HIV STANDARD SERVICE PACKAGE for KEY POPULATIONS

Ministry of Health and Population
National Centre for AIDS and STD Control
Teku, Kathmandu, Nepal
2020

HIV
Standard Service Package
For
Key Populations

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Acknowledgments

It is my pleasure to present you with the National Standard Service Package (SSP) for HIV Program for Nepal 2020. This document is targeted towards brining uniformity and quality in HIV program throughout the country. This development of this document has been made possible with the tireless involvement of experts from the government and non-government organizations including key populations and people living with HIV, both at national and provincial level. There had been numerous consultations with beneficiaries, policy makers, service providers and implementers to build up consensus while developing this document. I would like to take this opportunity to thank all contributors, national networks of key populations and people living with HIV, LINAKGES Nepal Project/FHI 360, Save the Children/Global Fund, AHF, WHO, UNAIDS, and the entire NCASC team for their relentless effort in bringing in this document. Last but not the least, I would especially like to thank Madan K. Shrestha for taking lead and Prevention, Treatment and Care and SI unit of NCASC for their leadership and facilitation in developing this document.

Thank you

Dr. Sudha Devkota
Director
National Centre for AIDS and STD Control

Abbreviations

ART	Antiretroviral Therapy
ARV	Antiretroviral
BCC	Behavior Change Communication
CM	Community Mobilizers
EPOA	Enhanced Peer Outreach Approach
HIV	Human Immunodeficiency Virus
IEC	Information, Education, and Communication
MIS	Management Information Systems
NCASC	National Centre for AIDS and STD Control
NGO	Nongovernmental Organization
OE	Outreach Educator
OST	Opioid Substitution Therapy
PEP	Post-exposure Prophylaxis
PrEP	Pre-exposure Prophylaxis
STI	Sexually Transmitted Infection
TB	Tuberculosis

Introduction

The National Centre for AIDS and STD Control (NCASC), Ministry of Health and Population (MoHP) is leading, coordinating, and overseeing Nepal's HIV response. After the first case of HIV detection in 1988, Nepal has made tremendous gains in controlling the HIV epidemic. Key component of the Government of Nepal's *HIV Strategic Plan 2016–2021* is to identify and reach key populations (KPs); to test and find the new HIV cases; to treat people living with HIV (PLHIV); and retain them on treatment for viral load suppression. KPs include female sex workers (FSWs); transgender sex workers; male sex workers (MSWs); clients of sex workers; transgender people; gay men and other men who have sex with men (MSM); people who inject drugs (PWID); prison and migrant populations. The *National HIV Strategic Plan 2016-2021* also focuses on Elimination of Vertical Transmission on all pregnant women. The standard service package aims to address services for these populations, providing the standard prevention, diagnosis, treatment and care.

Standard Service Package

Nepal aims to close the service gap and reach the 95-95-95 by 2030 and ending AIDS as public health threat by 2030 targets in line with its adoption of a strategy to identify, reach, test, treat, and retain (IRRTTR). This *HIV Standard Service Package (SSP)* for KPs was created to document and standardize the effective and innovative approaches to HIV service delivery implemented in Nepal. The standard service package is expected to be implemented by all stakeholders working in HIV service delivery. It was developed through a collaborative process with input from a range of stakeholders, including government and non-government officials and community members.

This document lists the HIV interventions and approaches included in the standard service package grouped by KP (Table 1). The document then describes human resource requirements and staff ratios for relevant interventions (Tables 2-8). The document concludes with minimum training standards for program staff (Table 9). The Annexes contain more detailed descriptions of service delivery points and standards (Annex 1); more information on each intervention in the service package including beneficiaries, commodities required, and intended service delivery points to deliver the intervention (Annex 2); description of key enabling environment activities needed for successful package implementation (Annex 3); and finally staff qualifications are listed (Annex 4).

A workshop among key stakeholders including MOHP, NCASC, and partners (AHF, FHI 360/ LINKAGES, Health Policy Plus, Save the Children/Global Fund, USAID, UNAIDS, WHO, and national networks of KPs, PLHIV and civil societies) held in Kathmandu in mid-May 2019

reviewed, finalized and prioritized a list of technical HIV interventions and approaches comprised of a combination of conventional and innovative approaches, grouped in four categories: (1) prevention, (2) HIV testing (including case finding), (3) treatment, adherence and retention, and (4) viral load testing and suppression. The first draft of the SSP was then reviewed by experts and and was further discussed in series of meetings and workshops. One-on-one consultation meeting with key stakeholders including government, non-government and UN agencies implementing HIV program, and national networks of KPs, PLHIV and civil societies were organized to identify the needs, gaps, and recommendations. A workshop conducted among key stakeholders in September 12-13, 2019 and another consultation meetings held on October 21, 2019 among all national networks KPs, PLHIV, civil societies, and key stakeholders made a consensus and moved ahead for finalization. Parallel meetings were held with PLHIV network and PWID network to agree on thier key concerns.

Standard Service Package

Interventions and Approaches by Prevention, First, Second, and Third 95

Table 1. Standard Service Package Interventions and Approaches for Key Populations

Interventions	People Who Inject Drugs	Men Who Have Sex with Men/ Male Sex Workers/ Transgender People	Female Sex Workers	Clients of Sex Workers	Migrants and their Spouses	Prisoners	People Living with HIV
Prevention							
Outreach	■	■	■	■	■		
Prevention education, referral, and follow-up	■	■	■	■	■	■[1]	
Condoms	■	■	■	■	■		■
Lubricant		■	■				
Information, education, and communication (IEC)/ behavior change communication (BCC)	■	■	■	■	■	■	■
e-Reach	■	■	■	■	■		■

Interventions	People Who Inject Drugs	Men Who Have Sex with Men/Male Sex Workers/ Transgender People	Female Sex Workers	Clients of Sex Workers	Migrants and their Spouses	Prisoners	People Living with HIV
Harm reduction							
Opioid substitution therapy (OST)	■						
Needle and syringe program	■						
Prevention of mother-to-child transmission (PMTCT) refearrl and follow-up	■	■	■	■	■	■	■
Pre-exposure prophylaxis (PrEP)[2]		■	■				Discordant Couple
Post-exposure prophylaxis (PEP)	■	■	■	■	■	■	■
Sexually transmitted infection (STI) management/referral and follow-up	■	■	■	■	■	■	■
First 95: Case Finding							
HIV testing							
Community-led	■	■	■	■	■		
Self	■	■	■	■	■		
Index	■	■	■	■	■	■	■
Mobile					■	■	
Enhanced peer outreach/pay for performance -based case finding	■	■	■	■			■
Fixed/static	■	■	■	■	■	■	
Provider-initiated testing and counseling	■	■	■	■	■	■	
Early infant diagnosis[3]							

Interventions	People Who Inject Drugs	Men Who Have Sex with Men/Male Sex Workers/ Transgender People	Female Sex Workers	Clients of Sex Workers	Migrants and their Spouses	Prisoners	People Living with HIV
Second 95: Linkage, Treatment, Adherence, and Retention							
Treatment, referral, linkage and follow-up							
Antiretroviral therapy							■
Coinfection management (hepatitis C, tuberculosis, opportunistic infections)							■
Adherence and Retention							■
Care and support							■
Third 95: Viral Suppression							
Viral load testing (referral, linkage and follow-up)							■
Sample collection and transportation							■

Note: Peoplewho do not self-identify as a member of a key population or do not disclose their key population status but are at high risk, as well as partners, spouses, and children of people living with HIV, should also be provided HIV services and recorded and reported as "other high-risk people"; interventions for people who inject drugs, prisoners, and people living with HIV are for both male and female members of these populations.

[1] *Peer education only in prisons*

[2] *For groups at high risk*

[3] *For infants and linked with PMTCT program*

Interventions and Approaches by Key Population

Standard Service Package: Men Who Have Sex with Men, Male Sex Workers, Transgender People

Prevention

- Outreach
- Prevention, education, referral, and follow-up
- Condoms
- Lubricant
- IEC/BCC
- e-Reach
- PMTCT *referral and follow-up*
- PrEP
- PEP
- STI management

First 95: Case Finding

- HIV Testing: community-led, self, index
- Enhanced peer outreach/incentive-based case finding
- Fixed/static
- Provider-initiated testing and counseling

Second 95: Linkage, Treatment, Adherence, and Retention

- Referral, linkage and follow-up and care and support

Third 95: Viral Suppression

- *See 'People Living with HIV'*

Standard Service Package: People Who Inject Drugs

Prevention

- Outreach
- Prevention, education, referral, and follow-up
- Condoms
- IEC/BCC
- e-Reach
- Harm reduction: OST, needle and syringe program
- PMTCT *referral and follow-ups*
- PEP

First 95: Case Finding

- HIV Testing: community-led, self, index, mobile
- Enhanced peer outreach/incentive-based case finding
- Fixed/static
- Provider-initiated testing and counseling

Second 95: Linkage, Treatment, Adherence, and Retention

- Referral, linkage and follow-up and care and support

Third 95: Viral Suppression

- *See 'People Living with HIV'*

Standard Service Package: Female Sex Workers

Prevention

- Outreach
- Prevention, education, referral, and follow-up
- Condoms
- Lubricant
- IEC/BCC
- e-Reach
- PMTCT referral and follow-up
- PrEP
- PEP
- STI management

First 95: Case Finding

- HIV Testing: community-led, self, index
- Enhanced peer outreach/incentive-based case finding
- Fixed/static
- Provider-initiated testing and counseling

Second 95: Linkage, Treatment, Adherence, and Retention

- Referral, linkages and follow-up and care and support

Third 95: Viral Suppression

- *See 'People Living with HIV'*

Standard Service Package: Prisoners

Prevention

- Peer education
- IEC/BCC
- PMTCT *referrals and follow-up*
- PEP
- STI management

First 95: Case Finding

- HIV Testing: Index, mobile
- Static
- Provider-initiated testing and counseling

Second 95: Linkage, Treatment, Adherence, and Retention

- Referral, linkages and follow-up and care and support

Third 95: Viral Suppression

- *See 'People Living with HIV'*

Standard Service Package: Clients of Sex Workers

Prevention

- Outreach
- Prevention, education, referral, and follow-up
- Condoms
- IEC/BCC
- e-Reach
- PEP
- STI management

First 95: Case Finding

- HIV Testing: community-led, self, index
- Enhanced peer outreach/incentive-based case finding
- Fixed/static
- Provider-initiated testing and counseling

Second 95: Linkage, Treatment, Adherence, and Retention

- Referral,linkages and follow-up, and care and support

Third 95: Viral Suppression

- *See 'People Living with HIV'*

Standard Service Package: People Living with HIV

Prevention

- Condoms
- Lubricant
- IEC/BCC
- e-Reach
- PMTCT referrals ans follow-up
- PrEP *(for discordant couples)*
- PEP *(for discordant couples)*
- STI management

First 95: Case Finding

- HIV Testing: index
- Enhanced peer outreach/incentive-based case finding

Second 95: Linkage, Treatment, Adherence, and Retention

- Referral, linkages and follow-up and care and support

Third 95: Viral Suppression

- Referral, linkages and follow-up
- *Sample and collection transportation*

Human Resource Needs

The tables below reflects an ideal list of human resources (staff) needed for NGOs to run the program activities. This, however, varies according to the size of the project, existing expertise of the NGOs and other needs.

Table 2. Proposed Staff Positions

Position	1–5 Districts	5 or More Districts
Program coordinator	1	1
Administrative/finance officer	1	1
Administrative/finance assistant	1 per district	1 per district
Monitoring and evaluation (M&E) Officer and other M&E support[1]	1	1
Program officer/supervisor		1
Laboratory assistant[2]	1 per district or clinic	
Health assistant[3]	1 per district or clinic	
Waiting room[4]operator	1 per waiting room/exchange center	
Helper	1 per clinic	1 per clinic
Office assistant	1 per district	1 per district

Note: Staffing structure for national-level positions of NGO will vary according to need.

[1] May require additional staff based on number of people served in the district(s)

[2] May need this position for confirmatory testing and quality control of community-led testing, and number may increase based on need

[3] Where sexually transmitted infection and HIV case management services are available, one health assistant per district or clinic

[4] Waiting area should be co-located with HIV testing and counseling and sexually transmitted infection clinic or project office. No stand-alone waiting established or operated.

Table 3. Staff Positions in Opioid Substitution Therapy (OST) Sites

# of Clients	Site In-charge/M&E Officer	Finance Assistant	Social mobilizer	Dispensing Nurse	Pharmacist	Clinician	Counselor	Outreach Staff	Guard	Office assistant
Up to 100	1	1	1	2	1	1	1	2	1	1
More than 100	1	1					2	3	1	1
Additional counselor and outreach staff for every additional 100 clients										

Note: The staffing structure of OST site should be as recommended by OST guidelines of Ministry of Home Affairs (MoHA), Nepal

Table 4. Ratio of DIC/Exchange Centre to people who inject drugs

Number of PWID	<500	500–1000	Additional 500
Number of DIC/Exchange Center	1	2	1

Staff Ratios (based on National HIV Investment Plan 2014-2016)

Regular "Reach" and Community-led Testing Staff to Key Population Ratios

Table 5. Ratio of Outreach Staff to Key Population Individuals

Key Populations	<150	150–250	250–500	500–1000	1,000–2,000	More Than 2,000
Men who have sex with men/male sex workers/ transgender people	1	2	3	4	6	Additional 1 per 500 key population individuals
People who inject drugs	1	2	4	6	8	Additional 1 per 300 key population individuals
Female sex workers	1	2	3	4	6	Additional 1 per 400 key population individuals

Key Populations	<150	150–250	250–500	500–1000	1,000–2,000	More Than 2,000
Clients of sex workers	1		2	3	4	Additional 1 per 1,000 key population individuals
Migrants and their spouse[1]					2	Additional 1 per 1,000 key population individuals
Prisoners[2]						

[1]*Mobilize Female Community Health Volunteers for community outreach and demand generation for testing*

[2]*Mobilize one peer educator per block*

Table 6. Ratio of Outreach staff to Peer Educator (PE)

Key Populations	I/ORW:PE ratio	Remarks
Men who have sex with men/ male sex workers/transgender people	1:5	I.e., 5 peer educators/outreach workers
People who inject drugs	1:4	I.e.,4 peer educators
Female sex workers/clients	1:4	I.e., 4 community mobilizers/peer educators/peer mobilizers for each in/outreach workers

[1]*Mobilize Female Community Health Volunteers for community outreach and demand generation for testing*

Community-home Based Care Worker and Peer Navigator to PLHIV Ratio

Table 7. Ratio of CommunityHome-Based Care Workersand Peer Navigators to PLHIV

	<80	80–160	160–250	250–450	More than 450
People living with HIV	1	2	3	4	Additional 1 per 200 key population individuals

Note: This is an average calculation; the ratio may vary according to geography and concentration of people living with HIV.

Annex 1: Service Delivery Points and Standards

The following section describes HIV service delivery points, defined as the health unit or facility providing HIV-related services. Community-based and facility-based service delivery points are described in detail below, including basic requirements and standards for each.

Community-Based Service Delivery Points

This section describes community-based service delivery points used to implement the standard service package, including community care centers and community home-based care teams, community-based antiretroviral therapy (ART) sites, and mobile testing sites. Community-based service delivery points are physically located within the target beneficiary community and/or involve community members in service delivery point management and service delivery. Community-based service delivery points aim to increase access to HIV services including prevention programming, HIV testing services, access to ART, and adherence interventions.

Care and Support in the Community

People living with HIV need care and support services in health facilities and in the community. This section provides details of care and support in the community through various mechanisms according to area, type of people living with HIV, and distance to ART centers/dispensing centers.

Community Care Centers and Community Home-Based Care

Community care centers provide clinical care and counseling to people living with HIV, transportation between the community and the ART centers, and food/nutritional support and shelter, and should be within 2 kilometers of an ART center. Clients can stay for a maximum of 15 days at a time at a community care center. People who stay in community care centers are primarily those living with HIV who are starting tuberculosis (TB) or HIV treatment, until they fully adapt to their new treatment regimen (recommended observation period is 15 days) and so that side effects can be monitored and managed. Community care centers are meant to be a bridge between the hospital and community for people living with HIV who need additional support services. They provide overnight accommodation where clients can stay during follow-up visits or appointments for CD4 and viral load testing if they are unable to return to their home the same day.

The basic requirements for a community care center are that it must:

- Have five to 10 beds (separated for male/female clients including children and clients with advanced disease)
- Employ the following staff: one in-charge (paramedic–health assistant/ staff nurse), one care taker (peer), one support staff (literate), one cook, finance staff

Community and home-based care

Community home-based care workers follow up with people living with HIV, refer community members for HIV testing, link people living with HIV to care, transport and accompany people living with HIV from the community to the clinic, and provide psychosocial support and referrals to other services. A paramedic staff member to support the community home-based care worker can also be added, depending upon the needs of the area/clients. CCC staff can also serve as CHBC workers.

Other Community-Based Care and Support Services

Apart from community home-based care workers, other community healthcare workers also provide care and support services in the community, including accompanied referral and support for navigation to seek services, adherence and support for ART retention, index testing including risk network referral, positive prevention, and other healthcare-related support required by people living with HIV.

Service providers include peer navigators, case management team members, and in/out-reach workers depending upon the project needs.

Community-Based ART service

Community-based ART services are close to KPs and the community, improving access to services and reducing stigma and discrimination.

There are two types of community-based ART services:

1. ART dispensing sites
2. Community-based sites

ART Dispensing Sites

ART dispensing sites provide antiretroviral (ARV) refills through trained health workers. ART dispensing sites are located in government-managed health posts and other sites approved by NCASC. They are part of the ART centers, and all reporting is done through the centers.

Community-Based Sites

Community-based sites are the existing sites with HIV confirmatory services, mostly run for or by the KPs and PLHIV where ART services are added without additional cost implication. They provide HIV testing and counselling services and provide confirmatory HIV testing results, ART initiation, refill and adherence support, and support for pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP). These sites initiate immediate ART to those KPs living with HIV who do not want to go to ART sites mainly because of fear of disclosure, stigma and discrimination and ART site being far from the clinics. The site must coordinate and collaborate with and transfer PLHIV who initiated treatment from the site to the ART sites.

The site must provide services as per the National HIV Testing and Treatment Guidelines 2020.

The basic requirement for community-based sites is that it must serve at least 50 percent of the key populations of the catchment area. The site must have prescribing medical doctor with HIV clinical management training.

Community-Based HIV Testing

Community-based HIV testing provides access to HIV testing to populations living away from HIV testing and counseling centers. Community-based testing sites can be run by trained lay providers or conducted in coordination with government labs. Community-based testing is conducted through community-led testing and mobile testing.

Community-Led Testing

Lay community providers, including community home-based care workers and drop-in center operators, are trained to screen for HIV and report back to program staff. They provide HIV screening services to their respective communities (key populations/people living with HIV and geographical communities).

Mobile Testing

Mobile testing is used to provide HIV screening in rural and hard-to-access areas. Laboratory staff or trained lay providers, along with other supporting human resources (outreach staff, loader/packer etc) as required, travel to areas identified to conduct mobile HIV screening.

Opioid Substitution Therapy (OST)

OST sites provide methadone/buprenorphine treatment and counseling for opioid-dependent individuals, at locations near the concentration of people who use durgs. These sites use a combined approach that includes functions of both a medical unit and

social support unit. Services must be provided as per government-approved guidelines. Depending upon the needs of the clients and access to existing services, satellite OST sites can also be added to bring the service closer to the community. Any changes and additions to OST-related services are subject to approval from the Ministry of Home Affairs. OST services should also include provision of overdose management. Referral for abscess management and detox services should also form part of OST services.
The basic requirements for OST sites are that they:

- Have a dispensing room with two counters, a storefront, waiting area, administrative/data room

Co-Located Waiting Room (Drop-in Centers) and Needle and Syringe Exchange Center

Waiting rooms (drop-in centers) or safe spaces are rented rooms that provide community members with a comfortable place to obtain information and interact with each other. Co-located waiting rooms (drop-in centers) are co-located with health facilities, whereas needle and syringe exchange centers are stand-alone centers and provide needle and syringe exchange facilities.
The basic requirements for a waiting room/needle and syringe program center are that they have:

- One center operator
- One room
- One television
- Internet access
- Information, education, and communication (IEC) materials
- Education and entertainment materials
- Condom box

Annex 2: Standard Service Package Interventions

The following section describes the standard service package interventions, categorized into prevention, case finding, linkage, treatment, adherence and retention, and approaches to viral load testing. Interventions included in the standard service package are defined as direct service delivery interventions that span the entire HIV care continuum. Standard service package interventions are aimed at reaching populations at risk with prevention programs to prevent the transmission of HIV, identifying people living with HIV through case finding and HIV testing, and ensuring that people living with HIV are linked to treatment and supported to reach viral suppression. Descriptions of standard service package interventions below include main objectives of the intervention, implementation details, required commodities, the intervention service delivery point, and target beneficiaries.

Prevention Interventions

Outreach

Behavior Change Interventions,Including Education, Counseling, and Referral

HIV prevention education, counseling, and referral are key components of HIV programs to create demand for services. Behavioral interventions—such as IEC and strategic behavior change communication—provide information, motivation, education, and skills building to help individuals reduce risky behaviors and sustain positive changes, as well as prevent transmission of HIV and modify HIV risk behaviors. Social and behavior change interventions may address individuals or groups. One-on-one contacts may focus on awareness of personal risk, risk assessment, categorization, and risk-reduction strategies; for example, in/outreach staff or community workers may discuss risk behaviors, relate a participant's actions directly to HIV risk, and consider strategies to reduce this risk through motivational interviewing sessions.

Beneficiaries

- Men who have sex with men, male sex workers, transgender people, female sex workers, clients of sex workers, people who inject drugs (male and female), prisoners, migrants and their spouses, adolescents, and people living with HIV

Commodities

- Behavior change and communication materials in Nepali (can be electronic and paper-based, or through media such as broadcast radio or television and online platform)

Service Delivery Points

- Community
- Drop-in centers/exchange centers
- Community care centers/community home-based care teams
- HIV confirmatory sites
- Mobile testing sites
- ART service sites
- OST sites
- Other health facilities

Condom and Lubricant Distribution

The regular supply, distribution, and promotion of condoms, together with condom-compatible lubricants for selected key populations, are essential to successful HIV and STI prevention, as well as for prevention of unwanted pregnancy. Condom demonstration for correct and consistent use skills will be ensured before and after distribution using IEC materials.

Condom and Lubricant Distribution Standards

Table 8. Current Standards of Condom and Lubricant Distribution (per Month)

Key Populations	Condom and Lubricant Minimum Requirement for Distribution
Female sex workers	30 condoms
Clients of female sex workers	10 condoms
Men who have sex with men and male sex workers	30 condoms and 30 lubricants
Transgender people	30condoms and 30 lubricants
People who inject drugs	10
Migrants and their spouses	10

Note: This is an average quantity based on number of clients served and clients visited per day as per IBBS survey. Male and female condoms should be distributed as per needs and demand.

Beneficiaries

- **Condoms:** Men who have sex with men, male sex workers, transgender people, female sex workers, clients of sex workers, people who inject drugs (male and female), migrants and their spouses, people living with HIV
- **Lubricant:** Female sex workers, men who have sex with men, male sex workers, transgender people, and people living with HIV

Service Delivery Points

- Community
- Drop-in centers/exchange centers
- Community care centers/community home-based care teams
- HIV confirmatory sites
- ART service sites
- Other health facilities

Who Will Distribute?

- Community workers
- Clinical staff

e-Reach

e-Reach approaches to HIV prevention and testing involve harnessing online platforms to expand access to previously unreached individuals facing high risk, and to more conveniently reach existing program beneficiaries who already use online and mobile platforms. Key population members can be contacted through social media (Facebook, Instagram), dating applications (Grindr, Tinder, blued, BigoLive, Hornet) and messaging services (Imo, Viber, WhatsApp, Messenger). Outreach staff build rapport with individuals online; if they agree to be tested, they can be referred to book an appointment online (for example, www.merosathi.net) or they can be met in person by the in/outreach staff or at a clinic.

Beneficiaries

- Individuals at high risk and key populations

Who Will Deliver?

- Community workers and online in/outreach staff

Harm Reduction
Needle and Syringe Program

The provision of sterile injecting equipment through the needle and syringe program

is highly effective for reducing transmission of HIV, STI and hepatitis B and C. Needle and syringe programs facilitate the use of sterile needles and syringes and reduce the number of injections with unsterile or used equipment. NSP service should also include provision of primary health care and referral for abscess management, OST and other drug treatment. Used syringes should be brought back to exchange centres either by the clients or the staff.

Beneficiaries

- People who inject drugs

Commodities

Number of needles and syringes to be distributed:

- Minimum 120 needles and syringes per year with two alcohol swabs per syringe

Service Delivery Points

- Community
- Drop-in centers/exchange centers

Opioid Substitution Therapy (OST)

OST has been proven to be the most effective drug-dependence treatment for preventing HIV among people who inject and are dependent on opioids. OST is an effective, safe, and cost-effective medical treatment that is also proven to reduce the frequency of injecting heroin or other opioids and the associated risks of overdose, infection and transmission of blood borne viruses, and criminal activity. In addition, OST is effective for encouraging adherence to ART for people who are HIV positive. This reduces HIV risk behavior and prevents HIV, STI, and hepatitis B and C transmission.

Beneficiaries

- PWID

Commodities

- Methadone,buprenorphine and naloxone

Service Delivery Points

- OST sites

Pre-Exposure Prophylaxis (PrEP)

Oral PrEP is the use of ARV drugs by people uninfected with HIV prior to any potential exposure in order to prevent acquisition of the virus. PrEP can be event based or regular.

Beneficiaries

- MSM, MSW, TG people, FSWs and negative partner of PLHIV at substantial risk of HIV as indicated by National HIV Testing and Treatmnet Guidelines, 2020.

Commodities

- ARVs as per recommendations in the latest *National HIV Testing and Treatment Guidelines*

Service Delivery Points

- HIV confirmatory site
- ART service sites

Post-Exposure Prophylaxis (PEP)

PEP is the short-term use of ARV drugs (first-line ART regimen) to help prevent HIV transmission. The rationale is that ARVs taken immediately after exposure can stop the virus from disseminating in the body and establishing infection.

PEP is provided in both occupational and non occupational exposures to HIV. Trained doctors can make decisions to provide PEP for other populations exposed to HIV. It is recommended to start a 28-day course of ARVs within 72 hours of exposure.

Beneficiaries

- HIV-negative people exposed to the risk of HIV infection

Commodities

- ARVs as per recommendations in the latest *National HIV Testing and Treatment Guidelines*

Service Delivery Points

- ART service sites
- Starter pack in health facilities where ART services are not available

Sexually Transmitted Infection (STI) Management

STI management includes prevention, diagnosis, and treatment of STIs for key populations and others who seek services.

Beneficiaries

- Men who have sex with men, male sex workers, transgender people, female sex workers, clients of sex workers, people who inject drugs (male and female), migrants and their spouses, other populations at high risk, and people living with HIV

Who Will Deliver?

- Clinical staff

Service Delivery Points

- ART service sites
- HIV confirmatory sites
- Other healthcare facilities including all levels of government health institutions starting from health posts

Guidelines

- For recommendations, refer to the latest National Guidelines on Case Management of Sexually Transmitted Infections, 2014.

First 95: Case Finding

HIV testing programs are designed for people unaware of their status or at risk of HIV to get tested and linked to HIV prevention, treatment, and care services, as needed. New testing technologies have revolutionized the HIV response by getting HIV tests into the community and out of the health facility. HIV self-testing and other innovative approaches can increase uptake of HIV testing among populations who do not engage with conventional health services. The following HIV testing approaches are included in the standard service package: community-led testing, index testing, risk network referral, provider-initiated testing and counseling, mobile testing, self-testing, early infant diagnosis, the enhanced peer outreach approach (EPOA), and online to offline approaches.

HIV Testing

Community-Led Testing

Community-led HIV testing is an HIV screening approach whereby trained lay providers perform a single, rapid diagnostic test in a community-based setting. Community-led HIV testing aims to expand uptake of community-based HIV testing services among populations at higher risk of HIV, particularly those who may not otherwise get tested for HIV.

Beneficiaries

- Men who have sex with men, male sex workers, transgender people, female sex workers, clients of sex workers, people who inject drugs (male and female), migrants and their spouses, and other populations at high risk

Who Will Conduct?

- Community-led or community-based service provider as per the latest *National Guidelines on Community-led HIV Testing, 2017*

Service Delivery Points

- Community

Index Testing

Index testing is often referred to as the testing of contacts of HIV-positive index cases. This is a focused HIV testing service approach that includes the testing of sexual and injecting partners of individuals living with HIV, their biological children, and the biological parents of HIV-positive children.

Beneficiaries

- Sexual and injecting partners of individuals living with HIV, their biological children, and the biological parents of HIV-positive children

Service Delivery Points

- Community
- Community care centers/community home-based care teams
- HIV confirmatory sites
- ART services sites
- Other health facilities

Who Will Conduct?

- Community workers
- Clinical staff

Risk Network Referral

Risk network referral is the referral of people in the networks of HIV-positive index clients who have similar risk but are not a sexual or injecting partner. Referrals are primarily made through anonymous coupons provided to HIV-positive index clients.

Beneficiaries

Individuals in the network of HIV-positive index clients who share similar high-risk behaviors. These people do not have sexual contact or share needles with the index client.

Who Will Conduct?

- Community workers
- Clinical staff

Service Delivery Points

- Community
- Community care centers/community home-based care teams
- HIV confirmatory sites
- ART service sites
- Other health facilities

Provider-Initiated Testing and Counseling

Provider-initiated HIV testing and counseling refers to HIV testing services recommended by health professionals to individuals visiting healthcare facilities for reasons other than HIV services.

Beneficiaries

- Men who have sex with men, male sex workers, transgender people, female sex workers, clients of sex workers, people who inject drugs (male and female), migrants and their spouses, and other populations at high risk

Who Will Deliver?

- Clinician
- Laboratory staff

Service Delivery Points

- ART service sites
- OST sites
- TB/STI clinics
- Antenatal care clinics
- Other health facilities

Mobile Testing

Mobile testing refers to HIV testing and counseling conducted in various community settings, including places where people socialize, live and work. Mobile testing can be

used to reach hard-to-reach populations, including seasonal migrants, prison and key population members.

Beneficiaries

- General population
- Men who have sex with men, male sex workers, transgender people, female sex workers, clients of sex workers, people who inject drugs (male and female), migrants and their spouses, prisoners, and other populations at high risk

Who Will Deliver?

- Laboratory staff
- Community lay service providers

Service Delivery Points

- Community outreach areas
- Mobile vans or testing camps

HIV Self-Testing

Self-testing is a process whereby individuals perform an HIV test and interpret the results on their own to learn their status. This could be either assisted/supervised or unassisted/unsupervised.

Beneficiaries

Men who have sex with men, male sex workers, transgender people, female sex workers, clients of sex workers, people who inject drugs (male and female), migrants and their spouses, and other populations at high risk

Who Will Deliver?

- HIV self-test kits distributed by community service providers

Commodities

- Oral fluid-based HIV self-test kits

Service Delivery Points

- In community through outreach

Enhanced Peer Outreach Approach (EPOA)/Pay for performance

EPOA is an incentive-based (monetory/non monetory) approach that engages previously unreached key population members for HIV testing and prevention—particularly those

who are hard to reach and may be at high risk of HIV or living with HIV. EPOA is led by peer mobilizers under the supervision of community-based supporters and peer navigators who engage key population members to persuade peers in their own social and sexual networks to be tested for HIV.
EPOA will be implemented based on funding available under each specific project.

Beneficiaries

- "Hidden" key populations

Who Will Deliver?

- Peer mobilizers, clinical and in/outreach staff

Second 95: Linkage, Treatment, Adherence, and Retention

Referral, Linkage and Follow-up

- Identified people living with HIV should be referred and liked to HIV treatment center for rapid initation of ART, and regularly followed-up for adherence and retention support PLHIV should also be referred and linked to and followed up for co-infection and opportunistic infection management.

Beneficiaries

- All people living with HIV

Who will deliver?

- Peer navigator/outreach workers/community home-based care teams

Retention

Care and Support Services

HIV infection is a chronic manageable disease that requires a continuum of care and support from different levels, including health facilities, community care centers/ community home-based care teams, and other community workers. This includes adherence and retention support, support for viral load testing, counseling through motivational interviewing, positive prevention, promotion of U=U messaging (i.e., undetectable equals untransmissible, meaning that people living with HIV whose viral load is undetectable cannot transmit HIV through sexual intercourse), disclosure support and linkage to livelihood and income-generation support.
Care and support for people living with HIV includes culturally competent tangible and emotional support that can help foster treatment adherence. It also includes treatment literacy approaches aimed at providing information to people living with HIV about drug regimens, the importance of maintaining healthy living and protective behaviors, and

strategies to overcome stigma and discrimination through promotion of U=U messaging.\

Beneficiaries

- All people living with HIV
- Family members, spouse, and partner(s) of people living with HIV

Service Delivery Points

- Community care centers
- Community
- Healthcare facilities
- HIV confirmatory sites

Who Will Deliver?

- Medical doctors trained on clinical management of HIV
- Healthcare providers trained on clinical management of HIV
- Community healthcare workers/community home-based care workers, peer navigators, case managers
- Peer groups

Third 95: Viral Suppression

Viral Load Testing Approaches

Sample Collection and Transportation

Viral load testing is the gold standard for HIV treatment monitoring. Periodic viral load tests are the most accurate way of determining whether ART is working to suppress replication of the virus. An elevated viral load suggests that treatment provision needs attention, including offering adherence support. Nepal recommends routine viral load monitoring as per National HIV Testing and Treatment Guidelines, 2020.

Beneficiaries

- All people living with HIV on ART

Service Delivery Points

- Viral load testing labs
- Viral load sample collection sites

Who Will Deliver?

- Laboratory staff
- Clinical staff
- Community workers

Guidelines

- For recommendations, refer to the latest *National HIV Testing and Treatment Guidelines 2020* and the viral load sample transportation protocol.

Annex 3: Enabling Environment

Coordination and Collaboration Mechanisms

Coordination and collaboration mechanisms among partners should be established at the central, provincial, district, and local levels to ensure implementation of the standard service package. At the central level, NCASC will initiate a forum for implementers to discuss achievements and challenges on a quarterly basis. Partners will develop a coordination mechanism at the provincial, district, and local levels and conduct sharing meetings with the district, including the local level, on a quarterly basis at a minimum.

Joint Monitoring and Supportive Visits

NGO partners implementing the standard service package in selected geographical areas will involve their board members and relevant health office/municipality staff in regular implementation monitoring. There will be quarterly monitoring visits from NGO board members, health officers, and the municipality in service delivery points. Joint monitoring of service delivery will also be conducted by a team of NCASC, National Public Health Laboratory, and agencies implementing HIV at central, provincial, or district levels.

Violence and Stigma Reduction

Stigma-and Discrimination-Reduction Training Specific to Key Population

Orientation on stigma and discrimination will be included in all types of trainings to be conducted by partners. Training activities to reduce stigma and discrimination will be based on the recently revised stigma toolkit. In addition, an information technologies platform will be created to address stigma and discrimination. Service delivery staff will be sensitized to provide competent services friendly to and tailored for key populations.

Gender-Based Violence Referrals

Key populations and people living with HIV should be screened for gender-based violence and referred for further services, as needed.

Monitoring and Evaluation

Standard Monitoring Tool to Measure Quality of Services

Partners will use standard recording and reporting tools prescribed by the government for HIV programs. All relevant national guidelines for specific service must be used. New staff will be oriented within one month. Relevant trainings listed in this document will be provided to each staff member as soon as trainings can be organized.

One National HIV Information System

Recording and reporting of nndividual level diaggregated data for whole continuum of care from HIV prevention, diagnosis, treatment, care and support should be ensured.

Planning

Hotspot Mapping and Microplanning

Programmatic or hotspot mapping will be done annually following standard guidelines for mapping 2019.

IEC/Behavior Change Communication/Social and Behavior Change Tools for Key Population

- **ART centers:** Posters, e-poster, flip charts, flow chart, brochures and flyers on ART
- **HIV testing and counseling centers:** Posters, e-posters, flip charts, flow chart, brochures and flyers on testing and counseling, penis models
- **STI clinics:** Posters, e-poster, flip charts, flow chart, brochures and flyers, penis models
- **Drop-in centers/exchange centers:** Posters, e-poster, flip charts, flow chart, brochures and flyers, education and entertainment materials (television, Internet facility), condom box
- **Outreach:** Flip charts, brochures, flyers, job aids, cards, mobile/tablet with Internet connectivity
- **OST site:** Posters, e-poster, flip chart, flow chart, brochures and flyers on OST
- **Community-led testing:** Brochures, flyers
- **Community care center/care and support:** Posters, e-poster, flip charts, flow chart, brochures and flyers

Waste Management

Safe disposal of used commodities following implementing partner standards and *National Health Care Waste Management Guidelines* of Nepal.
Safe disposal for expired medicines, used needle/syringes, test kits, and reagents following *National Health Care Waste Management Guidelines*.

Annex 4: Minimum Training Needs

Minimum Training Needs for Service Providers

(Trainings to listed and stated – trainings to be provided to each of the relevant staff)

Table 9. Minimum Training Needs for Service Providers

Training	People Who Inject Drugs	Men Who Have Sex with Men/ Transgender Women	Female Sex Workers	Clients of Sex Workers	Migrants	Prisoners	People Living with HIV
Outreach (EPOA, mapping, motivational interview, stigma and discrimination, e-Reach)	√	√	√	√	√		
Peer educators/ community mobilizers/ peer mobilizers	√	√	√	√	√	√	
Community-led testing/HIV testing/ Self Testing/mobile	√	√	√	√	√	√	√
Index testing	√	√	√	√	√		√
Case management including treatment literacy							√
Clinical Management Training							√
STI management[1]	√	√	√	√	√	√	
Counseling	√	√	√	√	√	√	√
Stigma and discrimination reduction	√	√	√	√	√	√	√
OST, including OST literacy[1]	√						

Note: Training on PMTCT will be provided to Government of Nepalstaff providing antenatal care services.

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