Nepal National Advocacy Plan on HIV and AIDS 2008 - 2011

National Centre for AIDS and STD Control
HIV/AIDS and STI Control Board

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"HIV prevention actually poses equally formidable challenges in the long term as HIV treatment is for life-but so is also HIV prevention, a point we tend to forget. I'd like to repeat; HIV prevention is for life-throughout the life of a person, the life of a generation, and the life of the next generations. This means that we must not only accelerate HIV prevention in the short term, but we must take far more seriously the matter of bringing about sustainable changes in societal norms and values, as well as in the structural forces that makes people more vulnerable to HIV (Dr. Peter Piot, 2005)

Foreword

HIV is multifaceted and multi-dimensional issue with an influence on all walks of life. In order to address HIV issues effectively, the prevailing environment and systems must change, and for this, consistent and coherent multi-sectoral efforts are needed.

Whenever the question of change emerges, advocacy has a key role to play. Advocacy is committed action directed at change. Advocacy involves putting an issue on the agenda, proposing a solution, and building support for that solution and for the necessary actions to carry it out. ***Results*** are the basic achievements of advocacy, rather than only claiming/ acclaiming, talking about, sensitizing or making people aware of a problem.

All of the actors involved in the response to HIV in Nepal – including the Government of Nepal, development partners, non-governmental organizations and local civil society partners -- have been working consistently to address the issues of HIV. The impact of these efforts on the epidemic gives some cause for satisfaction, but we cannot be sure of continued future improvement of their fullest potential. Exposing the facts that block the road to achievement- those mandated by the National Action Plan on HIV or committed to Millennium Development Goals -- can help all partners prepare to address the challenges around HIV epidemic.

No problem is insurmountable as such; the major question is how to position an issue for effective management. Many issues were identified during the preparation of this Advocacy Plan. However, in view of the magnitude of the resources, time and energy needed to address them, certain urgent and important key issues were prioritized. The Nepal National Advocacy Plan for the period 2008-2011 has been developed by maintaining the spirit of the National HIV/AIDS Strategy 2006-2011 through a collaborative process aiming to strengthen and focus advocacy efforts of all partners to achieve synergistic results in policy environment or programmatic interventions that bring improvements in the national response to the HIV epidemic in Nepal.

We would like to acknowledge the efforts of many individuals and organizations for their contribution in the development process of this Advocacy Plan. The collective inputs of a team composed of international and national experts were remarkably valuable.

We urge government, development partners and non-governmental organizations to benefit from and build upon this advocacy framework and to continue to find ways to operationalizing their commitment to protect human rights in the response to HIV.

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Acronyms

APACHA	Asian People's Alliance for Combating HIV and AIDS
BS	Bikram Sambat
CABA	Children Affected by AIDS
CAAFAG	Children Associated with Armed Forces and Armed Groups
CTEVT	Center for Technical Education and Vocational Training
DACC	District AIDS Coordination Committee
DDC	District Development Committee
DU	Drug User
EDPs	External Development Partners
HIV	Human Immuno- Deficiency Virus
IDU	Injecting Drug User
LGBT	Lesbian, Gay, Bisexual and Transgender
LSBE	Life Skill Based Education
MARP	Most-at-risk population
MOES	Ministry of Education and Sports
MOHP	Ministry of Health and Population
NAPN	National Association of People Living with HIV Nepal
NCASC	National Center for AIDS and STD Control
NPC	National Planning Commission
PLHIV	People living with HIV
SAE	Semi Autonomous Entity
SWs	Sex workers
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
VDC	Village Development Committee
WLHIV	Women Living with HIV
WHO	World Health Organization
MSM	Men who have Sex with Men
UN JTA	United Nations Joint Team on AIDS
MoHA	Ministry of Home Affaire
MoWCSW	Ministry of Women Children & Social Welfare

Table of Contents

A. Glossary of Terminologies

This advocacy plan includes a number of technical words and phrases. Some key words and phrases have been briefly defined to make it easier for the users. In the process of developing the advocacy plan, the task force decided to briefly provide such terminologies are based on the standard definitions. Some of the terminologies have been extracted from its original names or documents such as SAE from its formation order and some were defined together by the team of consultant and the facilitators.

Advocacy: Advocacy is the method and a process of influencing decision makers and public perceptions about an issue of concern, and mobilizing community actions to achieve social change, including legislative and policy reforms, to address the concern. For the purpose of National Advocacy plan, the advocacy will be directed towards achieving universal access targets to HIV prevention, treatment, care and support services aligning with the National HIV/AIDS Strategy (2006-2011), Nepal.

Advocacy Audience or Target Audience: The advocacy audience or target audience is the person or persons an advocacy or other message is intended to reach. In advocacy, the primary target audience is the person or persons who can act most directly to bring about the changes we are advocating for. A secondary target audience includes the person or persons other than secondary target audience who can influence the primary target audience to bring about the changes.

Advocacy Goal: The advocacy goal is the statement incorporating the most important result of a successful advocacy, in response to the issue.

Advocacy Partners: Advocacy Partners are those groups or individuals who are the best placed to carry out the advocacy efforts, usually by communicating with the target audience (those who have the direct power to make the changes required to reach the advocacy goal.) The nature and kind of key partners vary depending on the advocacy goal. The key partners may include the government bodies, civil society groups and networks, external development partners, APLF leaders or influential individuals, among others.

Advocacy Objectives: Advocacy objectives are the statements stating what we intend to achieve following successful advocacy activities. Advocacy objectives can also be viewed as a sub-component of the Advocacy Goal.

APLF leaders: The Melbourne Ministerial Meeting held in October 2001 decided to initiate the Asia Pacific Leadership Forum on HIV/AIDS and Development (APLF). It was reiterated in the Second Asia Pacific Ministerial Meeting on HIV/AIDS held in Bangkok in July 2004, and partnered it with UNAIDS. APLF responds to the commitment for strong leadership on HIV/AIDS agreed at the UN General Assembly (UNGASS) in June 2001. APLF was officially launched in September 2005 in Nepal. Nepal has established leadership panels on policy, youth, women and media as a part of this initiative and the social leaders who volunteered to work under this initiative are the APLF leaders.

Challenges: A challenge is a simple way to refer to a constraint, barrier, obstacle or risk that must be confronted to carry out a plan. This advocacy plan was developed with an eye to overcoming specific challenges the advocacy efforts might encounter.

Constituencies: Constituencies in this Advocacy Plan implies to the specific group or sector who the leader is accountable to. The leader takes decision on behalf of those constituencies, make deliberations and raise concerns and voices.

District Paralegal Committee (DPLC): UNICEF supported districts have committees constituted for protecting the children and women from human rights violations. These committees have branches at VDC level so that the issues of HR violations at the community level are also brought to the district level. These committees are actively creating awareness on HR protection and providing legal support. These committees are recognized by DDC and District Court as well. These committees could be best mobilized to integrate HIV related HR protections.

External Development Partners (EDPs): External Development Partners include donor organizations, bi-lateral, multilateral and international organizations (such as United Nations agencies) who support development programmes in Nepal, either through direct funding or by providing technical assistance and guidance to local development efforts.

Indicators of Success: Indicators of success are the specific achievements or standards designed to measure the success of each advocacy goal and objective. The review should be done based on the indicators set in the plan.

Key Advocacy Messages: Key advocacy messages are the core meanings or content that must be conveyed while carrying out advocacy communication. Every advocate will have his or her own way of expressing these meanings / content. Specific words and images need to be developed, and these may differ according to the advocacy audience and the situation. Nevertheless, the underlying meaning or content conveyed must be consistent across all advocacy partners..

Low-Risk Women: Women who have only one sexual partner (all married women who have only one sex partner) are often called Low-Risk Women. They may be vulnerable to HIV and STIs through their husband or regular partner. While the risk to any individual "low-risk woman" may be relatively low, Low-Risk Women as a group comprise surprisingly 26.5% of the estimated cases. Because these women are vulnerable due to the high risk behavior of their regular partners and are not likely to have other partners themselves, the risk of the spread of HIV to others from these women is also less, except for their unborn children.

Most-At-Risk Populations (MARPs): Most-at-risk populations, also called Key Populations at higher risk, are the population groups who are at the highest risk of HIV infection. In the context of Nepal's concentrated epidemic, these groups include Injecting Drug Users (IDUs), Sex Workers (SWs), Client of sex workers, Men having sex with Men (MSM), and Migrant Workers.

MDGs (Millennium Development Goals): During the Millennium Summit in 2000, the member states of the United Nations agreed to achieve eight international development goals by 2015, which is also considered as a ground-breaking international agenda. Among others the goal-6 incorporates HIV/AIDS.

Means of Communication: Means of communication, or channels of communication, are the ways through which advocacy messages can be shared with the wider advocacy audience. They may include interpersonal communication (such as individual meetings, visits to an official by a group or delegation, presentations by an individual to a group, or lobbying.) Other means of communication are public or semi-public events such as conferences, workshops, trainings, exposure visits, music concerts or dramatic presentations. Means of communication also include materials developed to support interpersonal advocacy communication, such as power point presentations, fact sheets or brochures. Similarly, means of communication may include the mass media: radio, television, billboards, websites, broadsheets, and others. For any given advocacy or communication activity, the best means of communication is the one which is the most effective in meeting the advocacy objectives.

SAE: The government of Nepal has formed the Semi Autonomous Entity (SAE) pursuant to the formation order approved by the government of Nepal under the Development Board Act, 2013 (BS). SAE has been formed as one coordinating body to oversee the multisectoral national response to AIDS epidemic. Its official Name is HIV/AIDS and Sexually Transmitted Infection Control Development Board Order 2064 (2007).

Strategies of Partnership: Strategies of partnership in this advocacy plan is the combination of ways that advocacy partner/s will use to reach the target audience with the message that push for achieving the advocacy objective/s. Some where strategies are designed as steps and somewhere various advocacy partners have their own strategies evolving in the process of advocacy. Strategic approaches vary widely, according to the advocacy audience, and the key partners who will carry out the advocacy activities so are flexible in adapting by each advocacy partner.

Targeted Materials: Targeted materials are the materials that are recommended to develop specifically for limited use with a special audience. They might include, for example, a brochure or a fact sheet or a PowerPoint presentation developed for a certain advocacy audience.

UNGASS: United Nations General Assembly Special Session on HIV/AIDS was held in June 2001 and 189 Member States including Nepal adopted

the Declarations of Commitment. It has set out 11 areas to be addressed at global, regional and country levels to prevent new infections, expand health services, and mitigate the epidemic's impact.

Universal Access(UA): Universal Access is the global commitment to make HIV prevention, testing, treatment, care and support services available to all those in need by 2010. This commitment is based on measurable, time-bound and realistic national targets specific to each country. National HIV/AIDS Strategy (2006-2011), Nepal also has set the Universal Access targets in its National HIV/AIDS Strategy (2006-2011).

VDC level Paralegal Committee (VDCPLC): Member of the DPLC is the chair of the VDCPLC. These committees are actively working on women and child rights protection. These committees could be best mobilized to protect human rights of women and children on HIV related human rights violations.

B. Glossary of UNAIDS Terminologies

Do not use this	Use this
HIV/AIDS	Use HIV unless specifically referring to AIDS. Examples include people living with HIV, the HIV epidemic, HIV prevalence, HIV prevention, HIV testing, HIV-related disease; AIDS diagnosis, children made vulnerable by AIDS, children orphaned by AIDS, the AIDS response. Both HIV epidemic and AIDS epidemic are acceptable.
AIDS virus	There is no "AIDS virus". The virus associated with AIDS is called the Human Immunodeficiency Virus, or HIV. Please note: the phrase HIV virus is redundant. Use HIV.
AIDS-infected	Avoid the term infected. Use person living with HIV or HIV-positive person. No one can be infected with AIDS, because it is not an infectious agent. AIDS is a surveillance definition meaning a syndrome of opportunistic infections and diseases that can develop as immunosuppression deepens along the continuum of HIV infection from primary infection to death.
AIDS test	There is no test for AIDS. Use HIV or HIV antibody test.
AIDS sufferer or victim	The word "victim" is disempowering. Use person living with HIV. Use the term AIDS only when referring to a person with a clinical AIDS diagnosis.
AIDS patient	Use the term patient only when referring to a clinical setting. Preferred: patient with HIV-related illness.
Risk of AIDS	Use risk of HIV infection; risk of exposure to HIV.
High(er) risk groups; vulnerable groups	Key populations at higher risk (both key to the epidemic's dynamics and key to the response)
Commercial sex work	Sex work or commercial sex or the sale of sexual services
Prostitute	Use only in respect to juvenile prostitution; otherwise use sex worker.
Intravenous drug user	Use injecting drug user. Drugs may be injected subcutaneously, intramuscularly or intravenously.
Sharing (needles, syringes)	Use non-sterile injecting equipment if referring to risk of HIV exposure; use contaminated injecting equipment if the equipment is known to contain HIV or if HIV transmission has occurred.
Fight against AIDS	Response to AIDS
Evidence-based	Evidence-informed
HIV prevalence rates	Use HIV prevalence. The word 'rates' connotes the passage of time and should not be used here.
Acronyms and abbreviations	Please spell out all terms in full. For example PMTCT should be prevention of mother-to-child transmission, etc.

I. Introduction

Advocacy plan provides comprehensive guidelines to the concerned advocacy group/s to concentrate their efforts to ensure change. It explains the major issue that need to be addressed by the advocates as the specific target area on which advocacy needs to be continued. The advocacy group/s should be clear on their goal and objectives that help them to be focused, persistent and to have patience in their efforts. Similarly, the advocacy group/s should also identify the advocacy partners who can influence the change and take collaborative actions.

This Advocacy Plan has been developed to strongly support the implementation of the National Action Plan on AIDS 2008-2011 based on the National HIV/AIDS Strategy 2006-2011 and thereby accelerate an expanded response on HIV and AIDS in Nepal. Relevant international, regional and national documents served as guiding principles in developing this Plan. The documents include the following: 2007 National Estimates of HIV Infections, UNGASS, Millennium Development Goals, the Report of the Commission on AIDS in Asia (Redefining AIDS in Asia – Creating an Effective Response), the Progress Report on the Global Response to the HIV/AIDS Epidemic, 2008 and the United Nations Development Assistance Framework for Nepal 2008-2010 (UNDAF). This Advocacy Plan will also help to synergize advocacy efforts in line with UNGASS, MDGs and Nepal's other international commitments, and high level recommendations for effective response to HIV.

All national partners working on HIV and AIDS program are supporting advocacy effort towards a common cause. However, there are instances when approaches are unaligned to the national strategy, messages are confusing, and results are neither concrete nor measurable. Realizing this, the National Center on AIDS and STD Control, with support from UNAIDS led the process of developing this Plan.

This Advocacy Plan is likewise envisaged to bridge the gap between policy and programmes, and to assist partners in deciding priority advocacy program based on Nepal's changing realities and advocacy needs.

II. Methodology

This Advocacy Plan was developed using a collaborative methodology, with the participation of a number of partners. The process was led by the National Center for AIDS and STD Control (NCASC), with technical support from UNAIDS. For the purpose, a task force comprising civil society, government and development partners was established to guide the process and provide technical inputs.

The first step for developing this advocacy plan was the gap analysis (see Key Advocacy Gaps and Issues). In identifying gaps, the following study methodologies were employed:

(a) Review of relevant literatures including documents, reports, legal provisions, annual reports, HIV related documents, etc. These are listed in the bibliography.

(b) Formal and informal discussions with government officials, civil society that include networks of MARPs, PLHIV, NGOs working in HIV, youth organizations, media groups, students, corporate groups, etc .

(c) Interactive workshops in districts (Doti and Surkhet) and a consultative workshop at central level (Kathmandu).

(d) Visits to selected districts (Morang, Makawanpur, Kaski, Dang, Banke, Bardiya, Kailali, Kanchanpur, Dadhedura). Interview of local politicians, district level government officials, NGO members, civil society, students, and community members (women and men).

(d) Questionnaires to gather information and perspectives of different groups of people (leaders of networks of MARPs, PLHIV, leaders and members of NGOs working on HIV related issues, Youth Organizations, Media groups, Students, and local leaders)on the national response to HIV. These groups were selected on the basis of convenience sampling.

(e) Observation of rehabilitation centres (Doti, Pokhara, Kathmandu), a health post (Surkhet) and a hospital (Doti).

Following the gap analysis, the task force, together with key relevant partners, prioritized the issues to be addressed in the period from 2008 to 2011. The Advocacy Plan presented here is prepared on the basis of the prioritized list. The draft list of priorities was shared with the members of the UN Joint Team on AIDS and the taskforce members, and their feedback was incorporated. After prioritization, the task force agreed on a framework for the Advocacy Plan.

A Workshop on Finalization and Use of the Advocacy Plan was then held, with the key advocacy partners from civil society, to gather their inputs and opinions on the content and to build their capacity for advocacy and communication before finalizing the advocacy plan. The matrix format included in this advocacy plan was adapted from the format recommended at the Regional Advocacy and Partnership Workshop organized by UNAIDS Regional Support Team for Asia and Pacific (UNAIDS RST-AP).

III. Key Advocacy Gaps and Issues

An extremely important activity in formulating any plan of action, gap analysis explores the difference between an ideal situation and the reality, from the point of view of various stakeholders. Gap analysis is useful in determining priorities for action, both in the short- and long-term.

Gaps occur when individuals and groups have problems, needs, expectations and prospects, for which their individual efforts may not be sufficient. Gaps also occur with the changing priorities at any situation and at any point of time. With respect to HIV, PLHIV, groups at risk, vulnerable groups, the government at all levels and civil society partners have concerns that need to be addressed through action at the individual, group, social, national or international levels, depending upon the nature and gravity of the issue.

This Advocacy Plan is based on a gap analysis process, which was particularly comprehensive and participatory in nature, based on formal and informal discussions and consultations with stakeholders at different levels, as well as observation and literature review. Gaps were identified in a number of areas, and advocacy issues were specified.

The major areas objectively selected and the advocacy gaps identified have been categorized during the process include:

1. **Legal Framework**: Constitution, Laws, Acts, Rules and regulations.
2. **Government's Policies and Strategies**: Government's share in response to HIV, mainstreaming HIV in development, communication policies, social policies, child policy and workplace policy.
3. **Government System:** Improving health systems, decentralization and multisectoral response.
4. **Institutional Structures and Coordination**: Leadership, Management and Coordination.

IV. Summary: Advocacy Plan

This advocacy plan is the product of a broader consultation of various stakeholders working on legal, policy, programme planning and implementation in response HIV epidemic in Nepal. This plan will bridge the gap between policy and programmes, and to assist partners in deciding priority advocacy issues and a program to address the specific issue/s in a systematic manner as an advocacy partner, which will feed in to the national programme for reaching the needy people and realizing the universal access targets set by the country.

The plan has been divided into six thematic areas for the period 2008-2011 in view of its relevance, practicality, and feasibility to address the gaps and the issues identified above. The six thematic areas are:

1. Constitutional and Legal
2. Leadership
3. Multi-sectoral

4. Prevention
5. Human Rights and Gender
6. Treatment, Care And Support

Advocacy partners have flexibility to select their relevant issues and areas for advocacy for their specific advocacy programme. However, it is advisable that they need to adhere to the "indicators of success" and the Advocacy goals and objectives in the respective section. Advocacy must bring the result hence its success indicators have been set in the plan that indicate to monitor and evaluate the pace, direction and dynamics of advocacy activities.

This plan is a result of the vigorous work and valuable contribution of the major relevant stakeholders in the country. Therefore, it is assumed that the implementation of the plan will get a high priority for advocacy partners and they own it for equal share of the result of the advocacy activities targeted to each issue identified in the plan. Advocacy partners are also encouraged to anticipate the possible challenges that could hinder in accomplishing advocacy results and take pro-active step to respond to such challenges.

The details of advocacy plan on the prioritized six thematic areas have been described in the Advocacy Plan Framework.

V. Advocacy Plan Framework

V.1 Thematic Area 1: Constitutional and Legal

1.1 Issue to Address: The current constitution is silent on ensuring the rights of PLHIV and most-at-risk populations.	
1.1.1 Advocacy Goal: Nepal's new constitution will address the issues of PLHIV and most-at-risk populations in its Directive Principles.	
1.1.2 Advocacy Objectives: ❖ The new Constitution will guarantee the health rights of sex workers; LGBTs, PLHIV and drug users inline with the international charters/declarations. ❖ The Directive Principles will provide space for formulating laws, rules and regulations to protect the health rights of migrants, prisoners, MSMs, MARPs, CABA, SWs, PLHIV and other vulnerable populations to access quality prevention and treatment services, working in non-discriminatory workplace and living a dignified life.	
1.1.3 Target Audiences: (Who have power to change)	❖ Constituent Assembly Members ❖ Leaders of the political parties ❖ CA members of the Policy Advocacy Panel
1.1.4 Advocacy Partners (Who can influence the change)	❖ Ministry of Health & Populations ❖ External Development Partners ❖ Civil society networks ❖ Media ❖ APLF leaders ❖ Other leaders
1.1.5 Challenges	All members of the Constituent Assembly are not equally aware about the importance of addressing HIV related issues by the constitution.
1.1.6 Strategies of partnership for advocacy	❖ CA members of the Policy Advocacy Panel advocate to the parliamentarians and political leaders through one to one meeting, workshops, exposure visits, and presentations, supported by targeted media and examples of good constitutional provisions and laws related to HIV. ❖ They should also be provided with draft policies/directives and implementation plan.
1.1.7 Key Advocacy Messages	It is the obligation of the state to ensure all the fundamental rights of PLHIV and MARPs as equal to other citizen of the state and that should be guaranteed by the new constitution of Nepal.
1.1.8 Means of Communication	❖ One to one meeting, ❖ Workshop, ❖ Real case visit, ❖ Mass media, ❖ Sharing of draft constitution/directives, ❖ CA billing session.
1.1.9 Indicators of Success	Constitution mentions the rights concerning to HIVPrinciples of Directives focuses upon the rights of people living with and affected by HIV and MARPs

V.2 Thematic Area 2: Leadership

2.1 Issue to Address: Non-functional high level mechanism on AIDS (National AIDS Council headed by the Prime Minister)	
2.1.1 Advocacy Goal: Strengthen the national leadership and stewardship in response to the AIDS epidemic in line with Three ONES	
2.1.2 Advocacy Objectives: ❖ The government will realize the significance of a strong, dedicated and committed action-oriented leadership in effective response to AIDS epidemic for achieving UA targets by 2010 to realize the MDG 6. ❖ Reform and revitalize the high level government coordinating body-National AIDS Council (NAC) and establish a functional secretariat.	
2.1.3 Target Audiences (Who have power to change)	❖ Prime Minister ❖ National Planning Commission Vice-Chair ❖ Minister for Finance
2.1.4 Advocacy Partners (Who can influence the change)	❖ Minister for Health and Populations ❖ External Development Partners (bilateral, multilateral, UN) ❖ Network of Civil Society Leaders ❖ Minister for Transport and Labor ❖ Media ❖ APLF leaders
2.1.5 Challenges	Political issue may overshadow HIV issue.
2.1.6 Strategies of partnership for advocacy	❖ EDPs and civil society hold an advocacy meeting with the Minister for Health. ❖ Minister for Health advocates to the Prime Minister by reminding and drawing attention of the later on the international commitment, guidelines and strategies that Nepal has signed. The minister also points out the need for revitalizing the high level national mechanism that was formed but could not function actively. ❖ The PM expresses commitment of activating the NAC publicly ❖ Offer advice on the importance of establishing a secretariat of NAC to play its crucial role effectively. This will be followed by action for initiating institutional reform measures. ❖ Review the current TOR of the NAC, membership and its functioning. ❖ Identify the issues that need to be adjusted with the changing situation and leadership commitments. ❖ Revise a doable TOR, propose a sizable and effective membership with a minimum operational guideline and share with the Minister for Health and Populations as well as with other stakeholders. ❖ The Prime Minister approves the establishment of a secretariat and urges the Ministry of Finance to allocate budget for it.
2.1.7 Key Advocacy Messages	❖ Nepal has made a number of international commitments on HIV/AIDS ❖ It is important to materialize the high level commitments into action ❖ HIV is an issue where everybody has a role to play and contribute, even the Prime Minister.
2.1.8 Means of Communication	❖ One-to-one meetings ❖ Develop leaflets on UN Declarations of Commitment on HIV/AIDS ❖ Prepare and disseminate fact sheet on the status ❖ Develop brochure on the THREE ONES and UA targets. ❖ Presentations with visual aids ❖ Sharing of the international commitments made by Nepal ❖ Revised/updated TOR, membership and operational guideline of the NAC
2.1.9 Indicators of Success	❖ Documentation of the Prime Minister's commitment to revitalize the NAC. ❖ Secretariat established. ❖ Monitoring mechanism developed for keeping track of the activities carried out by the sectoral ministries based on the HIV indicators. ❖ Relationship of NAC with other key structures such as CCM of Global Fund established.

2.2. Issue to Address:
Leaders of networks of MARPs, PLHIV and youth lack skills to contribute meaningfully to the national response, to be fully accountable to their constituencies and to mobilze support for themselves.

2.2.1 Advocacy Goal:
Networks of MARPs, PLHIV and youth will have skills to contribute meaningfully to the national response and to mobilize support for reaching their constituencies.

2.2.3 Advocacy Objectives:

- Leaders of networks of MARPs, PLHIV and youth will have skills and opportunity to provide constructive feedback on the issues regarding the national response to HIV.
- Leaders of networks of MARPs, PLHIV and youth will be able to manage the network effectively.
- Leaders of networks of MARPs, PLHIV and Youth will be able to mobilize support in order to meet the needs of their constituencies.

2.2.4 Target Audiences (Who have power to change)	❖ Leaders of networks of MARPs, PLHIV and Youth
2.2.5 Advocacy Partners (Who can influence the change)	❖ NGOs working on human rights and governance sectors ❖ EDPs ❖ Government ❖ SAE ❖ Media ❖ APLF Leaders
2.2.6 Challenges	All the leaders of networks may not realize the need for the improvement in network management and accountability to their respective constituencies.
2.2.7 Strategies of partnership for advocacy	❖ SAE will call a meeting to review network management of respective networks. ❖ Leaders of networks of MARPs, PLHIV and Youth will identify the skills they require for contributing constructively in the national response to the HIV issue and provide feedback to their respective constituencies. ❖ Develop/adapt a minimum standard or a code of conduct for civil society organizations. ❖ Member organizations of network will sign and adopt the code of conduct and monitor its implementation. ❖ These networks approach to EDPs to seek support in the skill development programme .
2.2.8 Key Advocacy Messages	❖ Right person with proper skill can bring a change. ❖ Civil society plays critical role in changing the environment for the increased access to HIV prevention, treatment and care services. ❖ Network organizations should exhibit exemplarily leadership role for their constituencies. ❖ Internationally recommended guidelines are useful tools for civil society for their meaningful participation in the national response to HIV epidemic. ❖ Signing a code of conduct is showing commitment to the constituencies.
2.2.9 Means of Communication	❖ Group meeting (leaders of network organization) ❖ One-to-one meeting with network leaders ❖ Workshops and training
2.2.10 Indicators of Success	❖ Code of conduct signed by network organizations. ❖ Status report on the implementation of the code of conduct.

2.3 Issue to Address:

Persistent of denial attitude among rural and urban youth and the youth leaders about their vulnerability to HIV. Youth tend to stay away from the services due to inaccessible HIV prevention services.

2.3.1 Advocacy Goal:

Youth leaders will enhance the capacity and skills to convince the fellow youth members that they are vulnerable to HIV irrespective to their societal and residential areas (rural/urban). Youth leaders and policy makers will be responsive and accountable to increase the involvement of youth in HIV prevention activities.

2.3.2 Advocacy Objectives:

- Youth leaders will enhance skills to convince the policy makers for provision of youth-friendly prevention and treatment services to all youth
- Rural and urban youth will have an easy access to HIV prevention services.

2.3.3 Target Audiences (Who have power to change)	❖ Minister of Youth and Sports ❖ National Planning Commission ❖ Policy Makers ❖ Youth Leaders ❖ EDPs
2.3.4 Advocacy Partners (Who can influence the change)	❖ Youth Leadership Forum ❖ Youth-focused Organizations/ Organization working for Youth ❖ EDPs ❖ Media ❖ APLF Leaders ❖ Sports icons, celebrities etc.
2.3.5 Challenges	Reaching out all youth with the youth-friendly services is a challenge as youth in Nepal are not well organized and have no common represented forum from all the sectors.
2.3.6 Strategies of partnership for advocacy	❖ SAE calls a meeting for the youth leaders to review the status of youth involvement in response to HIV and the strategies to scale-up the youth-friendly services. ❖ Leaders of youth organization/s will approach the policy makers through the Ministry of Youth and Sports to brief the need for formulating youth leadership policy and programme for addressing the HIV-related issues. ❖ Network of youth organizations will approach the political parties to integrate HIV in the leadership development programme. ❖ Youth Organizations will approach the EDPs seeking support for the youth leadership development programme.
2.3.7 Key Advocacy Messages	❖ The trends show that youth get into new behaviors such as taking drugs and sex as a trial ignoring the fact that such behaviors increase the vulnerability to HIV. ❖ Safe sex, safe behavior can protect you from HIV and other STI infection.
2.3.8 Means of Communication	❖ Prevention of HIV is in your hand, you can make it happen. ❖ Save youth to save the nation. ❖ Youth are the most powerful agent for change. ❖ Youth have power to hold the wave of HIV epidemic. ❖ Provocative/Intellectual workshop with youth leaders and policy makers ❖ Drama, Forum Theatre ❖ Comics ❖ SMS ❖ E-forums ❖ New media (e.g.:Facebook and Blogs) ❖ Relevant documentaries and movies
2.3.9 Indicators of Success	❖ An HIV Advisor appointed to the Ministry of Youth and Sports ❖ Increased knowledge and practices documented among youth. ❖ Youth policy clearly includes HIV as their issue and measures of reaching urban and rural youths with prevention services.

V.3 Thematic Area 3: Multisectoral

3.1 Issue to Address: Inadequate HIV contents in the formal school curriculum impart only limited knowledge about HIV among the students.	
3.1.1 Advocacy Goal: The Ministry of Education will integrate HIV in the life skill based education (LSBE) curriculum with adequate content at different levels.	
3.1.2 Advocacy Objectives: ❖ Ministry of Education will accept responsibility for imparting knowledge and skills for HIV prevention among youth through school curriculum including colleges and universities. ❖ Ministry of Education will integrate HIV in the regular training curriculum for teacher on LSBE	
3.1.3 Target Audiences (Who have power to change)	Minister and the Secretary in the Ministry of Education
3.1.4 Advocacy Partners (Who can influence the change)	❖ Ministry of Health ❖ Teachers' organizations ❖ Student and Youth organizations ❖ EDPs (e.g. UNICEF, UNFPA, NGOs working in HIV and education) ❖ Media ❖ APLF Leaders
3.1.5 Challenges	Revising the entire curriculum for including HIV only may not be cost effective.
3.1.6 Strategies of partnership for advocacy	❖ Meeting with Ministry of Education to lobby for the needs of protecting youth from HIV transmission. ❖ Facilitate the development of draft curriculum, field testing and sharing with all concerned stakeholders including MOE. ❖ Initiate discussions to include HIV prevention education in college and university courses ❖ Review the existing curriculum with the Curriculum Development Department to incorporate HIV.
3.1.7 Key Advocacy Messages:	❖ Early the message, early the prevention. ❖ Little knowledge is more dangerous. ❖ Sow the seed, so the fruit. ❖ Healthy kids are resources never a burden.
3.1.8 Means of Communication:	❖ Person to person meetings ❖ Relevant EDPs lobby to the MOE ❖ Training/Education/Workshops ❖ Dissemination of research reports
3.1.9 Indicators of Success:	❖ Secondary school curriculum includes adequate contents on risk behaviors for HIV transmission and its prevention services. ❖ Ministry of Education integrate LSBE training in teachers' training curriculum ❖ LSBE training in regular teacher training

3.2 Issue to Address: Ministries that have the vulnerable populations have not realized them as their target populations hence no integrated programme and budget for HIV.	
3.2.1 Advocacy Goal: Ministries consider HIV as development issues and integrate HIV related programmes into their regular programmes	
3.2.2 Advocacy Objectives: ❖ Key ministries will integrate HIV into their regular programme and identify indicators for reporting	
3.2.3 Target Audiences (Who have power to change)	❖ Minister for Information and Communication ❖ Minister for Tourism and Civil Aviation ❖ Minister for Industry ❖ Minister for Agriculture and Cooperative ❖ Minister for Forests and Soil Conservation ❖ Minister for Physical Planning and Works ❖ Minister for Peace and Reconstruction
3.2.4 Advocacy Partners (Who can influence the change)	❖ SAE ❖ Women & Youth leaders ❖ Policy Advocacy Panel ❖ Media ❖ APLF Leaders ❖ Farmers' groups ❖ EDPs
3.2.5 Challenges	Concerned ministries may consider it as part of a project activity.
3.2.6 Strategies of partnership for advocacy	❖ SAE calls for a meeting with concerned ministries in collaboration with network organizations to review the activities and achievements made so far in their areas with respect to HIV. Identify the key areas for future action. ❖ Policy panels along with other stakeholder's groups visit the concerned ministries to discuss over the activities and budget allocation for their constituencies with respect to HIV.
3.2.7 Key Advocacy Messages	❖ The key ministries have responsibilities to integrate HIV in their programme to address HIV as development issues. ❖ We should all act proactively to prevent HIV so that we could protect the country from going to a generalized epidemic.
3.2.8 Means of Communication	❖ Meeting with concerned ministries. ❖ Public hearing about the need of multisectoral response to HIV epidemic. ❖ Programme review and sharing
3.2.9 Indicators of Success	❖ HIV related activities included as regular activities in the annual plan of concerned ministries.

3.3 Issue to Address: Ministries dealing with MARPs as direct constituencies are less focused on their constituencies and less accountable for their relevant indicators on UNGASS reporting.	
3.3.1 Advocacy Goal: Ministries with MARPs as direct constituencies will be accountable for their relevant indicators as identified by national and international plans.	
3.3.2 Advocacy Objectives: Ministries dealing with MARPs as direct constituents will: ❖ have indicator-based HIV programmes. ❖ share the resources to the national programme. ❖ collaborate with each others to implement and monitor the programme	
3.3.3 Target Audiences (Who have power to change)	❖ Minister for Home Affairs ❖ Minister for Education ❖ Minister of Labor and Transport Management ❖ Minister of Women, Children and Social Welfare
3.3.4 Advocacy Partners (Who can influence the change)	❖ SAE ❖ Network of MARPs & PLHIV ❖ Policy Advocacy Panel ❖ EDPs ❖ Media ❖ APLF Leaders
3.3.5 Challenges	❖ Technical skills may not be adequate for addressing the HIV related needs of the MARPs and setting indicators by the Ministries themselves.
3.3.6 Strategies of partnership for advocacy	❖ Policy panel members along with other stakeholder's groups discuss with concerned ministries about the programme designed for addressing HIV issues from the ministerial level to fulfill the sector-wise responsibility. ❖ SAE invites/ calls for a meeting with concerned ministries in collaboration with network organizations to review the performance of concerned ministries regarding its achievements with respect to HIV indicators. ❖ Provide guidelines on setting HIV indicators. ❖ Commitment on reporting regularly against the indicators.
3.3.7 Key Advocacy Messages	❖ The ministries with MARPs as direct constituents must be accountable for its HIV related indicators and need to develop programme accordingly as compliance to UNGASS. ❖ Already initiated programme need to be contributing to the UNGASS indicators.
3.3.8 Means of Communication	❖ Meeting with concerned ministries ❖ Public hearing about the budget allocation and programme ❖ Public audit ❖ Monitoring and documenting the progress as per the set indicators. ❖ Policy position papers on the specific needs of the MARPs related to the different Ministries.
3.3.9 Indicators of Success	❖ Indicator-based HIV related programme planned by relevant ministries. ❖ Relevant HIV indicators identified in the programme and submitted to the Office of the Prime Minister for monitoring.

3.4 Issue to Address: Business or corporate sectors are less aware about the possible problems that they could have if HIV is not addressed.	
3.4.1 Advocacy Goal: Workplace policy will be operational in full-fledged manner	
3.4.2 Advocacy Objectives: ❖ A mechanism will be activated to ensure the implementation of the national workplace policy on HIV ❖ Public and private sectors will demonstrate commitment in implementing the National Workplace Policy as a model in the key ministers	
3.4.3 Target Audiences (Who have power to change)	❖ Minister for Labor and Transport Management ❖ Minister for Industry ❖ Minister for Peace and Reconstruction ❖ Minister for Youth and Sports ❖ Private sector organizations/companies/industries (labour intensive) ❖ Labour and trade unions ❖ Employers' Union (eg: FNCCI)
3.4.4 Advocacy Partners (Who can influence the change)	❖ Trade Unions· SAE ❖ Human rights organizations ❖ ILO ❖ Media ❖ APLF Leaders ❖ Business Leaders
3.4.5 Challenges	❖ Technical capacity of the ministries to lead the process of implementation in practice.
3.4.6 Strategies of partnership for advocacy	❖ Trade Unions, ILO and MOLTM will organize an advocacy meeting with the key ministries. ❖ SAE in collaboration with ILO calls a meeting with MOLTM and works out the process of the implementation of the workplace policy in the public sector. ❖ EDPs will provide technical assistance to support for implementing the policy.
3.4.7 Key Advocacy Messages	❖ Relevant Ministries are responsible to adhere with international commitments, and its implementation and reporting. ❖ Workers have right to information and services for HIV prevention ❖ National Policies should be first implemented by the public sector.
3.4.8 Means of Communication	❖ Meeting (Group and one-to-one) ❖ Lobby by ILO and trade unions to MOLTM for implementing the policy that has already been developed develop.
3.4.9 Indicators of Success	❖ Each Ministry and selected private sector organizations adopt the workplace policy in a phase-wise manner, set up a HIV/AIDS workplace committee and has a clear plan of its implementation.

V.4 Thematic Area 4: Prevention

4.1 Issue to Address:
The recent UNGASS report shows that coverage of prevention services to MARPs is still very uneven. Changes are required at ministerial level with budget allocation and targeted prioritization of prevention programs, as well as at the level of individual health care providers.

4.1.1 Advocacy Goal:
The coverage and quality of prevention services to MARPs will be increased.

4.1.2 Advocacy Objectives:

- MOHP, MOHA, and MOWCSW will accept the importance of the role of their ministries in preventing HIV among MARPs and will develop appropriate programs to serve the MARPs.
- MOHP will strengthen systems to deliver required services to MARPs for HIV prevention, treatment and care.
- Health care personnel will extend services to MARPs wholeheartedly and with full vigor, as per the clients' needs.
- Access to services for MARPs will be increased.

4.1.3 Target Audiences: (Who have power to change)	❖ Minister for Health & Populations ❖ Minister for Information and Communication ❖ Minister for Home Affairs ❖ Minister for Women Children and Social Welfare
4.1.4 Advocacy Partners: (Who can influence the change)	❖ NGOs working in HIV sector ❖ Human Rights Organizations ❖ Networks of PLHIV and MARPs ❖ Media ❖ APLF Leaders ❖ Leaders of network of MARPs
4.1.5 Challenges :	❖ Traditional attitudes and discrimination towards MARPs may hamper accessing services for MARPs. ❖ Some health care facilities have limited capacity. ❖ There is a lack of a local strategy for scaling up specific services.
4.1.6 Strategies of partnership for advocacy:	❖ Compile information concerning quality and coverage of prevention services to MARPs. ❖ Concerned civil society organizations hold a Public Hearing to present the status of what the partners deliver ❖ Strengthen partnerships with NGO and private sector to deliver quality services backed by effective system and monitoring. ❖ Ministries, NGOs and private sector partners plan jointly for scaling up and filling gaps in services. ❖ Training for health care personnel in user-friendly and appropriate services for MARPs ❖ Concerned civil society organizations develop a system to provide public rewards for the best performers.
4.1.7 Key Advocacy Messages:	❖ Prevention for HIV among MARPs is the best measure to limit the spread of HIV to general population. This is international best practice, based on much evidences. Therefore, targeted programme for MARPs are very crucial. ❖ Traditional attitudes of stigma and discrimination towards MARPs are counterproductive for prevention. ❖ Health care personnel need special training in how to work sensitively with MARPs using latest guidelines. ❖ People are being infected faster than we can get them on treatment so prevention must be a mainstay of the national response.
4.1.8 Means of Communication:	❖ Meetings ❖ Mass media for declarations of commitment and recognition of good work ❖ Public hearing ❖ Training for health care personnel
4.1.9 Indicators of Success:	❖ Scaling up plan is in place. ❖ Training are held for health care providers. ❖ A survey indicates that MARPs have access to the services as per their needs.

4.2 Issue to Address:

Young people are situated at the center of Nepal's HIV epidemic and are vulnerable to HIV for many reasons, but many of them are not informed or do not perceive their behavior putting them at the risk of HIV transmission. For example, only 35.6% of young people of 15-24 years know how to prevent sexual transmission of HIV and reject misconceptions about HIV transmission. There is still no targeted prevention program for youth.

4.2.1 Advocacy Goal:

Rural and urban youth will be informed about HIV, will understand their vulnerability, and know how to access services. They will both correctly identify ways of preventing sexual transmission of HIV and reject misconceptions about HIV transmission.

4.2.2 Advocacy Objectives:

- Young people will feel comfortable discussing HIV among themselves.
- Young people of 15-24 years will have correct knowledge on ways of prevention of HIV transmission.
- Young people will have the skills to protect themselves from HIV, including sexual decision-making and access to services.

4.2.3 Target Audiences (Who have power to change)	❖ Youth leaders/organizations ❖ Youth in general ❖ Youth clubs ❖ Schools ❖ NGOs ❖ Parents/Guardians ❖ Others ❖ Minister for Youth and Sports ❖ Minister for Education
4.2.4 Advocacy Partners (Who can influence the change)	❖ EDPs ❖ Sports sector ❖ Child rights organizations ❖ Media ❖ APLF Leaders ❖ Sports icon, celebrities ❖ Educational institutions ❖ RJs/DJs ❖ Others
4.2.5 Challenges	❖ Prevalent denial among youth on their vulnerability to HIV ❖ There is a traditional cultural and social expectation of not talking about sex.
4.2.6 Strategies of partnership for advocacy	❖ Youth clubs, youth leaders and schools provide correct information to youth about HIV, and about youth-friendly services for youth in urban and rural settings. ❖ NGOs, UN agencies and other EDPs advocate for youth's right to services and to mobilize resources. ❖ Mass media communicators raise the profile of HIV prevention for youth and integrate it into their lives through a variety of entertainment channels attractive and interesting to the rural and/or urban youth, including sports events, music, drama, and/or the internet. ❖ Partner with a music channel, such as MTV, to produce spots, shows or live events relating to HIV. ❖ Mass media campaign, with the support from EDPs. ❖ Youth leaders trained and actively function to discuss HIV and its prevention at youth meetings. ❖ Mass media addressing HIV as youth's issue and provide correct information. ❖ Partnership with RJs/DJs are key messages and they will carry these messages to youth in between entertainment.
4.2.7 Key Advocacy Messages	❖ It is the right of young people to get correct information and services to protect themselves from HIV and other sexually transmitted infections. ❖ HIV is a crucial concern for youth today – not something to deny or feel shy about. ❖ It's smart to talk about HIV with your friends; it's cool to protect yourself from HIV ❖ Young people are the ones …who can turn the tide of HIV
4.2.8 Means of Communication	❖ Youth Ambassadors' personal visits and mass media appearances ❖ Training for youth leaders ❖ Music concerts ❖ TV and radio spots ❖ Live events, such as music concerts ❖ Billboards, posters, stickers, postcards etc. ❖ Messages through RJs/DJs
4.2.9 Indicators of Success	❖ Knowledge, attitude and practice of youth on HIV prevention increased.

4.3 Issue to Address:
There are currently inadequate youth-friendly HIV prevention services available to general youth.

4.3.1 Advocacy Goal:
Youth friendly services will be accessible and available to general youth.

4.3.2 Advocacy Objectives:

- Ministry of Health and Populations and private sector service providers will believe that HIV prevention for youth is a crucial component of a national strategy for HIV prevention and that the system is responsible to provide HIV prevention services to youth.
- MOHP will introduce a youth-friendly service delivery plan, programme and mechanism.
- Health care staff dealing with youth will know how to deliver HIV prevention services to youth more effectively.

4.3.3 Target Audience (Who have the power to change)	❖ Minister for Health and Populations ❖ Private sector service providers ❖ Minister for Youth and Sports
4.3.4 Advocacy Partners (Who can influence the change)	❖ SAE ❖ Youth clubs ❖ Media ❖ Student Unions ❖ Youth Leaders ❖ EDPs ❖ APLF Leaders
4.3.5 Challenges	❖ Policy makers may not think of HIV as a problem for youth. ❖ Youth themselves do not feel at risk for HIV
4.3.6 Strategies of partnership for advocacy	❖ A workshop led by youth leaders inviting relevant stakeholders to discuss issues related to youth's health and their vulnerability to HIV /STI/other problems. As a result of this meeting, a strategy will be developed, and a committee will be formed to develop a delivery plan and carry it forward. ❖ Develop a strategy for providing prevention services to youth. ❖ Form a committee and hold a meeting to come up with the implementation plan. ❖ Mobilize resources for the implementation of the plan. ❖ Trainings for health care providers in youth-friendly service delivery. ❖ Mobilize youth for reaching the youth with accurate information on availability and use of the services. ❖ Integrate the information into celebrations of Youth Day, Human Rights Day, World AIDS Day. ❖ Provide services through the youth-friendly service camps in various places.
4.3.7 Key Advocacy Messages	❖ It is the right of youth to have appropriate services to protect them from HIV and STIs. ❖ It is Government's responsibility to make HIV prevention services available and accessible to all youth. ❖ Everyone who now has HIV was HIV negative once and they could have been prevented from getting it. ❖ Among the young there are many who will get HIV, unless we act now to prevent it. ❖ Prevention services must be targeted specifically to youth and must be accessible and friendly to them. ❖ Preventing new infections among youth is protecting country's economy.
4.3.8 Means of Communication	❖ Workshops and meetings ❖ Trainings for health care staff and youth leaders ❖ Person-to-person communication ❖ Case studies ❖ Drama, health camps, speeches, forum theatre by youth PLHIV ❖ Postcards and other youth friendly means
4.3.9 Indicators of Success	❖ Youth-friendly services integrated into the national action plan on AIDS ❖ Youth-friendly services integrated into the Family Health programme of the Ministry of Health and Populations.

V.5 Thematic Area 5: Human Rights and Gender

5.1 Issue to address:
Lack of community support mechanism for social, legal, and economic empowerment of women, adolescent girls, youth, children infected and affected by AIDS, MARPs, and PLHIV. They have no support mechanism for filing their grievances.

5.1.1 Advocacy Goal:
Establish a community support mechanism and strengthen it for providing social legal and economic support for women, adolescent girls, youth, CABA, MARPs, and PLHIV and link women including the female partners of mobile populations with local bodies and local administration for managing their grievances.

5.1.2 Advocacy Objectives:

- A support mechanism will be set up for women affected by HIV at local level for addressing their grievances in highly affected districts of Nepal
- Existing community groups will take up HIV related issues and provide support to groups at risk or affected by HIV in the respective communities.
- Women, youth, MARPs, PLHIV,CABA and other marginalized groups will have access to local development and empowerment programme in the communities

5.1.3 Target Audiences: (Who have power to change)	❖ Minister for Home Affairs ❖ Minister for Women, Children and Social Welfare ❖ Minister for Local Development ❖ HIV/AIDS and STD Control Board and National Center for AIDS and STD Control ❖ UNICEF/DDCs ❖ Women Wings of political parties
5.1.4 Advocacy Partners: (Who can influence the change)	❖ Women development officers ❖ Women leaders ❖ Paralegal committees ❖ Local women organizations ❖ Youth leaders ❖ Networks and organizatoins of women living with HIV ❖ DACC ❖ Media ❖ APLF Leaders ❖ Networks of MARPs and human rights organizations
5.1.5 Challenges	❖ Women and other groups affected by HIV are less aware of the scope of paralegal committees and local support mechanisms. ❖ Paralegal committee members are unaware of the rights/legal issues and provisions for PLHIV and MARPs.
5.1.6 Strategies of partnership for advocacy	❖ Ministry of women mobilizes its district offices to create a mechanism for linking women to local administration and support to file their complaints. ❖ Local development offices/DACC plan women empowerment programme integrated in the district plan and local development plans. ❖ Human rights organization will regularly advocate and support for providing justice to women & other groups affected by and vulnerable to HIV. ❖ Media reports on the incidents of human rights violation and advocates to high level leaders for addressing such issues. ❖ Paralegal committees will be provided with training/orientation on the issues related to PLHIV and MARPs in coordination with UNICEF and respective DDCs
5.1.7 Key Messages	❖ Human rights organizations must include prevention of HR violations of MARPs, PLHIV and CABA. ❖ Women should be supported for exercising their basic rights of social justice as equal citizen. ❖ Numerous HR violations cases are evident at the community level. So, there should be a strong support mechanism to address such issues at the local level. ❖ Rural women affected by HIV need special support from the community to protect their human rights.
5.1.8 Means of Communication	❖ Advocacy meeting with the women's rights activist ❖ Sensitization to the para-legal committees ❖ Partnership with media for advocating a need of a local support system to those women, who are facing discrimination and other HR violations. ❖ Engaging local community groups in AIDS response especially gender issues. ❖ Enter to partnership with existing paralegal committees at the local level with UNICEF/DDC support.
5.1.9 Indicators of Success	❖ Women have access to local bodies to share their grievances. ❖ Paralegal committees and other existing community support mechanism at local level handle cases of human rights violation regarding PLHIV and other vulnerable women and children.

5.2 Issue to address: Lack of economic opportunities for PLHIV including women and MARPs	
5.2.1 Advocacy Goal: National Poverty Reduction Programme Linked with PLHIV and MARPs	
5.2.2 Advocacy Objectives: ❖ Poverty reduction programme will be accessible to PLHIV and MARPs in the programme districts. ❖ Economic opportunities provided by poverty reduction programme will be fully utilized by PLHIV, and MARPs.	
5.2.3 Target Audiences (Who have power to change)	❖ Poverty Alleviation Fund (PAF) board ❖ Regional Offices of PAF ❖ National Planning Commission
5.2.4 Advocacy Partners (Who can influence the change)	❖ EDPs ❖ Policy Advocacy Panel ❖ Women leadership forum ❖ Network of MARPs & PLHIV ❖ DACC ❖ Media ❖ APLF Leaders ❖ Human rights organizations ❖ Local political leaders.
5.2.5 Challenges	Limited knowledge and skills of PAF staff to address the interrelationship of HIV and poverty
5.2.6 Strategies of partnership for advocacy	❖ Advocacy partners will hold a meeting with PAF and National Planning Commission and present the scenario of the people affected by HIV. ❖ The PAF board will internalize the interrelationship of causes and consequences of poverty and HIV. ❖ PAF board will orient and urge its regional offices for including PLHIV and MARPs in the programme supported by the PAF
5.2.7 Key Messages	❖ There is a strong relationship between poverty and HIV and AIDS ❖ HIV is one of the major causes and consequences of poverty ❖ HIV could be addressed in a sustainable way only by including it in the poverty targeted programme. ❖ PLHIV and MARPs have right to access the PAF programme ❖ Advocacy partners will continuously advocate for implementing such programme and for developing a mechanism and partnership for monitoring.
5.2.8 Means of Communication	❖ Advocacy meetings with PAF board. ❖ One to one meeting by using fact sheet. ❖ Field visit and interaction with PLHIV and MARPs. ❖ Media coverage of the issues and need of such support. ❖ Dialogue between the groups and the board members. ❖ Other means of communications as relevant.
5.2.9 Indicators of Success	Women, PLHIV and MARPs participate in and benefit from the PAF programme in the relevant districts and documentation carried out.

5.3 Issue to address:
PLHIV faces stigmatization and discrimination in the society that hampers preventing new infections

5.3.1 Advocacy Goal:
Attitude of acceptance of PLHIV improved among the general populations, reducing the prevailing stigma and discrimination against PLHIV

5.3.2 Advocacy Objectives:

- General population will internalize the relationship between HIV prevention and addressing the issue of PLHIV.
- Stigma and discrimination will be reduced against the PLHIV hence reduced the risk of HIV transmission to general people

5.3.3 Target Audiences (Who have power to change)	❖ Prime Minister ❖ Ministers ❖ Parliamentarians/CA Members ❖ Celebrities of sports, music, films, and television ❖ Social and religious leaders ❖ PLHIV network ❖ Policy panel ❖ UNRC ❖ First lady ❖ Others.
5.3.4 Advocacy Partners (Who can influence the change)	❖ Media ❖ Sports ❖ APLF Leaders ❖ MARPs leaders and ❖ Other human rights organizations
5.3.5 Challenges	Perceptions on Reducing stigma VS promoting infection
5.3.6 Strategies of partnership for advocacy	❖ High level leaders will pose public pictures with PLHIV and model that they are treated equally. ❖ Media will highlight such behaviors to public and encourage for acceptance. ❖ Key leaders will take public stands and model acceptance of PLHIV with media attention
5.3.7 Key Messages	❖ Stigma is harmful than the virus itself ❖ High level people have to be role model to change the societal perception towards PLHIVs ❖ Unless PLHIV are accepted, halting the epidemic is not possible
5.3.8 Means of Communication	❖ One to one meeting ❖ Media coverage ❖ Posters, leaflets, hoarding boards ❖ Writing articles ❖ New Media (Facebook, Blogs) ❖ Testimonies etc ❖ Friendly matches between PLHIV and other celebrities
5.3.9 Indicators of Success	Well documented acceptance of PLHIV in the society and PLHIV participate more actively in the prevention programme well documented.

5.4 Issue to address: Prevailing discrimination in health care settings towards PLHIV	
5.4.1 Advocacy Goal: Universal precaution guidelines enforced in health care settings as a way to prevent discrimination by health care providers.	
5.4.2 Advocacy Objectives: ❖ Health workers will practice Universal precautions for all patients at health care settings regardless of HIV status ❖ Health management will ensure enough, timely and properly managed supplies for Universal precautions in the health care settings	
5.4.3 Target Audiences (Who have power to change)	❖ Minister for Health ❖ Health care institutions managers ❖ Health workers
5.4.4 Advocacy Partners (Who can influence the change)	❖ WHO ❖ Civil society leaders ❖ Rights activists ❖ Consumers' forum ❖ Media ❖ APLF Leaders
5.4.5 Challenges	Proper management of supplies together with regular availability is required for the Universal precautions practices
5.4.6 Strategies of partnership for advocacy	❖ Advocacy partners meet the authority of the ministry for ensuring effective implementation of the Universal precautions guidelines ❖ Ministry of Health introduce a mechanism to monitor the enough supply of the precautions supplies and practices in each health care institutions ❖ WHO support to set up a monitoring mechanism of strictly practicing the Universal precautions for all patients in each health care setting. ❖ Training to the health workers on need of Universal Precaution and providing non-discriminatory services to all the patients. ❖ PLHIV share the progress of good practices on application of Universal precautions
5.4.7 Key Messages	❖ Applying Universal Precaution in each health facility is a must to protect health care providers and other patients from cross infection of blood borne infections including HIV ❖ All the health facilities should have enough and regular supplies to practice the Universal precautions. ❖ Consumers have right to get non-discriminated services in any health care setting irrespective of nature of infections they have. ❖ WHO should play a critical role in making the recommended guidelines implemented and in monitoring the standard of services.
5.4.8 Means of Communication	❖ One to one meeting ❖ Delegation along with the testimonies ❖ Press conference ❖ Media reporting of the cases ❖ Appeal letters to the minister & to the human rights institutions and other relevant stakeholders. ❖ Documentation and sharing of best practices. ❖ Leaflets on Universal Precaution. ❖ Posters and other relevant means.
5.4.9 Indicators of Success	❖ PLHIV receive equal services as other patients in the health care settings. ❖ Case studies/documentation on best services provided without any discrimination to all patients.

5.5 Issue to address:
Denial of existence of MARPs in the society

5.5.1 Advocacy Goal:
The public will recognize the existence of MARPs (drug users and sex workers and MSM), and acknowledge the vulnerability and addressing the needs of MARPs in relation to HIV prevention

5.5.2 Advocacy Objectives:

- Public will accept the facets of life and recognize that all societies include SWs, MSM and IDUs.
- Public will understand that not recognizing or discriminating these groups will increase community's risk of spreading HIV to others.
- Public will model greater tolerance and recognition of the needs of SWs, IDUs and MSM to achieve the MDG on HIV (6)
- All sectoral partners will view SWs, MSM and IDUs as potential partners in Nepal's national response to HIV

5.5.3 Target Audiences (Who have power to change)	❖ National and local opinion leaders, including social leaders ❖ The leaders from faith based organizations
5.5.4 Advocacy Partners (Who can influence the change)	❖ Media ❖ Network of MARPs ❖ EDPs ❖ Human rights organizations ❖ APLF Leaders ❖ Other relevant organizations/institutions
5.5.5 Challenges	Advocacy partners may not be comfortable to taking the issue of MARPs for advocacy due to fear of being blamed for promoting them
5.5.6 Strategies of partnership for advocacy	❖ MARPs need to lead to organize meetings with opinion leaders and share their issues with the support from EDPs and human rights organizations. ❖ MARPs need to show responsible behavior to society and win trust that they are accepted as a part of the society. ❖ Media brings attention to public through various campaigns, coverage and drama and other methods. ❖ Human rights organization support them protecting from the HR violations.
5.5.7 Key Messages	❖ A Society is a combination of all kinds of people including MARPs. ❖ Human rights organizations need to consider the MARPs as equal citizen. ❖ MARPs have rights to live in a society as equal citizen. ❖ State machinery should pay attention to educate public that all citizens are equal in the eyes of the state and law.
5.5.8 Means of Communication	❖ Mass media and interpersonal communication. ❖ Exposure visits to areas where MARPs have demonstrated a constructive contribution to a society and are the real partners in halting the epidemic. ❖ Media campaign. ❖ Groups and one to one meetings. ❖ Drama/comics. ❖ Public hearings. ❖ Posters. ❖ Facts on HIV infections among MARPs and need to address their needs to prevent the epidemic.
5.5.9 Indicators of Success	More harmonized society where MARPs can participate freely in the HIV prevention programme and they have access to relevant required services.

5.6 Issue to address:
Women, mainly housewives in both rural and urban areas are ignorant about their vulnerability to HIV

5.6.1 Advocacy Goal:
Rural and urban women are informed and understand their vulnerability to HIV and are able to access prevention services

5.6.2 Advocacy Objectives:

- Women leaders will understand the vulnerability factors and situation of women for spousal transmission of HIV.
- Rural and urban women will have access to correct information and services for prevention of HIV mainly from their spouses.
- Programmer will plan and implement focused programme for reducing vulnerability of women to HIV infection. It will be reflected in the budget and resource allocation as well.

5.6.3 Target Audiences (Who have power to change)	❖ Minister for Women, Children and Social welfare ❖ National Women's Commission ❖ Women's rights organizations ❖ Political leaders ❖ Minister for Health and Populations ❖ NGOs
5.6.4 Advocacy Partners (Who can influence the change)	❖ Network of women living with HIV ❖ Women's groups & Mothers' groups ❖ NGOs ❖ Women leaders ❖ Media ❖ APLF Leaders
5.6.5 Challenges	Some women rights activists themselves are stigmatizing HIV and people link to it. Eg: sex workers, PLHIV.
5.6.6 Strategies of partnership for advocacy	❖ Presentation of facts on HIV infection among the low risk women to the advocacy partners ❖ Advocacy partners make the audience understand and internalize the vulnerability of low risk women to HIV and their vulnerability factors ❖ All the women development and NGOs' programmes include women empowerment programme so as to reduce vulnerability to HIV ❖ Organize workshops on women's needs and identify local solutions to reduce vulnerability ❖ Develop audio-visual materials with dramatic presentations of the real situation and how women could save from being infected ❖ Adopt mix methods of communication to reach all level of low risk women with correct information and success stories to protect them from infection by their spouses. ❖ Create a pressure group of women leaders at local level and partner with them on protecting from sexual rights violations.
5.6.7 Key Messages:	❖ Low risk women are getting HIV from their spouses and that children borne with her are born with HIV ❖ Out of total estimated people living with HIV by 2007, 26% are the low risk women from rural and urban areas ❖ It is an urgent need of protecting the low risk women from getting HIV to halt the epidemic ❖ Without addressing gender issues and empowering women, we will not be able to reduce the new infections among the women. ❖ There should be a legal treatment of protecting rights of low risk women.
5.6.8 Means of Communication:	❖ Advocacy meetings supported with factual presentation of the epidemiological status of women living with HIV and children born to them. ❖ Workshops on making women understand their vulnerability. ❖ Training to partners on women empowerment strategies. ❖ Advocacy with EDPs on resource mobilization for women empowerment programme at local level. ❖ Women rights organizations support, watch and report back to national leaders, programme and media on the cases from the field and share successes. ❖ Link with other programme to those women and children who are at need of special assistance. ❖ Women rights activists take up the issue of HIV as their agenda.
5.6.9 Indicators of Success	❖ New infections and prevalence among low risk female population reduced. ❖ Success cases documentation of organizations and protection from HIV transmission.

V.6 Thematic Area 6: Treatment, Care and Support

6.1 Issue to Address: Services for care, support and treatment have not yet reached all populations, who need them.	
6.1.1 Advocacy Goal: Existing care, support and treatment services will continue uninterrupted and will be scaled up to reach the presently un-reached populations.	
6.1.2 Advocacy Objectives: ❖ Government will develop and implement HIV related service delivery plan focusing upon the quantity, quality, accessibility and regularity of existing care, support and treatment services. ❖ Government will formulate HIV related strategic service delivery plan to expand its services to serve the population that is un-served or underserved until today for achieving the UA targets by 2010.	
6.1.3 Target Audiences (Who have power to change)	❖ Policymakers (Ministers, Secretaries and Joint secretaries) ❖ MOHP (Director of NCASC) and HIV central board. ❖ WHO ❖ EDPs ❖ NAPN/NFWLHA
6.1.4 Advocacy Partners (Who can influence the change)	❖ SAE ❖ PLHIV groups ❖ Network organizations ❖ Human Rights organizations ❖ Media ❖ APLF Leaders
6.1.5 Challenges	Government's regular mechanism may not be able to provide services to people who live in hinterland.
6.1.6 Strategies of partnership for advocacy	❖ SAE/Network organizations collect the information from the district level government and non-government organizations about the status of service performance and gap remained in terms of population that are not served. ❖ First approach will be made to NCASC to maintain and upgrade the existing care, support and treatment services and urge to prepare and implement a regular HIV related service delivery plan. ❖ Secondly, approach will be made to Ministry of Health to prepare the HIV related Strategic Health Service Delivery Plan, specifically, concerning HIV and follow it strictly.
6.1.7 Key Advocacy Messages	❖ HIV is not yet curable, but treatable like other long term chronic illness. ❖ Human lives can be prolonged through providing continuous care, support and treatment. ❖ No one should be deprived of the services delivered by the state. ❖ If provided treatment PLHIV could contribute actively to the societal development.
6.1.8 Means of Communication	❖ Meetings ❖ Lobbying ❖ Reports ❖ Public Hearing ❖ Peaceful demonstrations and protests ❖ Other relevant
6.1.9 Success Indicators	❖ No complaints and grievances regarding the services delivered. ❖ Service delivery plan in place. ❖ Increased coverage of treatment.

6.2 Issue to Address:

Health service system has not been attuned with delivering differentiated services following the universal service guidelines for population.

6.2.1 Advocacy Goal:

Health service system strengthened in delivering differentiated services following the universal service guidelines for populations (ART/ TB, PMTCT, Harm reduction, VCT, Diagnostic tests, Condom availability, STI treatment, and Reproductive Health Services).

6.2.2 Advocacy Objectives:

- Government will develop and implement standard service delivery packages for different groups of population.
- Government will establish service delivery and monitoring mechanism and arrangements, and follow them. Government will develop and strictly implement the human resource development plan and policies in line with the requirements of the service delivery.

6.2.3 Target Audiences (Who have power to change)	❖ MOHP ❖ WHO ❖ EDPs ❖ NCASC ❖ UNFPA
6.2.4 Advocacy Partners(Who can influence change)	❖ SAE ❖ Network organizations ❖ Media ❖ APLF Leaders ❖ Policy Advocacy Panel ❖ Parliamentarians
6.2.5 Challenges	The present umbrella type of civil service rules and regulation may hinder the human resource plan and policy.
6.2.6 Strategies of partnership for advocacy	❖ SAE/Network organizations discuss with MOHP about the status of following the universal service guidelines suited to the different groups of population. ❖ MOHP will formulate HIV related service delivery mechanism and arrangements. ❖ Technical support will be sought from WHO in formulating and educating the standards for different groups of population. ❖ EDPs will ensure resource mobilization for delivering such services and implant the plan.
6.2.7 Key Advocacy Messages	❖ Different groups of population require different nature of diagnostic treatment services on time that may help them to keep longer life. ❖ PLHIV can contribute in the society as other people.
6.2.8 Means of Communication	❖ Meetings ❖ Lobbying ❖ Reports ❖ Media Reporting ❖ Case Presentations
6.2.9 Success Indicators	❖ Diagnostic and treatment services accessed by all the PLHIV who are in need. ❖ Success stories documented and shared

VI. Monitoring & Evaluation of the National Advocacy Plan

Monitoring is the continuous assessment of activities to assess their status in relation to agreed schedules, and the use of inputs, infrastructure, and services by programme beneficiaries. Evaluation is the periodic assessment of a programme's relevance performance, efficiency, and impact.

In monitoring, a given situation is observed, supervised and followed. Monitoring compares the set targets with achievements and actual performance. This allows timely corrective actions as needed.

Evaluation assesses, appraises and judges the outputs, outcomes, impacts and the assumptions, usually referring to the expected results. Evaluation, thus, allows for recommendations to be made about modifying and adapting or updating plans, including the decision to change the basic programme approaches and partnerships.

For the monitoring and evaluation plan, the indicators of success should be determined against the set goal and objectives in the specific communication plan for advocating on the relevant issues by the respective advocating partners. For each partner, the advocacy component of any kind of programme could be picked up from the national advocacy plan and have its own communication plan by using the same format as used in the advocacy plan framework, focussing on the goals and objectives in the respective issues and reporting the indicators of success as output indicators of each advocacy activity.

VI.1. Monitoring and reporting format

Time period:

Advocacy Issues	Goal	Objectives	Indicators of success	Status

There should be a regular monitoring and reporting system to know the level of performance for each of the goals and objectives. An indicator-based monitoring description should be developed.

- Periodic monitoring and reporting as per the requirement of the funding agency
- Six monthly monitoring
- Annual monitoring on the indicators of success and report

Monitoring and reporting system should be included in each advocacy plan developed by the advocacy partners on their respective components that will contribute to the national advocacy plan goals, objectives and indicator of success.

VI.2: Evaluation of Implementation of the Advocacy Plan

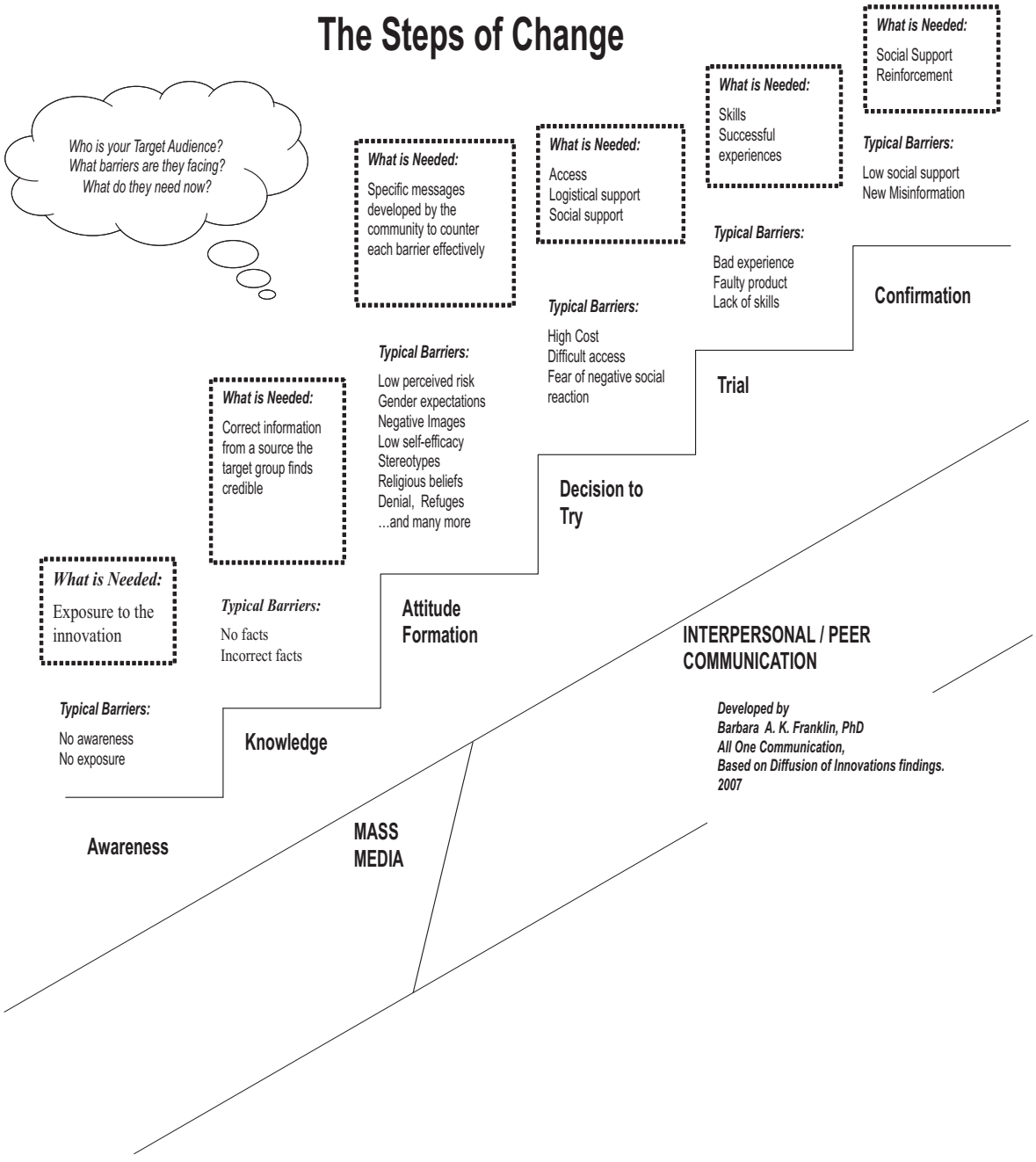
The indicator of successful implementation of this National Advocacy Plan will be measured with the implementation status of the National Action Plan 2008-2011 as the advocacy is directed for improving mechanisms, policy-legal frameworks, reducing discrimination and delivering services to the targeted populations.

Annex 1: Long Term Advocacy Issues

During the consultations numerous issues came up from the participants. However, the plan period could not accommodate all the issues in the current period. All the valuable issues and concerns raised during the consultations and which are of the long-term nature have been presented in the following table so that it can be considered as effective reference in the next cycle.

Advocacy Areas and Issues	Objectives for the advocacy campaign
Government's system, policies and strategies	
Enlarge Government's share to the AIDS spending	To intensify the commitment of government dealing with HIV issues
Mainstream HIV and AIDS into all national economic development planning process	To incorporate HIV and AIDS issues in the national plan
Promote effective mechanism for decentralized and coordinated activities on HIV and AIDS prevention.	To strengthen the local level mechanism to address HIV and AIDS
Enlarge the community participation in policy designs	To increase the community participation in policy design
Enhance the role of Human Rights Commission	
Integrate the condom use with other community and private sector initiated programmes	To ensure Human rights of PLWH To promote condom use
Introduce and institutionalized national health insurance service programme (package insurance products for PLWH)	To increase private sector's involvement through promoting market based instruments
Legal	
Revise Laws/Acts /Rules	To ensure the rights of people
Services Delivery	
Expand the evidence based PMTCT services	To expand the PMTCT services
Intensify and expand Co-management of Tuberculosis and HIV Treatment	To extend Collaborative intervention to reduce the effects
Mechanism to speed up the harm-reduction initiatives for IDUs	To expand the coverage of Harm reduction initiatives
Resource Mobilization and Management	
Ensure equitable distribution and targeting of resources	To optimize the resource utilization though effective resource allocation
Partnership Issues	
Enhance the capabilities of Network organizations working in HIV and AIDS for promoting network management for network advocacy	To promote network advocacy
Involve private sector in HIV and AIDS prevention programme through corporate social responsibility	To enhance the effectiveness HIV prevention programme
Social Aspects	
Promote enabling environment in opening up the risky behaviors and to protect vulnerable populations	To develop congenial and supportive environment to open risky behaviors
Scale up the services for more hidden and less visible groups of female sex workers	To promote service system and mechanism to be reached in all places
Prevention, Care and Support, and Treatment	
Mainstream gender into all prevention, care, and treatment programmes	To increase the involvement and participation of gender in all HIV and AIDS issues and its management
Promote awareness creation targeting the general population, particularly men, to support PMTCT	To make general population aware to support PMTCT
Strengthen capacity of family members, PLH and communities to provide home based care and support, including care for CABA	To extend community and home based care and support
Impact Mitigation	
Promote linkages among key social and economic development institutions for reducing poverty among the HIV affected and afflicted.	To increase the involvement of social and economic development institutions

Annex 2:


The Steps of Change
Who is your Target Audience?
What barriers are they facing?
What do they need now?
What is Needed:
Exposure to the innovation
Typical Barriers:
No awareness
No exposure
Awareness
What is Needed:
Correct information from a source the target group finds credible
Typical Barriers:
No facts
Incorrect facts
Knowledge
What is Needed:
Specific messages developed by the community to counter each barrier effectively
Typical Barriers:
Low perceived risk
Gender expectations
Negative Images
Low self-efficacy
Stereotypes
Religious beliefs
Denial, Refuges
...and many more
Attitude Formation
What is Needed:
Access
Logistical support
Social support
Typical Barriers:
High Cost
Difficult access
Fear of negative social reaction
Decision to Try
What is Needed:
Skills
Successful experiences
Typical Barriers:
Bad experience
Faulty product
Lack of skills
Trial
What is Needed:
Social Support
Reinforcement
Typical Barriers:
Low social support
New Misinformation
Confirmation
MASS MEDIA
INTERPERSONAL / PEER COMMUNICATION
Developed by
Barbara A. K. Franklin, PhD
All One Communication,
Based on Diffusion of Innovations findings.
2007

Annex III: List of participants and contributors to the advocacy plan

Annex III.1. Members of the Task force to develop the advocacy plan

1. Dr. B.R. Khanal, NCASC
2. Mr. Sudin Sherchan, NAPN
3. Ms. Chirring Sherpa/ Gauri Tulachan, NFWLHA
4. Ms. Sumi Devkota/ Mr. Pranab Rajbhandari, AHSA
5. Mr. Gokarna Bhatta, Media Leadership Forum
6. Ms. Narmada Acharya, UNAIDS

Annex III.2. Participants of Interactive Workshop held in Doti

SN	Name	Organization
1.	Mr. Sher Bdr. Malla	NGO Federation
2.	Mr. Devi Lal Upadhyaya	Samaj Sewa
3.	Mr. Prakash Chandra Madai	CDP
4.	Ms. Archana Shrestha	DACC
5.	Ms. Geeta Nepali	RDN
6.	Mr. Suresh Lama	NKP
7.	Mr. Raju Ghale	PKS
8.	Mr. Lal Mahara	GGD
9.	Mr. Kishor Magar	NKP
10.	Mr. Sher Bdr. Saud	Lali Gurans
11.	Mr. Guatam Rokaya	Journalist
12.	Mr. Min Bam	Journalist
13.	Mr. Dil Bdr. Chatyal	Journalist
14.	Mr. Shyam Pd. Joshi	RUWDUC
15.	Mr. Raju Neplai	EDC
16.	Mr. Dev Bohara	NFCS
17.	Mr. Shankar Thapa	Media Development Group
18.	Ms. Devi Bhandari	Doti Plus
19.	Mr. Mahendra Pd. Shrestha	District Health Office
20.	Mr. Gokarna Pd. Sharma	DDC
21.	Mr. R. Pyakural	CARE Nepal
22.	Ms. Basanti Bhatta	GG
23.	Mr. Rojedra Joshi	GG
24.	Ms. Nirmala K.C.	CDPA
25.	Mr. Shree Krishna Shrestha	CDPA
26.	Ms. Narmada Acharya	UNAIDS

Annex III.3. Participants of Interactive Workshop held in Surkhet

SN	Name	Organization
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2.	Mr. Sanju Singh Bishwokarma	Dalit Sewa Sangh
3.	Mr. Khem Raj Paudel	Digo Bikash Kosh
4.	Mr. Bal Kumar Shakya	Kakre Bihar Plus
5.	Mr. Yamu Kandel	Journalist
6.	Mr. Chandra Bishwokarma	Naya Nepal
7.	Mr. Khadanada Lamichane	Journalist
8.	Mr. Dipendra Pd. Sharma	Good governance forum for Development
9.	Mr. Shahabir Sunar	SAC, Nepal
10.	Mr. Dipendra Pd. Joshi	Ekata Good Governance Club
11.	Mr. Dinesh Pd. Joshi	Samaj Sudhar Youth Center
12.	Mr. Durga Pd. Sapkota	Human Rights and People Development Center
13.	Mr. Sudeep Puri	Bulbule FM
14.	Mr. Himalaya Bam	GGC
15.	Mr. Nabin Prakash Sharma	Sahakarmin Samaj
16.	Mr. Bijaya Pd. Ghimire	NGOCC
17.	Mr. Shanti Pd. Kandel	WACC, Nepal
18.	Ms. Padma Joshi	Ekl
19.	Mr. Mohan Malla	Rafio Bheri Awaj
20.	Mr. Bikendra Dhakal	GGCDCC
21.	Mr. Kul Pd. Chapai	CINET
22.	Mr. Sukra Bdr. B.K.	Journalist
23.	Mr. Ramesh Pd. Adhikari	District Health Office
24.	Ms. Smriti Bhatta	Ekata GGClub
25.	Mr. Chakra Bdr. Gharti	Pro Public
26.	Mr. ShreeKrishna Shrestha	CDPA
27.	Ms. Narmada Acharya	UNAIDS

Annex III.4. Participants of One-to-One Discussion with Kathmandu-based NGO

Organization	Participants
SPARSA	Abhimanyu Bista and Agni Ojha
Nepal Red Cross Society	Bipul Neupane
Youth Vision	Pushpa Tandukar/ Rajendra Thapa
Prerana	Asha Chettri
Navakiran	Sibu Giri
Nap+ N	Basanta Chhetri, Sudin Sherchan
Nepal Plus	Salim Akhtar
NANGAN	Hari Pd. Awasthi
NEHA	Rishi Raj Ojha
SAHARA Plus	Deepak Khadaki and Parbata Panday
Richmond Fellowship	Bishnu Sharma
NCASC	Usha Bhatta, Shrijan Shrestha, Dr. Rajendra Panta
Pro Public	Ashok Pandey
Blue Diamond Society	Shanjeev Gurung
NFWHA	Chhirign Sherpa, Gauri Tulachan
APLF Media Leaders	Gokarna Bhatta

Annex III.5. Organizations visited and consulted

Place	Organizations
Biratnagar	♦ Help Group
Makwanpur	♦ Highway Static Clinic ♦ Meet Makwanpur ♦ Nava Jeevan Jyoti Club , Chaughada ♦ Ashrya Hetauda
Kaski	♦ Naulo Ghumti , Pokhara ♦ Blue Diamond Society, Pokhara ♦ SISO , Pokhara ♦ Samudayik Sewa Kendra Pokhara ♦ SEDA Kaski
Rupandehi	♦ Namuna Integrated Development Council ♦ WATCH, Bhairahawa and Sunauli
Surkhet	♦ Family Planning Association of Nepal, Surkhet ♦ Sustainable Development Trust (Digo Bikas Kosh) ♦ Nepal Red Cross Society, Surkhet ♦ Social Awareness Centre, Surkhet
Kailali	♦ Association of Helping the Helpless, Dhangadi
Dadeldhura	♦ MPDS , Dadeldhura
Kanchanpur	♦ STI/VCT Clinic Nepal

Annex III.6. Informal Discussion with Different personnel of Government of Nepal

SN	Name	Designation	Organization
1.	Mr. Bishnu Prasad Lamsal	Joint Secretary	Ministry of Labour and Transport Management
2.	Mr. Prajwal Sharma Aryal	Under Secretary	Ministry of Labour and Transport Management
3.	Mr. Babu Ram Gautam	Under Secretary	Ministry of Local Development
4.	Mr. Surya Acharya	Under Secretary	Ministry of Local Development
5.	Mr. Narayan Bd. Thapa	Under Secretary	Ministry of Local Development
6.	Mr. Arjun Bahadur Bhandari	Joint Secretary	Ministry of Education & Sports
7.	Mr. Lav Dev Awasthi	Under Secretary	Ministry of Education & Sports
8.	Mr. Chaitanya Subba	Former Member	National Planning Commission
9.	Dr. Padam B. Chand	Director	NCASC
10.	Dr. Bishwa Raj Khanal	Senior Medical Officer	NCASC

Annex III.7. Joint UN Team Members on HIV/AIDS

Chair: Dr. Maria Elena G. Filio-Borromeo, UCC for Nepal

Name	UN Organization
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Ms. Anjani Bhattarai	UNDP
Ms. Archana Singh	ILO
Ms. Bina Pokharel	UNAIDS
Mr. Deepak Karki	UNFPA
Mr. Erkki Kumpala	FAO
Mr. Hellstrom, Jan-marcus	UNAIDS
Ms. Isabel Tavitian Exley	UNAIDS
Ms. Manju Karki	UNODC
Mr. Madhav Sivakoti	WFP
Mr. Mohammed Siddig	UNDP -PMU
Ms. Narmada Acharya	UNAIDS
Dr. Nastu Sharma	WB
Ms. Salina Joshi	UNIFEM
Ms. Sara Beslow-Nyanti	UNICEF
Mr. Shashi Shah	UNESCO
Mr. Vincent Omunga	OCHA

Annex III.8. Particiapnts of the consultation workshop on Finalizing and use of the National Advocay Plan, Kathmandu

Name	Organization
Dr. B.R. Khanal	NCASC
Mr. Rosan Sapkota	Recovering Nepal
Ms. Suni Lama	NEFIN
Mr. Kabindra Burlakoti	AYON
Mr. Narad Khatiwad	Media
Ms. Nirmala KC	TEWA
Mr. Chunna Gyanwali	Sakriya
Mr. Rishi Ojha	NEHA
Ms. Jyotsna Shrestha	NHRC
Dr. Ranhga Raj Dhungana	Hasti-aids
Mr. Dal Bdr. G.C.	NANGAN
Ms. Archan Singh	ILO
Ms. Manju Karki	UNODC
Ms. Chirring Sherpa	NFWLHA
Mr. Amit Gurung	Sneha Samaj
Mr. Ram Shrestha	DPA-TU
Ms. Narmada Acharya	UNAIDS
Dr. Barbra Franklin	UNDP-Consultant
Dr. Shreekrishna Shrestha	UNAIDS Consultant

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Millennium Development Goal 6: Combat HIV/AIDS, Malaria and Other Diseases

Target 7: Have halted by 2015 and begin to reverse the spread of HIV/AIDS

United Nations General Assembly Special Session on HIV/AIDS (UNGASS)

UNGASS Areas of Commitments:

1. Strong leadership at all levels of society is essential for an effective response to the epidemic;
2. Prevention must be the mainstay of our response;
3. Care, support and treatment are fundamental elements of an effective response;
4. Realization of human rights and fundamental freedom for all is essential to reduce vulnerability to HIV;
5. The vulnerable sector must be given priority in the response;
6. Children orphaned and affected by HIV/AIDS need special assistance;
7. Alleviating social and economic impact through sustainable development;
8. Research and development is crucial for cures and effective responses;
9. HIV/AIDS in conflict and disasters-affected regions;
10. New, additional and sustained resources are required to meet the HIV/AIDS challenge; and
11. Follow-up and monitoring progress is essential for maintaining momentum