REPORT ON THE COMMUNITY CONSULTATION
OF

FEMALE SEX WORKERS, WOMEN LIVING WITH HIV AND YOUNG KEY AFFECTED POPULATIONS

ON

SEXUAL REPRODUCTIVE HEALTH AND RIGHTS

FAITH

AMPLIFYCHANGE

ACKNOWLEDGMENTS

This report would not have been possible without the engagement and cooperation of the organisations and individuals who participated in the study; their dedication to improving the lives of women living with HIV and those at risk from HIV transmission is admirable.

The consultation workshops was conducted from September 2017 – February 2018 in twelve districts. Our sincere thanks to Liz Tremlett who synthesised and analysed and wrote this report.

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CCM	**Country coordinating mechanism**
CSO	**Civil Society Organisation**
EID	**Early Infant Diagnosis**
FHD	**Family Health Division**
FP	**Family Planning**
FSW	**Female Sex Worker**
GBV	**Gender based violence**
HIV	**Human Immuno-deficiency Virus**
IVF	**In Vitro Fertilization**
MoHP	**Ministry of Health and Population**
NCASC	**National Centre for AIDS and STI Control**
PCR	**Polymerase Chain Reaction - test used to detect the presence of HIV's genetic material before antibodies have been built up e.g. in in Early Infant diagnosis.**
PHC	**Primary Health Centre**
PPTCT	**Prevention from Parent to Child Transmission (HIV)**
PEP	**Post exposure prophylaxis**
PrEP	**Pre – exposure prophylaxis**
RHSC	**Reproductive Health Steering Committee**
SRH	**Sexual and Reproductive Health**
STI	**Sexually Transmitted Infections**
TB	**Tuberculosis**
WHO	**World Health Organization**
WLHIV	**Women living with HIV**
FWUD	**Female who use drugs**

EXECUTIVE SUMMARY

IF WOMEN DON'T FEEL ABLE TO EXPRESS THEIR IDENTITY AS FSW, SOMEONE LIVING WITH HIV, AS A DRUG/ ALCOHOL USER OR AS UNMARRIED THEY MAY NOT BE GETTING THE SERVICES, TREATMENT OR SUPPORT THEY NEED. THE NEEDS ARE NOT COMPLEX BUT THEY ARE SPECIFIC.

Many women struggle to access SRHR services and face stigma and discrimination and other forms of violence in their homes, their community and in health care facilities. This has profound consequences for women's own health and well-being and it can be a barrier to accessing services and achieving further advances in health outcomes for women their children and/or other dependents.

Sexual transmission accounts for 85% of new HIV infections in Nepal this marks a real shift in the nature of the epidemic in Nepal (away from injecting drug use as the primary mode of transmission) and there is a need for a shift in the response to reflect this, it is also an opportunity to improve SRH services more broadly (health system strengthening). Access to ARV treatment, maternal and newborn health has improved over the last decade, it is still not optimal.

Nepal is at a critical moment with the federal structure already underway, ensuring that the issues of women living with HIV, female sex workers, female who use drugs, young key affected population and other marginalized groups are kept on the agenda and are adapting to the current situation.A more robust health system / SRH service should be available to these women throughout the country.

The aim of the consultation was to establish where the gaps were in sexual and reproductive health service provision as well as understanding of the need from the above mentioned community members themselves. The intention of the consultation was not to just focus on women of reproductive age but to look at all stages of women's life course.

The findings showed many shortcomings in the existing services for both WLHIV and FSWs and young key affected population. Some of the shortcomings were based on a lack of understanding of laws, policies by the services users, their inability to seek redress where they were being abused but a large part was around stigmatising and discrimination of these women which was often abusive but most importantly curbed any health seeking behaviour.

The recommendations include upholding and strengthening the rights based, patient centred approach, and eradicating stigma and discrimination, confidentiality breaches etc.

The final part of the report gives in depth action plans for the following stakeholders – the list is not exhaustive but it aims to providing a starting point for further discussion and accountability.

INTRODUCTION

Many women in Nepal struggle to access SRHR services and face stigma and discrimination and other forms of violence in their homes, their community and in health care facilities. This is not only a human rights violation in itself, which can have deep physical, psychological and material consequences for women's own health and well-being but the violence itself can be a barrier to accessing services and achieving further advances in health outcomes for women their children and/or other dependents, in particularly those women who face additional layers of stigma.

INTRODUCTION

Many women in Nepal struggle to access SRHR services and face stigma and discrimination and other forms of violence in their homes, their community and in health care facilities. This is not only a human rights violation in itself, which can have deep physical, psychological and material consequences for women's own health and well-being but the violence itself can be a barrier to accessing services and achieving further advances in health outcomes for women their children and/or other dependents, in particularly those women who face additional layers of stigma. Although access to ARV treatment, maternal and newborn health has improved over the last decade, this is still not optimal. Nepal is at a critical moment with the federal structure already underway, ensuring that the issues of women living with HIV, female sex workers, female who use drugs, young key affected population and other marginalized groups are kept on the agenda is going to of utmost importance.

LITERATURE REVIEW FINDINGS:

The consultation was preceded by a literature review which gave an in-depth understanding of policy and programming in Nepal both past, present and plans for the future. To date there has been little attemptin Nepal to integrate HIV and SRH services or policy. However recent changes in the funding mechanisms, in particular for HIV, namely the reduction in available funding, has prompted a move towards integration [1]. According to the literature plans for integration appear to be at best partial (only with family planning) and also combined with other services such as immunisation, TB and Maternal and new-born child health so it runs the risk of being diluted.

Family Planning alone doesn't take into account the full remit of SRH services that women require e.g. the needs of women who are not concerned with having babies (too young, too old, don't want to have children, don't want to have more children, can't have children etc).

It seems likely that any attempt to integrate HIV and SRH is likely to be based on a financial – cost saving need. It is clear there is a real need to tackle sexually transmitted infections in Nepal since recent statistic state sexual transmission accounts for 85% of new HIV infections in Nepal this marks a real shift in the nature of the epidemic in Nepal (away from injecting drug use as the primary mode of transmission) and there is a need for a shift in the response to reflect this, it is also an opportunity to improve SRH services more broadly (health system strengthening).

[1] *"Integration: Different kinds of SRH and HIV services or operational programmes that can be joined together to ensure and perhaps maximize collective outcomes. This would include referrals from one service to another, for example. It is based on the need to offer comprehensive and integrated services. Integration means offering a full range of services through the same institution or tied up with referral to another institution that meet SRH and HIV needs of clients simultaneously." Rapid Assessment Tool FPAN and FHD*

ABOUT THE CONSULTATION

The consultation sought to understand what is working well for women living with HIV, Female Sex Workers, young key affected populations as well as exploring how the existing system can be developed and strengthened to better respond to the their sexual and reproductive health needs in Nepal. The intention of the consultation was not to just focus on women of reproductive age but to look at all stages of women's life course.

THE CONSULTATION AIMS

- To identify key areas and priorities for further advocacy and action.
- To strengthen the capacity of Community Based Organisations (CBOs) from 12 districts to understand the impact and breadth of the issues and to take them up in their portfolios of work.
- To ensure the significance of the findings is understood by key stakeholders.

PARTICIPANTS

- Women living with HIV, young women living with HIV and Women living with or not living with HIV from one or more of the following communities: female who use drugs, female sex workers, young key affected populations. All 252 members are with CBOs partnering with FAITH.

METHODOLOGY USED

There was a pilot workshop in Lalitpur in September to ensure the questions and translations were clear and understood and the methodology robust.
The format of the consultation was a two-day orientation on SRH followed by two-day consultation where the key elements of SRH, human rights and gender in the Nepal context were discussed in detail.

CONSULTATION WORKSHOP FORMAT

- Pre and post evaluation was conducted
- The facilitator introduced each subject area and gives an appropriate amount of time for the women to discuss the issues.
- The facilitator clarified any issues where needed but otherwise the women would discuss the guiding questions in the time allocated.
- Both groups had voice recorders and the sessions are recorded only for the purpose of the Gap Analysis Report – any quotes used will be done so anonymously.
- Participants were free to change groups at any time.

DATA COLLECTION

There were twelve training sessions in 12 districts, a total of 252 women were consulted.The data collection took place between September 2017 – February 2018.

LIMITATIONS OF THE STUDY

Bringing women living with HIV, female sex workers, young key affected population together raised interesting issues and dynamics, the exchange was rich and allowed each to gain a better understanding of the others perspective, however the women living with HIV often deferred the importance of their SRH issues to the seemingly greater importance of those of the female sex workers.

Young participants were more reluctant to share their issues. No separate consultations were conducted with Female who use drugs in the workshop due to the limited number of participation.

THE FINDINGS FROM THE CONSULTATION

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FAMILY PLANNING

Family planning reinforces people's rights to determine the number and spacing of their children.

Successes

The participants stated that the availability of contraception in general was good in their districts, for example temporary contraception such as hormonal contraceptives: Nilocon white (21 hormonal tablets and 7 Iron tablets); Depo-Provera or Sangini (3 monthly injections), implants e.g. Norplant (5 years protection) and other pills, IUDs egcopper- T, condoms, and longer-term methods for men (vasectomy) and women (Mini-laparotomy) are also available but only in the government sector. Emergency contraceptive is also widely available.
Free advice is available from health workers/NGOs and some contraceptives are available for free atHealth posts, Clinics and some NGOs/INGOs and for sale at Pharmacies, Small grocery stores. FCHV (Female Community Health volunteer) are on hand to provide information.

Challenges and Barriers

However there are some important barriers to access to family planning for the targeted groups in the study – overlapping concerns are:

1. Social stigma in Nepal where it is taboo for women to access contraceptives of any kind. Specifically there were several anecdotes about female sex workers who carry condoms being harassed by Police and forced to explain why there are condoms in their purse or bags so were even taken into custody and money is needed to get released otherwise they are kept in jail.
2. Condoms are easily found but are not widely used- people have allergies, and they break since the quality isn't good. Oral/injecting contraceptivescan cause heavy bleeding and skin problems.
3. Unmarried/single women are not able to access contraceptives or abortions, they often face irrelevant but intrusive questions about where is their partner or how many partners they have etc which discourages them from returning to the free service, instead they seek out private services which are more confidential which they have to pay for.
4. Decisions about family planning are not shared decisions and not discussed with the partner.

Specifically for female sex workers:

- *Condoms are not available at night when the pharmacists have closed.*
- *It is very difficult for known female sex workers to get married, they are heavily discriminated against and judged by the society.*
- *When trying to access family planning services there is often abuse, this leads to self-stigma and further difficulty in ac cessing services such as treatment for STIs.*
- *FSWs are not aware of all of the ways that they can prevent unplanned pregnancy either by all of the forms of contraceptive available or about how to negotiate condom use without it impacting on their client number and aren't accessing counselling.*
- *FSWs felt their needs weren't prioritised or properly understood by those that could and should be helping them.*

Specifically for women living with HIV:

- *Services are not sensitive to the their SRH needs.*
- *WLHIV do have information about contraceptive use.*
- *WLHIV are unaware about HIV reinfection.*

SAFE MOTHERHOOD AND INFANT AND CHILD WELFARE

SAFE MOTHERHOOD MEANS ENSURING THAT ALL WOMEN RECEIVE THE CARE THEY NEED TO BE SAFE AND HEALTHY THROUGHOUT PREGNANCY AND CHILDBIRTH. IN THE CONTEXT HERE IT HAS BEEN EXPANDED TO INCLUDE NEWBORN HEALTH AS WELL. TO SUMMARIZE IT INCLUDES (FAMILY PLANNING), ANTENATAL CARE, OBSTETRIC CARE, POSTNATAL CARE, POST-ABORTION CARE, AND NEONATAL CARE.

> ***"We are blamed if our children are born HIV positive*** *- WLHIV"*

Successes

1. Information and services about safe motherhood is available to the general public however the specifics for FSWs, WLHIV, young Key Affected Populations are not tackled.
2. The following information and services were highlighted by the women interviewed as being widely available in general
    a. HIV/STI Testing and treatment during pregnancy often provided free of charge.
    b. Counselling on issues relating topregnancy, hygiene, sanitation and nutrition;Iron and calcium supplements during and after pregnancyis available through FCHV and other health providers.
    c. Time to time endoscope, ultra soundfacility is available for pregnant women.
    d. Free delivery and operation at Hospital and health post.
    e. The availability of blood in the event of a transfusion.
    f. Postpartum allowance for mother, infant clothes, cotton nappies and transportation cost are provided by government hospital.
    g. Vaccinations for the mother and child as part of a nationwide vaccination programme e.g. for the infant - T.T, Hepatitis B, measles and polio etc for the mother vitamin A, worm parasite medication.

Challenges, barriers, gaps

1. Lack of awareness and knowledge on safe motherhood and infant care among FSWs and WLHIV population.
2. Lack of formal education and stigma (both external and self stigma) can make it even more challenging finding the information they need to support decisions to plan for a pregnancy or make a decision about an unplanned pregnancy. There is also little family support in the prenatal phase.
3. Managing our own hopes and fears for ourselves and our children e.g. the risk of having a child born with HIV or when facing an unplanned pregnancy will having an abortion mean not conceiving baby in future, blood loss during abortion or miscarriage leading to anaemia and Possibility of death, how to pay for pregnancy and support a(nother) child.
4. Managing complication in pregnancy can be hard especially where additional medical costs are incurred especially for WLHIV. Often delivery through caesarean section and other complication cost too much and in most cases they don't have amount to pay.
5. Sub standard medical care.
    a. Blood for transfusion is often not available.
    b. The pay-first rule in hospital can mean we miss out;
    c. Medical report and medical notes go missing.
    d. There are no free tests of Uterus, X-ray/ Video X-ray.
    e. No regular check ups- ultra sound, blood pressure etc
    a. Difficulty to get to hospital, and when we arrive there aren't beds available. Lack of proper health facilities that cater to the special needs of WLHIV, FSWs.
    f. Inability to maintain confidentiality.
    g. Women under the PMTCT programme have to pay for a caesarean section themselves even if there is a risk of HIV transmission (e.g. the mother was diagnosed at a later stage of the pregnancy).
5. Attitude of health care worker prejudiced thinking or actual discrimination from service provider is a barrier for FSWs in seeking information and care related to safe motherhood.
    a. Discrimination and abuse (use of vulgar language) from hospital towards FSWs, WLHIV.
    b. We are treated differently (worse) as FSWsand WLHIV mothers, our cases are often put to the bottom of the list.
    c. Lack of counselling from health worker
6. Nutrition/breastfeeding for breast-feeding mothers, it is essential to maintain a good balanced diet. However due to financial crises, lack of nutritious food and care for mother and child can cause malnutrition amongst new-borns. In the cases where breast-feeding is not possible, the high cost of formula milk is hard to cover.
7. Societal Stigma - Many lack family supportand marginalised due to their status but also on the basis of giving birth to girl child, or having an unplanned pregnancy.
8. Legal recognition– There is a problem in making birth certificate and citizenship card for children of FSWs because their father identity is not known or not disclosed leading to difficulties in their later life. Children Living with HIV in lack of birth certificate are unable to enrol in social security allowance of 1000 NRs per month.

Specifically for women living with HIV:

- *WLHIV are unaware about PMTCT services, there is a lack of counselling to support the PMTCT service making it difficult to navigate. HIV services (ART and PMTCT) not available in PHC, medical hospital and clinic in all district and places.*
- *There is very little integration of services e.g. HIV and Obstetric care, leading to poor quality care. E.g. ART centre are not everywhere which makes it difficult for WLHIV to get access to PMTCT. Post Partum PMTCT - PCR service are not available in local hospitals for WLHIV in ART centres.*
- *Early infant diagnosis PCR testing should be available at provincial level to monitor if the child has been born with HIV or not.*
- *The prophylaxis medicine after child is born (as part of the prevention of parents to child transmission programme), is much easier for dispensing to infant when it comes in syrup form rather than tablet form as it is available now.*
- *Attitudes of health workers: All health worker do not know information about PMTCT so it gets late for treatment. They refuse to perform surgery on us.*
- *Financial strain - WLHIV (especially single mothers) due to rejection by their late husbands families also find it difficult to make ends meet and finding work as someone known to be living with HIV can also be challenging.*

Specifically for female sex workers:

- *Loss of income for FSWs they cannot work during late pregnancy and delivery which leads to financial crisis when they most need it. They are often single mothers with little resource or support. FSW's don't get time for rest, after giving a birth they have to return to work immediately to support additional costs. There may be additional burdens from their families and owner of hotels, including blackmailing which can result in them not going to a health service provider when needed.*
- *Lack of childcare provision during working hours so very often FSWs are taking their children with them to work.*

ADOLESCENT SRHR

ADOLESCENTS ARE AT THE FOREFRONT OF SOCIAL CHANGE HOWEVER THEY ARE SOMEWHAT RESTRICTED BY TRADITIONAL SOCIAL AND CULTURAL PRACTICES. THEY ARE ALSO FACING GENDER-BASED VIOLENCE, DIFFICULTIES IN ACCESSING CONTRACEPTIVES, TEENAGE PREGNANCY AND UNPLANNED PREGNANCY.

> ***"I was born with HIV. Does that mean I have to marry someone living with same disease? What if I fall in love with someone without it?***
> ***- YWLHIV"***

Successes

1. Education- There are various initiatives by NGOs reaching out to young people on SRHR, however the general school curriculum is very limited on this matter which means the reach is not as broad as it should be.
    a. Various organisations give orientation classes about mental, social, physical change of young girls and reproductive health.
    b. Reproductive education, family planning, free counselling, medicine distribution, menstrual hygiene and can access free sanitary pads through health post outreach and NGOs within schools and communities.
    c. SRH information is given via radio, newspaper and television

Barriers Gaps

1. YFSWs and YWLHIV are not able to share their SRH issues with parents or family members. Lack of family support and suggestion on SRH issues.
2. Organisations running adolescent SRH programmes do not include young FSW.
3. In planning, decision-making and service provision on SRH little attention is given to the needs of YFSWs and YWLHIV.
4. Social stigma - people are highly judgemental of those using contraceptives as adolescence. This is even more challenging for young women and girls living with HIV/ FSWs when they are also dealing with
    a. low self esteem and self worth
    b. Navigating the complexities of relationships and marriage
    c. Having a place in the family and potential property inheritance issues
    d. Concerns about drugs/alcohol use, HIV transmission among adolescent FSW group
5. STI treatment is not affordable for young FSWs which can lead to fertility issues. It is difficult to get support to check up on health issues e.g. heavy bleeding. Girls can't discuss these matters with family members and delays can lead them to suffer further.
6. Lack of confidentiality makes it less likely that YFSW, YWLHIV visit health care centres.
7. Loss of incomefor FSW in particular during menstruation can occur. There is medication available for abdominal pain during menstruation but there is not too much information about this.

Specifically for Young People living with HIV:

Young people living with HIV are reluctant to enter relationships and often suffer from depression this can lead to refusal to take their ART medication.

ADULT SRHR

Women experience different SRH needs throughout their life course, a common error is to ignore women above reproductive age group. Ensuring all women are able to access the services they needs is a crucial part of SRH as a fundamental human right, this starts at preparing girls with information about puberty right through to ensuring good SRH after menopause.

> ***"As an elder woman, I wish to live healthy and respected life - FSW"***

Successes

1. There are informal education program, vocational and skill development trainings, well being camps available for older women.
2. There is monthly allowance given to single and elder women.

Challenges and barriers

1. Older women are left out of any discussion of SRHR. Cultural barriers about widowhood and sexual activity over 45 years old keep this a taboo, as a result very little information is available about sexual health for this group including managing the menopause and it's after effects.
2. Older women are not expected to have or express any sexual desires and in some cases it is completely acceptable for the husband to take a younger wife to accommodate his needs. Some find this more acceptable than others and some take hormones to increase their sexual desire to stop their husband seeking another wife.
3. As well as a lack of information there is also a lack of specific tailored services for this group. E.g. managing the menopause and its impact on ART.
4. For some access to health care and allowance is difficult since they do not have identity cards.

HIV AND STIs

AN ESTIMATED 39,397 PEOPLE WERE LIVING WITH HIV IN NEPAL AT THE END OF 2015, IN 2018 IT IS REPORTED TO BE 32,000. IN 2015, 1,331 PEOPLE WERE NEWLY INFECTED WITH HIV AND THERE WERE 2,263 AIDS-RELATED DEATHS. RECENT DATA SHOWS 13,000 PEOPLE ARE RECEIVING ARV MEDICATION. HIV TRANSMISSION RATES ARE NOW 85% THROUGH SEXUAL CONTACT.

Apart from sharing their route of transmission there is strong evidence to support several biological mechanisms through which STIs facilitate HIV transmission by increasing both HIV infectiousness and HIV susceptibility. Therefore clinical services offering STI care are an important access point for people at high risk for both STIs and HIV. Identifying people with STIs allows for not only the benefit of treating the STI, but for prevention education, HIV testing, identifying HIV-infected persons in need of care.

Successes

1. The following HIV/STI related free services are available.
   a. STI screening, counselling and treatment service.
   b. Condom distributions, HIV testing and counselling, HIV related medicine, PreP and P.E.P Post Exposure prophylaxis, CD4 and Viral Load facilities, Community Care Centre for ART patient and Home Based Care facilities is free (Antiretroviral and for Opportunistic infections).
   c. Prevention of Parents to child transmission package including early Infant diagnosis
   d. In the case of poverty - nutritional supplements, clothes and educational materials, transportation costs are covered.
   e. Other related services e.g. TB screening, sputum test and chest x-ray and treatment for TB; Opioid Substitution Therapy (methadone), needle, Syringe exchange and rehabilitation.
2. HIV/STIs related public (prevention) awareness program are available.
3. Children living with HIV get a social security allowance of 1000NRS per month until the age of 18.
4. Income Generation support/skill oriented training are given from time to time.
5. Some erratic support for additional health conditions like MRI.
6. Confidentiality in organizations working in HIV.

Challenges, barriers

1. Health care access is complicate due to attitude of health care providers, distance needed to travel, financial hardship including transportation costs which is a significant issue.
2. No regular health check ups available including cervical cancer screening.
3. Continuum of care - many are lost to follow up for a number of reasons but there is little outreach or follow up to ensure services are taken up.

> ***"If I had known about PPTCT, I could have prevented my child from this hellish life."***
>
> *- WLHIV*

Specifically for female sex workers:

- *Lack of confidentiality lead to low HIV testing and treatment enrolment. FSWs going to health service sites and counselling centre feel shame and fear of being recognised.*
- *Lack of condom negotiation skill among FSWs.*
- *FSWs who use drugs are not included in needle syringe exchange programs.*
- *FSWs living with HIV faces additional burden of violence after their status*

Specifically for women living with HIV:

- *HIV infected people can't discuss about their health status including to their own children due to social stigma and shame.*
- *HIV infected people face travel restriction when going abroad.*
- *CD4 machine is functioning well however VIRAL LOAD/EID services not available in district.*
- *ART medicines are not easily available and the hospital is too far. Unaware about the side effect of ART. Lack of information about drug interactions e.g. ART and contraceptives/ hormone treatment. There was no any system or mechanism of whole body check up including monitoring side effects.*
- *Limited quota at Community Care Centres and Community home based care and it is not well organised.*
- *If child was born HIV negative he/she can't enrol in CLHIV social allowance.*
- *HIV infected children are expelled from school due to infection also unable to take medicine on time.*
- *Poor quality counselling services. Difficult to disclose status and get support from family and correct information from medical staff.*
- *Lack of complete information related to HIV/STIs. Condom supplies are inadequate and difficult to access. No proper information on organization that work on HIV/STI, and those organisations don't have good information about PMTCT.*
- *Discrimination towards WLHIV by health care professionals and in the community*
- *Economic hardship there is a lack of skill development and income generating program for WLHIV who often don't have much formal education. Lack of opportunity for HIV infected people.*
- *No awareness on sexual and reproductive health rights.*

FERTILITY

There are strong social pressures to have children and many women feel that they are not good women, wives etc. until they are mothers. The inability to have children is therefore highly stigmatised and can be a further layer of stigma for women who are already marginalised for other reasons.

Successes

1. The following services are available relating to fertility
   a. In government hospital and local health post,therearefree ticket system for reproductive issues.
   b. Infertility related advice and counselling, check up facilities, operation.
   c. Treatment is availablefor hormonal problem, STIs.
   d. Fertility cleanse – preparing the uterus for pregnancy (it is not clear but this could be dilatation and curettage)
   e. HSG (Hysterosalpingogram which examines the fallopian tubes)
   f. Sperm counts, Sperm Donation, In Vitro Fertilization (test tube Baby), Surrogate/Surrogacy

2. Other alternatives
   a. Ayurvedic Treatment
   b. Adoption

Challenges, barriers

1. Implementation of health/ SRH right is weak which can make access to these services difficult for some groups of women.
2. If a woman is not pregnant she has no idea where to go or what to do. Nor do they get support from their husband as well. Superstitions and cultural beliefs about infertility and visiting witch doctors.
3. Women themselves have their own fears about being abandoned by husbands, or that they remarry or who is going to look after them in old age.
4. Stigma and discrimination from society and self-stigma includes being labelled "bamshanash" (destroyer of generation of the family i.e. someone who can't have children).
5. Lack of awareness program on potential and preventative causes of infertility among FSWs and WLHIV. For example;
    a. Incorrect and excessive use of contraceptive pills and its impact on reproductive health including irregular menstruation cycle.
    b. Use of unauthorised/expired medication for abortion; impact of multiple abortions on fertility.
    c. Poor personal hygiene including STI management.
    d. Use of drug and alcohol
    e. Lack of nutritional information and support, avoiding malnutrition, anaemia, and iodine deficiency.
6. There are some practical difficulties when accessing medical services:
    a. Discrimination and de prioritising of FSWs and WLHIV. Lack of a confidential service.
    b. Cleaning of uterus practice is not available in government hospital.
    c. Medicine, video X-ray (ultra sound) and other tests are not free (except for STIs).
    d. Infertility medicines are not free for either men or women.
    e. Test Tube treatments are expensive, are not easily accessible; treatment is not 100% sure.
7. Legal adoption process is very difficult and complex.
8. There are very few organisations working on SRH issue of FSWs and WLHIV which makes it difficult to understand the issues and find a pathway into care.

> ***"To take treatment for infertility we have to go out of our district which is a huge problem, leaving our house for couple of days will bring big problem to family members back home."*** *- FSWV*

Specifically for female sex workers:

- *Lack of confidentiality lead to low HIV testing and treatment enrolment. FSWs going to health service sites and counselling centre feel shame and fear of being recognised.*
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UNPLANNED PREGNANCY AND ABORTION

SINCE 2002 ABORTION IS LEGAL IN NEPAL UP TO 12 WEEKS; AND UP TO 18 WEEKS IN THE CASE OF RAPE OR INCEST, ANY TIME THE PREGNANCY POSES DANGER TO THE LIFE OF PHYSICAL OR MENTAL HEALTH OF THE PREGNANT WOMAN OR THE FOETUS IS SERIOUSLY DEFORMED AND IT IS RECOMMENDED BY A DOCTOR; PERMISSION IS NOT REQUIRED FOR WOMEN OVER 16 YEARS.

Successes

1. Pregnancy test kits including blood test are widely available.
2. Free safe abortion counselling and service are available from government hospitals and MarieStopes and Family Planning Association.
3. Lots of information in the mass media for safe abortion and its service sites.

Challenges, barriers

1. In spite of free safe abortion in Nepal there are still illegal abortions taking place – due to lack of knowledge, being a WLHIV/FSW, being unmarried and single women, remoteness, or for abortions after 12 weeks.
2. There is a lack of information about where and how to access free pregnancy test, counselling and safe abortion services.
3. There were many examples of incorrect informationamong the participants e.g. "Without husband consent abortion is not done in hospital." Or "women living with HIV cannot get an abortion in her own right within 12 weeks". Or Without husband consent abortion is not done in hospital.
4. Lack of family support to FSWs for abortion increasing financial burden. Mental stress before and after having an abortion - managing the physical and mental loss, as well as managing the reaction of family members and the community including not being seen as fit for motherhood.
5. Stigma and discrimination from health workers leading to deprioritising of FSW and WLHIV. There is little respect or sensitivity while going for abortion men are present in the same room.
6. Lack of skilled/ trained health worker in service sites for example procedures that lead to excessive blood loss or damage; counsellors unaware of WLHIV/FSWs issues so the advice for general women is inapplicable.
7. There is a lack of confidentiality in public health care facilities.
8. Financial and health complication due to unsafe abortion.
9. Use ofAyurvedic medication, unauthorised medication for abortion leading to poor health conditions, lack post – abortion care.

"I have aborted twice till now. We do not have other option. In government hospital they ask many questions so I chose home remedies – FSWV"

GENDER BASED VIOLENCE

Successes

1. There is a law which focuses on Gender based Violence (GBV) and offenders are punished.
2. Legal aid support is available from organisations working on human rights of women and children.
3. Care and support can be sought from society.
4. Counselling, abortion, HIV/STI check-up are available.
5. District development committeeprovide trainings, skill development program to women and children affected by violence,
6. Information is available via Radio, T.V newspaper and the Internet.

Challenges, barriers

1. The implementation of the GBV law is weak from the Government of Nepal.
2. Women don't know their rights and don't know how to execute them, when they do try to take action there are many barriers in particular for marginalised groups:
   a) Fear of our safety when reporting a crime due to
      I. Black mailing/ harassment from the police
      II. Lack of trust in legal justiceas violence also comes from the police so where to report that?
   b) There is discrimination in police and judiciary system towards FSWs and cases are not prioritised.
   c) Cyber crime and bullying causes great pain and mental torture and can lead to suicide but it is hard to prove cyber crime.
   d) Difficult to engage with the law if you are working illegally and or don't have citizenship or birth certificate.
   e) Lack of financial support and accessing legal support organizations.
3. FSWs and WLHIV do not have proper information related to violence, there are few specific programmes working on this, so awareness and capacity to take action is low, this combined with low self esteem, and lack of empowerment means that many cases go unreported.
4. There is no government department or organization working specifically on FSWs violence case.
5. Women are often struggling with lots of questions before reporting GBV e.g. concerns about their children's and their own futures. Women are scared that their confidentiality will be bro ken, they feel powerless for fear of exposure.
6. The issue of children who have experienced violence e.g. FSWs children and HIV infected chil dren are not clear.
7. There is a quota system for residential care (safe houses) for women who have experienced GBV but this does not include WLHIV/FSWs.
8. Lack of self-defenceskill.

“Sex work is not a legal profession so it is hard to report a crime when the situation is already illegal and the FSW are working in a concealed way, which in turn makes them more vulnerable. If FSWs are found in hotels with their clients, they are taken to jail and clients are released. FSWs are kept for the highest amount of bail, if they fail to give the amount they are punished and are given more days of penalty. Even in jail FSWs are harassed/assaulted by the police and scolded using vulgar words. FSWs have to suffer different type of violence by their clients and larger society.”

By 2020, 90% of all people living with HIV will know their HIV status.

HUMAN RIGHTS

THERE ARE SOME GOOD LAWS AND POLICIES IN NEPAL CREATING A GOOD THEORETICAL BASIS UPON WHICH HUMAN RIGHTS CAN BE DEFENDED, HOWEVER THERE ARE CHALLENGES. THE NUMBER OR ORGANISATIONS THAT ARE WORKING TO DEFEND HUMAN RIGHTS GIVES SOME INDICATION THAT HAVING A LEGAL FRAMEWORK IN PLACE IS JUST PART OF THE PICTURE.

Successes

1. There are many organisations working to defend women's human rights.
2. Different trainings are being provided on women's rights.

Challenges, barriers

1. Low social status of FSWs and WLHIV which can lead to services being withheld, different or discriminatory treatment for a variety of, sometimes combined, reasons e.g. being a woman, being a sex worker, being HIV positive, being a drug/alcohol user, being unmarried and little interest in working with our human rights abuses.
2. Poverty can make exercising rights difficult, it is hard to pay a lawyer to prove your rights have been abused and court decisions can take a very long time.
3. Legal Status is compromised because of our status e.g. as single (widow) woman difficulties in getting marriage certificate or getting citizenship for their children, similarly FSWs have difficulties accessing birth certificates and citizenship for their children if the father is unknown, some couldn't enrol in the national health insurancedue to lack of citizenship.
4. There is a lack of understanding of human rights and no rights based approach in the health systemso WLHIV and sex workers are not treated fairly.
5. Harassment and violence from government authorities. There is no targeted desk in the gov ernment ensuring the rights of FSWs are upheld.
6. Corruption – need to pay bribes to be able to exercise our rights e.g. paying for citizenship/ birth certificates.

RECOMMENDATIONS

The following recommendations will need to be addressed in order for Nepal to contribute to global and national goals e.g. Sustainable Development Goals and 90-90-90 the national strategic plan for health

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The following recommendations will need to be addressed in order for Nepal to contribute to global and national goals e.g. Sustainable Development Goals and 90-90-90 the national strategic plan for health.

The following are crucial overarching recommendations which very strongly came out of the literature review and the community dialogues, what follows on are more in-depth actions which stakeholders can take to help address these overall recommendations. All of the action plans are connected and interrelated so should not be considered in isolation.

- Human Rights, including the right to sexual and reproductive health of all Nepali citizens is the same irrespective of their profession or health status. Health workers, government officials and society in general must uphold these human rights.
- Stigma as a depreciating label that society gives some groups and discrimination which is the, often harmful, enacting of stigma giving rise to devaluing of the lives of some compared to others is highly common particularly in health care settings but also in families and communities this prevents access to rights and services.
- The voices of the women themselves are reflected here and in order to address their needs effectively they must be ACTIVELY involve dat all stages from decision making to implemen tation, this also means that leaders are accountable to the people their represent.
- Integration of SRH and HIV is beyond PMTCT, itis an investment in the health system and will strengthen the overall health care for women, it is not a cost saving exercise but rather re quires specific investment and commitment from the Government of Nepal and all key stakeholders.
- A holistic patient-centred approach is critical to effective outcomes from these groups which also includes looking after their mental health, as a key component to any pro gramme.

The following recommended actions have been grouped according to who they are directed at, however all groups should read all of the recommendations since there will be overlaps and opportunities for synergies and working together.

By 2020, 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy. By 2020, 90% of all people receiving antiretroviral therapy will have viral suppression. UNAIDS

ACTION PLAN FOR THE HEALTH SYSTEM

1. Sensitisation on the right to health (of marginalised groups e.g. FSW,WLHIV) should be a part of basic training and in-service training for all Health care workersin cluding Female Communi ty Health Volunteers, midwives and include social aspects as well as medical.
2. *E*nsure that marginalised groups are included in the development and implementation of broader screening programmes e.g. Cervical and Breast cancer. In the case of cervical can cer this should be particularly targeting for WLHIV where the risk is higher.
3. Financial investment*,* e.g. at the level of service provision there is need of investment so that facilities can provide a greater range of services, and guarantee confidentiality of FSWs and WLHIV.
4. *Implementing comprehensive and* integrated SRH and HIV programmes to meet the health and rights of WLHIV, FSWsrequires initiatives that overcome barriers to service uptake, use and continued engagement. Strategies are needed across the health system to improve the accessibility, acceptability, affordability, uptake, equi table coverage, quality, effectiveness and efficiency of health services.
    a. Establish a multi-sectorial working group consisting of Ministry of Health, Family Health Division, Nepal society of obstetricians and gynaecologists (NESOG), Civil Society Organ izations and community representatives etc to give direction and oversight to the pro cess of integrating services and ensure there are political commitment and a collective re sponse. (This group would be replication across the 7 provinces).
    b. Advocate for SRH and HIV integration within Government health systems, health provid ers and private sectors and therefore increase funding/good will for integration.
    c. Develop guidelines for integration of HIV and SRH services.
    d. Establish technical hubs to provide locally relevant expert input into integration efforts.
    e. Task shifting/sharing needs to be considered especially at primary care level. E.g. specific guidelines for CHBC services to provide SRH services to their clients, linking FCHV to CHBC services.
    f. Review of laboratory facilities to ensure they meet the needs of integration.
5. National treatment guidelines must be updated to reflect the 2017 WHO Consolidated guideline on the SRHR of women living with HIV .
6. Stigma free, confidential, easily accessible and free SRH services which are sensitive to the needs of FSWs and WLHIV and their children, putting the patient at the centre of the treatment and care.
7. A comprehensive and sensitive counsellingservice (including partner counselling) should be availa ble to FSWs and WLHIV both through government medical facilities but also FSW / WLHIV organisations.
8. Family Planning
    a. Access - good quality condoms should be available 24 hours in hospitals for every one. All contraceptive tools should be available free of cost in every health site. Long-term family planning should be more easily available.
    b. Information - A comprehensive programme providing information (both for FSW and WL HIV) about what contraceptives are available and where, as well as counselling about appropriate options should be widely available. This could be part of a broader health pro gramme including screening camps for STIs, pregnancy, HIV, cervical cancer, contracep-

tion etc.

9. *WLHIV, FSW, FWUD (female who use drugs), young key affected population should also have easy access to all the contraceptive tools and safe abortion services without question or judgement.*
10. Safe motherhood
    a. Available services should be equipped to understand the specific needs of WLHIV and FSWs reducing current additionalfinancial burden.
    b. Improved labour and delivery services e.g.
        i. Counselling for those who have suffered a post partum trauma.
        ii. Hospital blood banks should provide services without discriminating to WLHIV.
    c. There gular free health checks for pregnant women, information and support about nutri tion during pregnancy, breast-feeding and beyond should be sensitive towards WLHIV and FSWs issue while maintaining their confidentiality.
    d. PMTCT programmes need to be strengthened and holistic, covering from conception, the whole pregnancy and the early years of the child. AZT prophylaxis for neonates must be available in syrup form (not tablet) to ensure effective take up.
    e. Ensure no stock outs e.g. ARVs, STI medicine.
11. Youth friendly services –both prevention and specific services for young women and girls living with HIV or young sex workers is essential. Health workers must be non-judgemental and sensitive to the sexual and reproductive health needs of young people including those engaged in transactional sex, drug use and those who are living with HIV. SRH services that are being provided should be tailored to these groups linking with HIV prevention, harm reduction and other programmes.
12. Fertility
    a. Tests to understand fertility issues should be free of charge.
    b. Treatment should be available at no cost to all women.
13. Abortion
    a. Remove barriers to WLHIV, FSWs, YKA Pand ensure services provided are free from stigma.
    b. There should be trained health worker for safe abortion, post abortion care in all health care posts.
14. Confidentiality(particularly in the government health system is a key issue for FSWs/WLHIV, YKAP) should be maintained to ensure utilisation of the available services.
15. There should be more ART centres e.g. at PHC level where treatment can be distributed but also where CD4, Viral Load and PCR machines are available. This would lead to more inte gration of SRH and HIV services.
16. Strengthen complaints procedures – and couch it in the context of constructive criticism, using patient feedback to build a stronger health system.

ACTION PLAN FOR LAW AND POLICY MAKERS (INCLUDING LAW ENFORCERS).

1. Ensuring equity of services: Everyone (including WLHIV, FSWs, YKAP) should get equal treat ment and this should be reflected in the law and in practice.
2. *There should be greater* alignment of HIV and SRH policies, strategies and budgets. Govern ment should be allocating a specific budget for SRH services targeting FSWs, WLHIV and YKAP.
3. Creating a safe environment where rights can be exercised:
   a. Government should bring new laws and policy for SRH of FSWs, WLHIV and YKAP.
   b. Create safe spaces where violence faced by FSWs, WLHIV and YKAP can report violence and seek assistance.
   c. Establisha legal advice centrein each district which gives appropriate legal advice to FSWs, WLHIV and YKAP (legal aid).
4. Law enforcers e.g. Police personnel should be sensitised to the situation of marginalised groups particularly FSWs, there is a need to work to change their attitudes. Those who abuse their power should be punished appropriately.
5. Ensuring everyone is able to exercise their humans rights by not denying those right e.g.
   a. Effective implementation of Right to birth certificate and citizenship of children through sole identity of mothers.
   b. The government of Nepal should lobby for the lifting of travel restrictions for people living with HIV e.g. to countries in the Middle East.
   c. In the case of polygamy, all wives should also have equal rights.

ACTION PLAN FOR EDUCATORS

1. Relationship education, sexual health, family planning, abortion, safe motherhood, and should be included in the school curriculum under a comprehensive sexuality education package.
2. All health workers and counsellors / educators sensitized on the issues facing FSWs and WL HIV to enable the provision of a safe stigma free environment where they can access SRH services without hesitation or prejudice towards them or their children.
3. Creating adolescent friendly environments where SRH issues facing young people can be openly discussed amongst peers but also with elders.
4. Children and young people living with HIV should be treated equally in school/college.
5. There should be child care provision for women who do not have family support and/or are single mothers.

ACTION PLAN FOR CIVIL SOCIETY

IT IS INCUMBENT ON THIS GROUP TO BE AWARE OF ALL OF THE ACTIONS MENTIONED THROUGHOUT THIS DOCUMENT SINCE IT IS CIVIL SOCIETY WHO MUST HOLD THE OTHERS ACCOUNTABLE FOR THEIR ACTIONS. IN THE SHORT TERM THE ROLE OF CIVIL SOCIETY IS TO BUILD THE RESILIENCE OF THE COMMUNITIES TO WITHSTAND STIGMA, DISCRIMINATION AND GIVE MORE SELF-ESTEEM AND CONFIDENCE SO THAT WOMEN CAN MAKE DECISIONS BASED ON ACCURATE INFORMATION. IN THE LONG TERM IT IS ABOUT ERADICATING STIGMA, DISCRIMINATION AND ENSURING WOMEN ARE ENABLE TO EXERCISE THEIR RIGHTS AND MAKE INFORMED, AUTONOMOUS DECISIONS AND CHOICES ABOUT THEIR LIVES, BODIES AND FUTURES.

1. Build the capacity of CSOs to access local funds: ensuring good technical knowledge and clear advocacy strategies to tackle technical issues and gaps in the SRH services they re ceive.
2. Community awareness programmes to reduce discriminatory attitudes towards WLHIV and FSW highlighting how human rights should also be respected including their right to sexual and reproductive health.
3. Provide a comprehensive and sensitive counselling service (including partner counselling) to FSWs and WLHIV.
4. Ensure that the integration of SRH and HIV services involves WLHIV, FSWs, YKAP from the out set to ensure the best possible outcomes from a community perspective, ensure there is meaningful representation on the CCM and the Reproductive Health Working Group (RHWG) etc.
5. Extensive age-appropriate SRHR capacity building training package and awareness pro gramme for FSW and WLHIV which could include the following components:
   a. An antenatal course to prepare pregnant women and their husbands, partners and families for the delivery and early childcare including around PMTCT and early infant diag nosis for both WLHIV and FSW.
   b. Increase public awareness on pregnancy, family planning, abortion, safe motherhood recognising that each woman's needs are different.
   c. Tailored courses for women in all our diversity and their family members and partners about safe abortion, sexual pleasure, safe motherhood, infertility and child care according to their specific situations.
   d. Eradicating prejudiced thinking and patriarchy from society through massive awareness activities e.g. street drama.
   e. Skills and livelihood training to generate income sources for women from these marginal ised groups.
   f. Practical self-defence training for women.
   g. Training of training *and peer counselling training so there are people within the community who can cascade information, skills and give advice.*

h. *Establish a community led programme for* older women *including provision of appropriate SRH services and income generating activities. Working with other established organi sations e.g. Aamasamuha (mother's group)*

6. An extensive Human Rights capacity building training package for FSWs and WLHIV which could include the following components:
   a. Accessing government and NGO support e.g. single woman allowance and free education for their children.
   b. Overcoming human rights abuses
      i. Getting citizen and birth certificates for themselves and their children.
      ii.Treatment literacy
      iii. Getting legal advices to challenge abuses
      iv. Engaging with law enforcers and the legal system
   c.Income generation support and motivation for women and their families.
7. There should be more research into the lives of the children of FSWs, Children living with HIV to better understand their SRH and other needs.
8. Greater awareness of the diversity of women and promoting their autonomy.
9. Greater social inclusion and acceptance of 'marginalised groups'.

References for further reading

- National HIV Strategic Plan 2016 - 2021 NCASC
- Nepal Health Sector strategy 2015 - 2020
- National Family Planning Costed Implementation Plan 2015-2020 FHD and UNFPA
- Hormonal contraceptive eligibility for women at high risk of HIV
- Guidance Statement WHO
- National safe motherhood and newbornhealth long term plan 2006- 2017 FHD
- Rapid Assessment of Sexual and Reproductive Health and HIV Linkages in Nepal FPAN and FHD
- Sexual and reproductive health and HIV/AIDS: a framework for priority linkages WHO UNFPA UNAIDS and IPPF
- WHO Consolidated guideline on sexual and reproductive health and rights of women living with HIV, http://apps.who.int/iris/bitstream/10665/254885/1/9789241549998-eng.pdf
- Health and Human Rights Journal, In Women's Eyes - Key Barriers to Women's Access to HIV Treat ment and a Rights-Based Approach to their Sustained Well-being https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5739367/
- WHO recommendations: intrapartum care for a positive childbirth experience
- "Building a safe house on firm ground: key findings from a global values and preferences suvey regarding the sexual and reproductive health and human rights of women living with HIV
- Sexual health and its linkages to reproductive health: an operational approach WHO.

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FRIENDS AFFECTED AND INFECTED TOGETHER IN HAND (FAITH)