Terms of Reference (TOR)

Comprehensive Package for Migrants and their Spouses

Background:

1. Nepal has a population of 26.5 million with 1.35 annual growth rates[1]. In 2013, the estimated number of people living with HIV was 40,720 and the adult HIV prevalence was estimated to be 0.23[2]. Almost 50% of people living with HIV and AIDS are located in the Terai highway districts, bordering India. The epidemic in Nepal is driven by injecting drug use and sexual transmission, and is categorized as a "concentrated epidemic". Based on the geographical spread of HIV, risk behaviour and other factors increasing vulnerability to HIV, Nepal has four epidemic zones: i) Kathmandu valley (3 districts); ii) Terai region - the highway districts (26 districts) – a trucking route running the length of the country; iii) the Far Western hills districts (7) – origin of most Nepali migrants into India; and iv) remaining 39 mountainous, remote districts.

2. As of July 2014, a total of 25,222 HIV positive cases had been reported to the National Centre for AIDS and STD Control (NCASC). A large proportion of all reported HIV infections are among male labour migrants (16%), male clients of female sex workers (3%), IDUs (7%), MSM (11%) and FSW (2%) and 30% are among rural women who may be wives or partners of HIV positive men[3]. Thus, Nepal's epidemic is concentrated among the key affected population. HIV transmission seems to be occurring within these groups or networks of individuals who have high levels of risk due to higher number of concurrent partners or sharing of needles or both. It is imperative to focus on the KAPs for prevention of HIV in Nepal.

3. As per recent IBBS findings, HIV prevalence among migrants and wives of migrants is as follows:

MARP	2006	2008	2010	2012
Returned Migrants (West & Mid - Far West)	West= 1.1% Far West= 2.8%	West= 1.4% Far West= 0.8%	West:1.4	West:1.1 Farwest:1.4
Wives of Migrants (4 districts F. West)	-	3.3%		

[1] CBS. Nepal in Figures, 2013
[2] NCASC, 2013
[3] NCASC

4. Integrated Bio-Behavioural Survey (IBBS) data show that 52.5% of young males in the West and 58.6% in the Mid-Far West migrate before the age of 20[4]. Recent data also show that around 18% of migrants engage in unprotected sex in India (never used condoms with FSWs in the past year) and as a result, this group now accounts for 40% of all HIV infections in Nepal with HIV cases also increasing among wives and partners. While HIV prevalence in migrants has remained relatively low in 1.1% (West) and 1.4% (Far West), prevalence in wives of migrants in the Far West is 3.3% and improvements in strategies to prevent secondary transmission from HIV positive migrants are crucial. Prevention coverage is low among migrants and their wives as is comprehensive knowledge and condom use compared to other MARPS.

5. **Not all migrants are at risk**, so it is important to clearly define and target those migrants who are at risk for HIV infection (e.g. migrants to high HIV prevalence districts in India).

6. Targeted interventions (TI) are a resource-effective way to implement HIV prevention programs in settings with concentrated HIV epidemics. Targeted interventions are aimed at offering prevention and care services to specific populations within communities by providing them with the information, means and skills they need to minimize HIV transmission and improving their access to care support and treatment services. The best-designed programs also improve sexual and reproductive health and improve general health. Implementing TIs does not negate the need for broader interventions in the community. In many settings, it optimizes the use of resources by focusing on the environments and populations in which the risk of HIV infection is the greatest. Targeted interventions:
    - Are for people within the community who are most at risk of HIV infection, and involves them in service delivery.
    - Are adapted to be culturally and socially appropriate to the target audience.
    - Focus limited resources on the most cost-effective interventions and where they can be used to the best benefit.
    - Effectively use the language and culture of the people at the centre
    - Acknowledge that barriers to accessing health-care services exist for some populations within communities.
    - Acknowledge that people who are at risk of HIV infection are often marginalized from the broader community, stigmatized and discriminated against.

7. The Government of Nepal (GoN) has decided to continue TI activities in order to scale up coverage and quality of HIV and AIDS prevention interventions targeted at Key Affected Population (KAP). The GoN intends to apply a portion of these funds to contract the services of qualified NGO/organization for the delivery of a defined package of services for migrants aimed at controlling and preventing the spread of HIV through safe sex, including condom promotion, peer education, treatment of sexually transmitted infections (STI) and voluntary testing and treatment services.

[4] IBBS 2012 among Male Labour Migrants in 11 Districts in Western and Mid to Far-Western Regions of Nepal.

8. The government intends to contract an organization to provide the package of services for FSWs in all identified districts. However, the selected NGO can subcontract other NGOs/community-based organizations in order to ensure effective reach in each of the identified districts.

9. The four (4) months contract will cover at least in the following twenty districts: Morang, Sarlahi, Dhanusha, Parsa, Kavre, Kaski, Syanja, Surkhet, Salyan, Bardiya, Jajarkot, Rukum, Kailali, Kanchanpur,, Kalikot, Bajura and Darchula, Rupandehi, Tanahun and Kathmandu. Additional two districts will be decided later. The contract will be a time based contract and output based rather than focused on inputs. The selected organization(s) will have considerable autonomy in deciding service delivery mechanisms to achieve project objectives. Payments will be made primarily on the success of the organization(s) in making progress towards the process indicators specified in Table 1 below. Sources of data for judging progress will include the management information system. Achievement of results on the ground will be considered of primary importance. The National Center for AIDS and STI Control (NCASC) of the Ministry of Health and Population, Nepal will work closely with the National Centre for AIDS and STD Control (NCASC) to start the contracting of organizations for delivery of the targeted interventions for most at risk populations, as part of the essential services of the health sector. NCASC will manage program activities. If the budget is available for the remaining period of the F/Y 2072/073 the contract period may extend.

10. **Objectives.** The objective of this contract is to control and prevent the spread of HIV in migrants and their spouses in Nepal. The contractor(s) will deliver a defined package of services described in the subsequent paragraphs. The work will be done in coordination with the NCASC during contract execution. Services will be implemented in accordance with written guidelines.[5]

11. The objectives to be achieved are that: i) 80% of migrants at risk in Nepal are reached with prevention interventions; ii) HIV prevalence among labour migrants will be reduced to 0.5 %.

12. **Scope of Services for Migrants and their spouses**. The implementing NGO will provide the following package of services to high risk migrants and their spouses taking into account source, transit and destination locations. It will prepare annual work plan to implement these services:

    - Increase safer sex practices and improve health care seeking behaviour through behaviour change interventions using outreach workers and drop in centres
    - Provide syndromic STI case management services based on updated national guideline through static and mobile clinic.
    - Provide HIV testing and counselling using updated national guidelines through static and mobile clinic.

[5] National Targeted Intervention Operational Guidelines, 2010, NCASC, Ministry of Health and Population, Nepal

- Condom programming /ensure availability of condoms (no stock-outs).
- PLHIV health care service linkage
- Promote an enabling environment and reduce stigma against migrants and their spouses

Below each of these services are described in detail. The design of the interventions will be continued with modification based on the experience the ongoing Pooled Funded migrant component intervention.

12.1 Implement behaviour change communication interventions at source and transit points to increase safer sex through an outreach program.

- Develop a pre-departure orientation program to meet health and safety needs of migrants and potential migrants.
- Hire and train outreach workers. Include returning/ed migrants, spouses of migrants and PLHIV with a minimum qualification and experience.
- Train outreach workers to build skills of migrants in proper condom use and disposal, HIV awareness, STI & HTC knowledge and recognition skills.
- The materials and activities should include education on condom and skills, sexual health and STIs and HTC. Educational and skills building material should be adopted for BCC.
- Develop mobile information booths for use at or near bus stations.
- Review and revise strategies and activities based on project implementation experience, behavioural surveillance results and in light of issues raised during review.

13.2. Provide health care services focused on prevention and care of STIs

- Provide a selected set of primary health care services including for syndromic STI infections to migrants and their spouse through static and mobile clinics.
- Provide services including syndromic case management of STIs, distribution of condoms, health education and counselling, etc.
- Regularly review and monitor the quality of services for STIs used by the migrants in the project area, using mystery clients, exist interviews and support the improvement and maintenance of quality services
- Link services for STIs with referral to specialist services

13.3 Provide access to HIV Testing (HTC) services

- Provide HTC services to migrants and their spouses through static and mobile clinics.
- Sensitize staff at existing HTC centres towards the needs of migrants and their spouses

- Monitor the experience of migrants in accessing HTC services, and take remedial action in improving HTC educational activities and testing facilities
- Refer/accompany HIV positive cases to ARV treatment centres

13.4 Provide condom and skills in use and negotiation

- Ensure that condoms easily available in the project area
- Promote condom use through free distribution of condoms through condom outlets, outreach workers, static and mobile STI/HTC clinics.
- Provide skills in condom use and disposal through outreach workers and include in materials developed for behaviour change intervention
- Review and revise condom education and distribution activities based on project experience and behavioural surveillance results

13.5 Promote an enabling environment to reduce stigma and support program implementation

- Identify potential groups or individuals who could hinder progress of project. Develop a plan to promote a more positive environment for HIV prevention activities among migrants and their spouses specifically tackling stigma.
- Undertake advocacy and educational activities to improve understanding of local police officials and other community members towards the importance of working with migrants for HIV prevention.
- Include anti-stigma messages in media campaigns
- Monitor harassment and violence against PLHIV by police and other local power brokers and take action as needed

13.6 HIV awareness and publicity to migrants going to abroad via Kathmandu international airport

- Develop a pre-departure orientation program to meet health and safety needs of abroad migrants
- Mobilize outreach workers to orient abroad migrant in Tribhuvan international airport
- Develop/update/revise the HIV component in the orientation package by collaborating with concerned department of GoN
- Educational and skills building materials to abroad migrants adopted for BCC.
- Develop mobile information booths for use at International Airport.

14 **Staffing:** In addition to program staff, the NGO will be required to have at least the following full time managerial staff on their payroll: Project Manager; M&E Officer, Admin/Finance Officer and Training Officer.

15 **Monitoring:** The implementing NGO(s) will provide the progress reports against the process indictors defined in M & E Matrix. In addition, NCASC will judge progress towards achieving the targets described M & E Matrix, by examining whether the NGO is demonstrating progress towards accomplishing milestones described below. Any

decision to terminate the contract or take other remedial action, specified in the contract will be based on past progress of the NGO, the existence of extraneous constraints, challenges, or impediments, a summary of all available quantitative information, and the latest results of integrated biological and behavioural surveys.

16 **Milestone** by the end of the first one month:

i) All project staff have been recruited and trained in the basic principles of HIV interventions for migrants and their spouses;
ii) Specific staff member is delegated and trained to conduct advocacy for an enabling environment; an advocacy program is begun with police or other important gatekeepers;
iii) At least a few returned migrants regularly advise project staff or are included on the staff in a defined position that contributes to decision-making;
iv) Basic infrastructure, i.e. transportation and main office, are completed;
v) Criteria for recruitment of all program staff including peer educators and outreach worker/peer educator manuals will be adopted.
vi) Specific staff member is delegated and trained for M&E; needed computer programs are installed and operating;
vii) Knowledge and skills in the technical aspects of STI management and HTC for migrants are improved with appropriate technical assistance;
viii) Infrastructure, i.e. computer programs, clinics, safe spaces, drug supplies, are secured and operating;
ix) Outreach worker and Peer Educator training has begun with required number of outreach workers and peer educators;
x) All staff are trained in the principles and practices of behaviour change interventions and non-discrimination, including medical staff and auxiliary staff, such as drivers; this training should include issues relating to empowerment and social inclusion;
xi) Materials (printed, video, audio, musical, etc.) used in discussions among migrants and their spouses are adopted.
xii) M&E framework completed, including indicators for coverage, exposure to intervention and changes in safer sex behaviours, STI treatment seeking behaviours, quality of STI care and effectiveness, of advocacy for an enabling environment

17 **Compliance with National Guidelines** The executing NGO (and its subcontractors) will follow the MoHP/NCASC's National Targeted Intervention Operational Guidelines for Migrants, Volume 5 for delivery of services to migrants and their spouses.

18 **Facilities that will be provided by the Government:** The Ministry of Health, through the NCASC will provide the following facilities to the successful NGO during the execution of the contract:

- Results of surveys including IBBS.
- Results of Mapping Studies of high risk migrants

- Updated national guidelines for management of STIs, HTC and testing standards and ethnical guidelines
- Standard recording and reporting formats – to be developed through mutual consultation
- Authorization from the government to work with migrants
- Copies of key reports and related research
- Access to public sector health services
- Access to public sector HIV testing facilities
- Access to ARV treatment centres
- Condoms, Test Kits and STI medicine will be supply from NCASC or D (P) HO.

19 **Accountability and Working Relationship:** The NGO will be accountable to the NCASC for the satisfactory delivery of the services defined here. They will work in close collaboration with the other relevant development partners, and other NGOs working with migrants and their spouses.

REPORTING REQUIREMENTS

The Consultant shall submit reports to the Client as follows:

- Submit monthly testing and counselling (T&C), HIV case report and STI report by 7th of succeeding month (Nepali calendar).
- Submit bi-monthly progress report and financial report by using the standard reporting format 10th of succeeding month (Nepali calendar).
- Share copy of each report with DACC of respective districts.
- Submit final report within 1 month of project completion.

In addition, the following are required:

(i) The NGO's staff (including peers educators or outreach workers) will maintain a daily log of their activities in sufficient detail to allow a review and assessment by the supervisory personnel of the quality of services, both internal and external;

(ii) The number of clients per day using the services and the regularity of clients in using services

(iii) Maintenance of stock registers to allow monitoring and reporting of stock-outs of essential commodities

(iv) Maintenance of a register of patients at the drop in centre and for HTC services in sufficient detail to allow data analysis and its interpretation, but keeping confidentiality of records from persons not related to program management and implementation

(v) Maintain income and expenditure statements of the project proceeds for external annual financial audit, and provide copy of the audit report to the client or its representative within three months after the completion of a fiscal year. The financial audit will be used solely to determine whether the organization is financially viable.

(vi) Preparation of progress reports to NCASC will be as follows :

- Progress made against the agreed work plan
- Submit reports as per reporting requirements.
- Challenges encountered and options used to resolved them
- Relations with stakeholders like IDUs, local police and community leaders