary Health Care Centres (PHCC) without having to pay for registration: they are eligible for free outpatient, emergency and in-patient services, as well as drugs. Further in this direction, a free basic health service package has already been prepared, though not endorsed. In addition, the Government of Nepal has allocated NPR 4.22 billion (USD 39.9 million) to other free health programs that provide free treatment for targeted diseases, such as heart disease in the elderly and children, leprosy, scrub typhus, leptospirosis, TB, HIV/AIDS, free lifetime haemodialysis, etc. Also included in free health programs are disease-targeted cash incentives such as subsistence allowances for cancer patients, cash support for kidney transplants, transportation costs for leprosy and Kalazar patients, and institutional delivery. The GoN has also made an arrangement to provide free emergency health care to the poor and needy from the Central Hospital.[73]

Additionally, Nepal launched the Social Health Insurance Scheme in 2016/2017 to increase financial protection for the poor by promoting pre-payment and risk pooling in the health sector. In order to make health insurance available to all citizens within three years, 40% of the population at all local levels will be covered by insurance next year. Health services other than basic health care will also be included in the health insurance program. The GoN has allocated NPR 7.50 billion (USD 70.9 million)[74] for the health insurance program.[75]

In the recent budget allocation (FY 2020/2021) of the Ministry of Health and Population, distribution was made as follows: USD 5577.2 billion at the federal level, USD 43.7 billion for the province level and USD 241.7 billion for the local level. Besides this, the Ministry of Finance has allocated USD 523.3 million and USD 856 million[76] in grants to the province and local levels respectively. The grants consists of block grants, conditional grants and special grants. Keeping in view of the fact that key populations and people living with HIV have not been fully accessing these government provisions, a number of activities have been planned or integrated with other activities in this funding request (Section 2.2) to access adequate information about these resources and design supportive activities to link the KPs and PLHIV to them. In addition, it is envisaged that the technical assistance to the MoHP will include an exploration of opportunities to access these resources to support service delivery by CSOs.

[73] Based on Budget Speech of Fiscal Year 2020/21 (2077/78) (Nepali Version), analysed by https://www.phpnepal.org.np/publication/current-issue/recently-released/243-health-sector-budget-of-nepal-for-fiscal-year-2020-21-2077-79

[74] Exchange rate USD 1 = NPR 105.77

[75] https://www.phpnepal.org.np/publication/current-issue/recently-released/243-health-sector-budget-of-nepal-for-fiscal-year-2020-21-2077-79

[76] Exchange rate USD 1 = NPR 105.77

Annex 1: Documents Checklist

Use the list below to verify the completeness of your application package.

☒	Funding Request Form
☒	Programmatic Gap Table(s)
☒	Funding Landscape Table(s)
☒	Performance Framework
☒	Budget
☒	Prioritized above allocation request (PAAR)
☒	Implementation Arrangement Map(s)[77]
☒	Essential Data Table(s) (updated)
☒	CCM Endorsement of Funding Request
☒	CCM Statement of Compliance
☒	Supporting documentation to confirm meeting co-financing requirements for current allocation period
☒	Supporting documentation for co-financing commitments for next allocation period
☐	Transition Readiness Assessment (if available)
☒	National Strategic Plans (Health Sector and Disease specific)
☒	All supporting documentation referenced in the funding request
☒	Health Product Management Tool (if applicable)
☒	List of Abbreviations and Annexes

[77] An updated implementation arrangement map is mandatory if the program is continuing with the same PR(s). In cases where the PR is changing, the implementation arrangement map may be submitted at the grant-making stage.