

**Addressing sexual and reproductive health rights and
needs of women living with HIV in Nepal**

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ADDRESSING SEXUAL AND REPRODUCTIVE HEALTH RIGHTS AND NEEDS OF WOMEN LIVING WITH HIV IN NEPAL

**A thesis submitted in partial fulfilment of the requirement for the
degree of
Master of Public Health**

**BY
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Declaration: Where other people's work has been used (either from a printed source, internet or any other source) this has been carefully acknowledged and referenced in accordance with departmental requirements.

The thesis "Addressing sexual and reproductive health rights and needs of women living with HIV in Nepal" is my own work.

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Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
APN+	Asia Pacific Network of People Living with HIV/AIDS
ART	Antiretroviral Therapy
CBO	Community-Based Organisation
DFID	Department for International Development (UK)
EDP	External Development Partner
FHD	Family Health Division
FHI	Family Health International
FP	Family Planning
FSW	Female Sex Worker
GFATM	The Global Fund to Fight AIDS, Tuberculosis and Malaria
GNP+	The Global Network for and by People Living with HIV
HIV	Human Immunodeficiency Virus
HTC	HIV testing and counselling
KP	Key Population
LGBTI	Lesbian, Gay, Bisexual, Transgender and Intersex
MoHP	Ministry of Health and Population
MSM	Men who have Sex with Men
NCASC	National Centre for AIDS and STD Control
NDHS	National Demographic Health Survey
NFWLHA	National Federation of Women Living with HIV and AIDS
NGO	Non-Governmental Organisation
NHIP	Nepal HIV Investment Plan 2014-2016
NHSP	Nepal Health Sector Programme
NSP	National HIV Strategy Plan
PLHIV	People living with HIV
PMTCT	Prevention of Mother to Child Transmission
PWID	People who Inject Drugs
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infection
SW	Sex Worker
UN	United Nations
UNAIDS	United Nations Joint Programme on AIDS
UNDP	United Nations Development Programme
USAID	United States Agency for International Development
WHO	World Health Organisation

Abstract

Background

Women living with HIV (WLHIV) like women in general are equally entitled to their sexual and reproductive health rights (SRHR) and requires additional support during their reproductive life due to HIV. Nepal is yet to acknowledge WLHIV's SRHR using rights based approach.

Objective

To identify SRHR and needs of WLHIV, factors that affect their accessibility of SRHR and services in Nepal so as to provide recommendations to National Centre for AIDS and STD Control, Family Health Division to improve their quality of life.

Methodology

Literature review and analysis on WLHIV's SRHR and services from Nepal and other low to middle income countries was carried out using a socio ecological framework.

Findings/Results

SRHR of WLHIV have been continuously violated and the following influencing factors were identified: intrapersonal such as low information about SRHR; interpersonal like poor attitude and behaviour from family, reinforcement from support groups; institutional like poor attitude and behaviour of health care providers; community like gender biases; policy like challenges in national law, policies and strategies.

Conclusion

Nepal needs to address WLHIV's SRHR in law, national HIV and FP strategies and implement SRHR programmes with a rights based approach to improve the SRHR of WLHIV.

Recommendations

Strategies like country-specific SRH/HIV integrated programme, inform WLHIV about SRH rights, train health care providers about SRHR and needs, sensitising families and communities on SRHR have potential to improve accessibility of SRHR of WLHIV.

Key words

HIV, WLHIV, SRHR, pregnancy, Nepal.

Word count: 11478

Introduction

I have been working in the field of HIV since 2005 as programme manager in a national NGO called Friends Affected & Infected Together in Hand (FAITH). It is an organisation advocating for the rights of marginalized and vulnerable communities including People Living with HIV (PLHIV), People who inject drugs (PWID), Lesbian, gay, bisexual, transgender and intersex (LGBTI), Female sex workers (FSW), migrant workers and their spouses.

In Nepal, it was estimated that more than one-third (34%) of infections are in women, out of which around 92.2% are in the reproductive age group (15-49 years) in 2013 ⁽¹⁾. The latest 2013 estimates also indicated that out of the total estimated PLHIV, the population group of females from general population accounts for 30% of the total infections ⁽¹⁾. HIV is becoming more of a chronic disease with availability of antiretroviral treatment (ART). It is natural that PLHIV want to have children, to have choice for family planning methods to avoid unintended pregnancy, unsafe abortion and ensure birth spacing.

My dissertation topic is sexual and reproductive health rights and needs of WLHIV in Nepal. I am interested in this topic because during my work, I have witnessed that WLHIV want to but feel guilty for wanting to get (re)-married, to have sex and wish for children like any other women. Their most trusted people like other PLHIV, support groups, counsellors also do not acknowledge, provide complete information and support their sexual and reproductive health rights and needs.

Hence, this thesis will help identify influencing factors for WLHIV to exercise their sexual and reproductive health rights. It will provide recommendations to the responsible government agencies like National Centre for AIDS and STD control (NCASC), Family Health Division (FHD) and other relevant stakeholders to support and create an enabling environment for WLHIV to address their SRHR and needs.

Chapter 1: Background information of Nepal

1.1 Country Profile

Nepal shares its border with India to the east, south and west and China to the north and is spread over 147,181 square kilometres ⁽²⁾. Topographically, there are three ecological zones: mountains, hills, and Terai. For administrative purposes, it is divided into five development regions: Eastern, Central, Western, Mid-western and Far western. (See Annex 1 – Map of Nepal)

Table 1: Population characteristics of Nepal

Estimated population	26.6 million
Population density	181 per square km
Sex composition	Males: 14133942 (50.16%) Female: 14043512 (49.84%)
Age structure	Less than 15 years: 39% 15-49 Years: 47% of males and 49.23% of females (in 2001)
Life expectancy at birth	64.1 years

Source: *Nepal Population Report 2011* ⁽³⁾

1.2 Economy

According to the Nepal Living Standard Survey, 2011, nearly one-fourth of the population lives below the poverty line ⁽⁴⁾. 76% of households are involved in agriculture sector ⁽⁴⁾. Remittance is the foremost sources of income as nearly 56% of households are receiving some sort of remittance ⁽⁴⁾. Around 62% of urban residents and only 14% of rural residents are from the richest quintile ⁽²⁾. The majority of employed married women are engaged in unpaid regular household chores and agriculture work ⁽²⁾. Restrictions in women's mobility limit their ability to leave home for work. Three-quarters of cash-earning women earn less than their husband ⁽²⁾.

1.3 Education

41% of women and 20% of males i.e. one in five men and about two in five women have never attended school ⁽²⁾. 40% of women compared to 14% of men aged 15-49 have no education ⁽²⁾. 79% of women from the highest wealth quintile and only 45% of women in the lowest wealth quintile have some educational attainment ⁽²⁾.

1.4 Socio-cultural norms and gender roles

Nepal scored 0.499 in the Gender-related Development Index and 0.509 in the Human Development Index ⁽⁵⁾. Gender-based discrimination is extensively reported to be a social phenomenon in the deeply rooted

patriarchal system. The sub-ordinated role of women in family is emphasized by the social, cultural norms and gender roles. For example, 54% of currently married women do not participate in decisions pertaining to their own health care, major household purchases and visits to their family or relatives ⁽²⁾. The 2006 NDHS reported that 23% of women and 21% of men believed that a husband is justified in hitting or beating his wife for at least one of five specified reasons such as; burning food, arguing with him, going out without his permission, neglecting children and refusing to have sex with him ⁽⁶⁾.

1.5 Health services and health situation

The government health service operates at national, regional, zonal, district levels and below like primary health care centres (PHCCs), health posts (HPs) as well as at community level. HP is the first contact point for basic health service. Referrals are made to each level above the HP to PHCC and to district, zonal and regional hospitals and to specialty tertiary care centres in Kathmandu ⁽⁷⁾. A total of 126 public hospitals, 208 Primary Health Care Centres (PHCCs), 1,559 Health Posts (HPs) and 2,247 Sub Health Posts (SHPs, converting slowly into HP) and 12,618 Primary Health Care/outreach Clinics (PHC/ORC) ⁽⁸⁾ are available in Nepal. Out of the total National budget, 5.89% was allocated for the health sector in the fiscal year 2013/14 ⁽⁸⁾. The health sector is struggling with inability to absorb the limited available budget, shortages of adequately trained personnel, underdeveloped infrastructure, poor public sector management and weak intra- and inter-sectoral co-ordination ⁽⁷⁾.

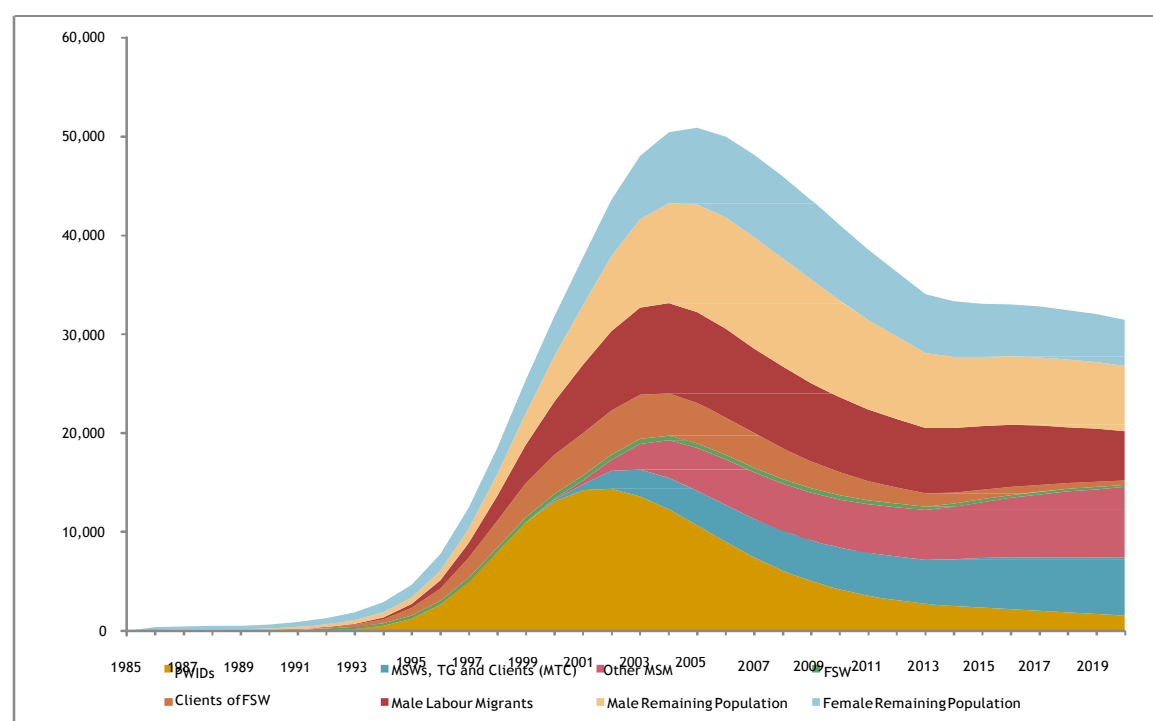
In Nepal, neonatal deaths, cancer and suicide are the top three leading causes of mortality whereas Acute Respiratory Infection, gastritis, Enteric Fever are leading causes of morbidity ⁽⁷⁾. Nepal health sector programme II has prioritized health programmes and it includes HIV and family planning programme.

a. The Family health division (FHD) is responsible for implementing reproductive health and population related activities ⁽⁹⁾. The family planning programme addresses the unmet need for FP among adolescents, residents of rural and hilly areas mainly in the eastern and western region, poor communities and unexpectedly educated groups. ⁽¹⁰⁾ The median age at first marriage for women is 17.8 in 2011 ⁽²⁾. The contraceptive prevalence rate (CPR) is 49.7% for any method, 43.2% for modern method and only 4.3% for condoms in 2011. The CPR has stagnated since 2006. The total fertility rate (TFR) is 2.6 births per woman in 2011. Two-fifths of pregnant women still are not receiving ANC services from skilled providers and two-thirds are not getting skilled attendance for delivery ⁽²⁾.

b. The National Centre for AIDS and STD Control (NCASC) is responsible for HIV and sexually transmitted infection (STI) control programme ⁽¹¹⁾.

Its target is to achieve universal access to HIV prevention, treatment, care and support. It aims to halve the incidence of HIV by 2016 from the 2010 baseline (including the reduction of new HIV infections in children by 90%) and reducing AIDS - related deaths by 25% ⁽⁹⁾. The estimated HIV prevalence among 15-49 years is 0.23% in 2013 with around 40,000 people living with HIV and out of which women accounted for 30% ⁽¹²⁾. Even though HIV prevalence among the general population is below 1%, it is above 5% among certain key population like People who Inject Drugs (PWID), Men who have Sex with Men (MSM), Transgender People, Female Sex Workers (FSW), Male labour migrants and their families ⁽¹²⁾ (Figure 1).

Figure 1: Distribution of Estimated HIV Infections by Sub-Population Groups, 1985-2020



Source: *Country Progress Report on HIV Response Nepal, 2014* ⁽¹²⁾

Chapter 2: Problem statement, Justification, Objectives and Methodology

2.1 Problem statement

Studies conducted in Asia and Nepal showed that sexual and reproductive health rights (SRHR) of women living with HIV (WLHIV) is continuously violated due to their HIV status, which has negative consequence in their overall health outcomes ^{(13) (14)}.

The UN International Conference on Population and Development (ICPD), in Cairo, 1994, recognising the SRHR of an individual, incorporated the rights to make informed choices about their sexuality and reproduction, access to SRHR information and appropriate high quality SRH services catering for needs; to use services with privacy and confidentiality, and to be treated with dignity and respect, freedom of individuals reproductive decision-making; freedom from discrimination, forced abortion and gender-based violence ⁽¹⁵⁾. WLHIV like any other women are equally entitled to every right concerning their SRH and require additional support during their reproductive age due to HIV ⁽¹⁶⁾.

A quantitative study on access to reproductive and maternal health care for WLHIV in six Asian countries (including Nepal) conducted by the Asia Pacific Network of People Living with HIV (APN+) ⁽¹³⁾ showed that despite international declarations to protect women's rights, many WLHIV experience extreme levels of discrimination and violations of their rights in relation to their sexual, reproductive and maternal health, including coercion into abortion and/or sterilization by family and health care workers. For example, condom is the only contraceptive promoted as dual contraceptive methods¹ creating an unmet need² for IUDs, pills and injectable. The lack of such contraceptives leads to unintended pregnancy and possible abortion specifically because of their status. WLHIV who want children have a challenging time finding a gynaecologist, some do not reveal their HIV status to health providers due to fear of discrimination and those who did so are unsatisfied because of breaches of their confidentiality. They are neglected and discriminated from maternal health care workers during child delivery and choice of delivery is utterly limited. Due to their HIV status, sterilization is recommended and also performed without their consent by health workers. Apart from this, many faced discrimination and violence at home due to status disclosure ⁽¹³⁾.

¹ Dual contraceptive method defined as use of condom to prevent STIs including HIV coupled with short or long-term (non condom) reversible contraceptive or sterilization to prevent pregnancy ⁽¹⁷⁾.

² Unmet need defined as women who are fecund and sexually active but are not using any method of contraception, and report not wanting any more children or wanting to delay the next child ⁽¹⁸⁾.

In Nepal, the HIV epidemic is largely driven by sexual transmission, which accounts for more than 4 of every 5 infections ⁽¹²⁾. WLHIV are heterogeneous coming from various backgrounds. Out of the total 9,300 reported cases of WLHIV, 76% are spouses of KP, 12% are sex workers, 8% are girls under 15 years and remaining 4% are FWID, migrant workers and clients of sex workers ⁽¹⁹⁾. A study in Asia by Petrunej, Minichiello et al 2012 on contraceptive needs of key populations affected by HIV in Asia showed that women from key populations experience greater challenges and barriers in terms of exercising their SRHR ⁽²⁰⁾. WLHIV face a double burden of stigma and discrimination especially when it comes to accessing sexual and reproductive health rights and related services ⁽¹³⁾.

2.2 Justification

Nepal like many other Asian countries has a concentrated HIV epidemic³ hence the country's HIV policy, strategies and programmes focuses more on HIV prevention among KP with limited attention given to the SRH rights and needs of WLHIV ⁽¹²⁾. Global efforts in addressing SRH rights and needs of PLHIV have been limited in Asia in comparison to Africa ⁽²⁰⁾.

There are limited peer reviewed journals and materials/resources on SRHR of WLHIV in Nepal. This study seeks to fill the information gap in the area of WLHIV SRHR and needs, their health and that of others (children, partners) and its benefits to the national health system. The findings will be made available to the MoHP, NCASC and FHD together with recommendations, which can guide these responsible government agencies in designing national strategies and interventions aiming to address SRH rights of WLHIV in Nepal.

2.3 Objectives

2.3.1 General objective

To identify SRH rights and needs of WLHIV, contributing factors that affects accessibility to SRHR and services in Nepal so as to provide recommendations to the National Centre for AIDS and STD Control, Family Health Division and improve the quality of life of WLHIV.

2.3.2 Specific objectives

- Identify and discuss HIV trends among women worldwide and in Nepal.
- Identify specific SRH rights and needs of WLHIV.
- Identify and analyse influencing factors (from right holder⁴ and duty bearers⁵ perspective) for WLHIV to exercise their SRH rights and access SRH services.

³ HIV prevalence is above 5% in key populations and below 1% in the general population ⁽²¹⁾.

⁴ Individuals and groups with claims ⁽²²⁾

- Review evidence from international and/or county level programmes that have been effective in improving WLHIV SRH rights and access to services.
- Develop recommendations for the Ministry of Health and Population, National Centre for AIDS and STD Control, Family Health Division and other relevant stakeholders to improve policy, strategies and interventions addressing SRH rights of WLHIV and for further research.

2.4 Research methodology

The research methodology is a secondary literature review. Literature published from year 2005 till 2015 in Nepali and English language is used.

Table 2: Search Strategy

Search strategy	Objective 1	Objective 2	Objective 3	Objective 4
	Key words			
VU library			Health HIV women's service, sexual reproductive health rights, women HIV, HIV pregnancy HIV, condom, abortion HIV, unintended pregnancy HIV, PMTCT, access SRH services HIV, gender HIV, policy HIV.	SRH/HIV integration interventions; SRHR HIV intervention, policy advocacy SRHR HIV women India
Pubmed				
Google Scholar				
Regular Google for grey literatures, websites of government like MoHP, NCASC, FHD; UN agencies like UNAIDS, WHO, UNICEF, UNFPA and other organisations like IPPF, GNP+, APN+, ICW.	HIV Incidence, prevalence Asia, Nepal; HIV annual report Nepal	Sexual and reproductive health rights women HIV; pregnant HIV		
Bibliography of selected articles				

2.5 Limitations of the study

- No primary data collection and analysis was done so this study is limited to information from already existing literature.
- Peer reviewed journal articles and studies on SRHR of women living with HIV in Nepal are limited.

2.6 Conceptual Framework

The study framework used is the social ecological framework ⁽²³⁾ developed by Kenneth, McLeroy, Bibeau et al in 1988 focusing both on individual and social environment factors for health promotion interventions. Other models like "the right to health" ⁽²⁴⁾, adopted by the UN committee on Economic, Social and Cultural Rights and "Andersen and

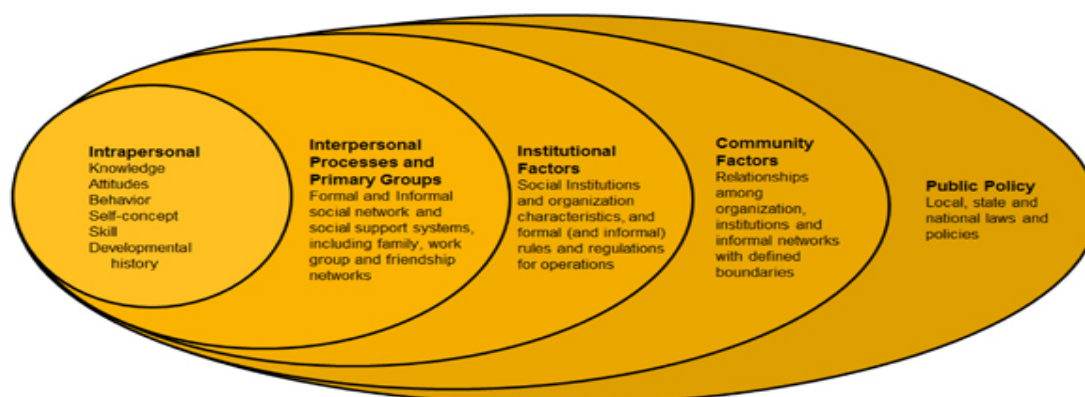
⁵ State and non-State actors with corresponding obligations. State actors refer to the government, while non-State actors include health service providers, husband, parents, religious leaders, elders, private sector companies or other parties that have obligations to rights-holders ⁽²²⁾.

Newman Framework of Health Services Utilization 1973”⁽²⁵⁾ were also considered to analyse the access of rights and service.

The social ecological model is selected as it detailed more factors, provides flexibility for sub-headings as per the needs of the study under the five main components and also includes factors mentioned in both models. The selected framework views rights violation as the outcome of interaction between factors at five levels — individual, interpersonal, institutional/organisational, community and public policy. It gives equal importance to the interaction of factors within a single level and between factors at different levels⁽²³⁾. The framework (as shown in Figure 2) is validated and has been used in a similar context in peer-reviewed journals and also by UN agencies like World Health Organisation (WHO).

- The individual factors, such as education, socio-economic status, health and rights information, knowledge, attitudes and behaviour influence how individuals behave and are likely to seek for their rights.
- The interpersonal factors, such as the influence of formal and informal social networks and social support systems, including intimate partners, family, and peers at the support groups are analysed. For example, if support groups do not discuss or support WLHIV sexual needs then it will be challenging for them to seek information on safer sex practices.
- The institutional and organisational factors include roles and national strategies of FHD and NCASC, distance to service centres, availability of services including equipment and other family planning related products, knowledge about SRH rights of WLHIV among health care service providers and their attitude towards WLHIV who seek SRH services is analysed.
- The community factor analyses informal networks within defined boundaries like gender, cultural norms and community groups.
- The public policies at national and global level that encouraged or inhibited rights violation of WLHIV is analysed.

Figure 2: The socio-ecological framework



Source: McLeroy KR, Steckler A, Glanz K and Bibeau D, 1988⁽²³⁾

Chapter 3: Overview of HIV trends among women

This chapter discusses HIV magnitude, trend and distribution among women globally, in Asia and particularly in Nepal.

According to the WHO, worldwide an estimated 35 million people were living with HIV (PLHIV) ⁽²⁶⁾ and nearly half (around 16 million) of them were women in 2013 ⁽²⁷⁾. *"This epidemic unfortunately remains an epidemic of women."* Mr Michel Sidibé, Executive Director of UNAIDS ⁽²⁸⁾. Around 1.5 million people have died of AIDS related illnesses in 2013 ⁽²⁶⁾. The United Nations Joint Programme on AIDS (UNAIDS) global HIV and AIDS factsheet 2014 shows that even though there has been decline in the number of new infections by 38% (down from 3.4 million) since 2001, still 2.3 million new HIV infections occurred globally in 2013 out of which 240,000 were children ⁽²⁶⁾. The same factsheet shows that in Asia and the Pacific in 2013, there were 4.8 million PLHIV with an estimate of 350,000 new HIV infections, which is a decline of 6% from 2005. Around 250,000 people have died of AIDS-related causes, which is a decline of 27% compare to the data from 2005. The treatment coverage is 33% and an estimated 3.1 million adults were still not on ART as per the WHO ART guidelines. Since 2009, this region has witnessed a decline in new HIV infections among children by 15% with 22,000 new infections in 2013 ⁽²⁶⁾.

Since 1997, Nepal has a concentrated HIV epidemic and the key populations (KP) are people who inject drugs (PWID), men who have sex with men (MSM), female sex workers (FSW) and their clients, labour migrants and their spouses. In 2013, NCASC estimated that around 40,000 people were living with HIV in Nepal ⁽¹⁾. The Nepal country progress report on HIV response 2014 showed that HIV prevalence has remained within 0.3 - 0.2% over the last five years and annual estimated incidence has reduced from 7500 in 2003 to 1400 in 2013 at the national level ⁽¹²⁾ (figure 3). The estimated HIV incidence is 66% among male and 34% among women ⁽³⁾ (figure 4). The latest NCASC report on 15th July 2014 showed that around 25,200 HIV cases are reported nationally and out of which around 15,800 are male, 9,300 are female and 40 are transgender ⁽¹⁹⁾.

According to the national ART guideline, ART is provided to PLHIV whose CD4 count are around 350. By December 2013, approximately 8,800 PLHIV were on ART out of which 4,300 are adult males, 3,800 are adult females, 30 are transgender and 630 are children ⁽¹²⁾. In 2013, around 86% of those on ART (increased from 82% in 2012) were still on treatment after 12 months of treatment initiation. However, only 139 i.e. 20% of pregnant WLHIV received ART to reduce the risk of mother-to-child transmission in 2013. 136 of them received ART for themselves or their infants during breastfeeding. Only 21 i.e. 3.1% of infants born to WLHIV received a virological test for HIV within 2 months of birth. In 2013, mother to child transmission was estimated to be around 35% ⁽¹²⁾.

The latest HIV estimation showed that the intimate partners or spouses of key populations like clients of FSW, MSW, male who inject drugs are at higher risk of HIV infection. An estimated 49% of the all new infections are within this group (See figure 5) ⁽¹²⁾. Beside this, out of the total 25,000 reported cases, 30% were female partners of KP ⁽¹⁹⁾.

Figure 3: Declining Trend of HIV Prevalence among 15-49 Years, 1985-2020

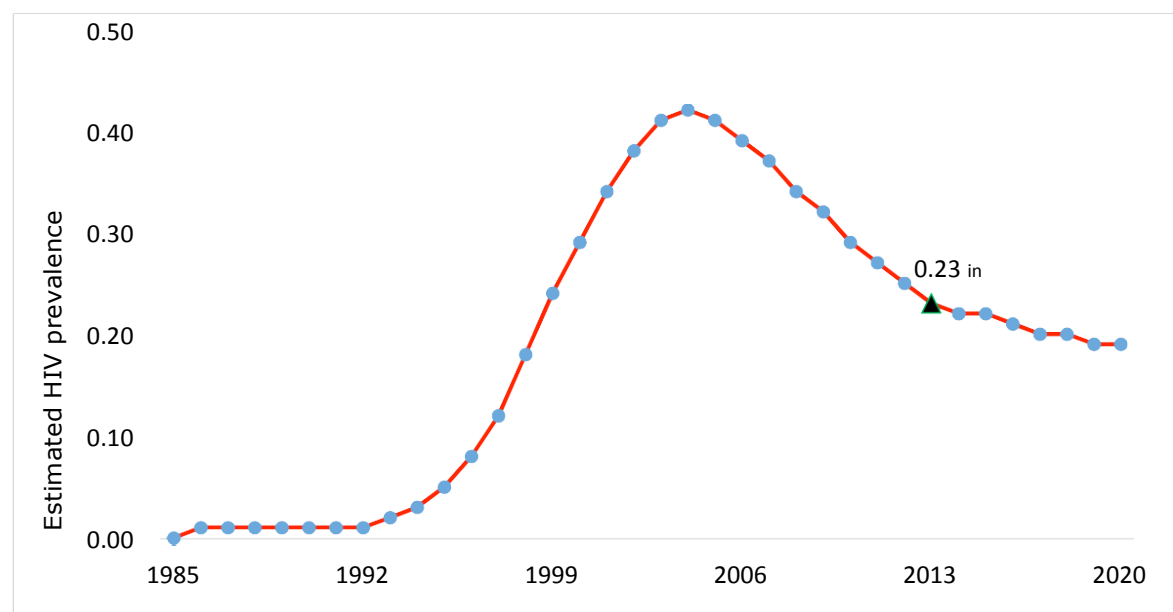


Figure 4: Estimated HIV Infections by Age and Sex in 2013

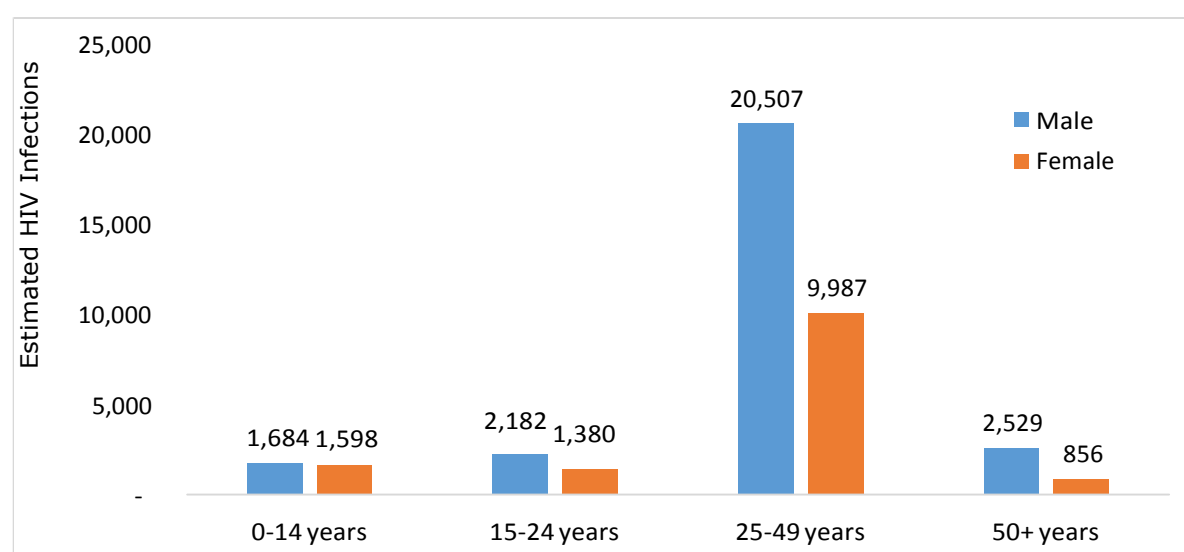
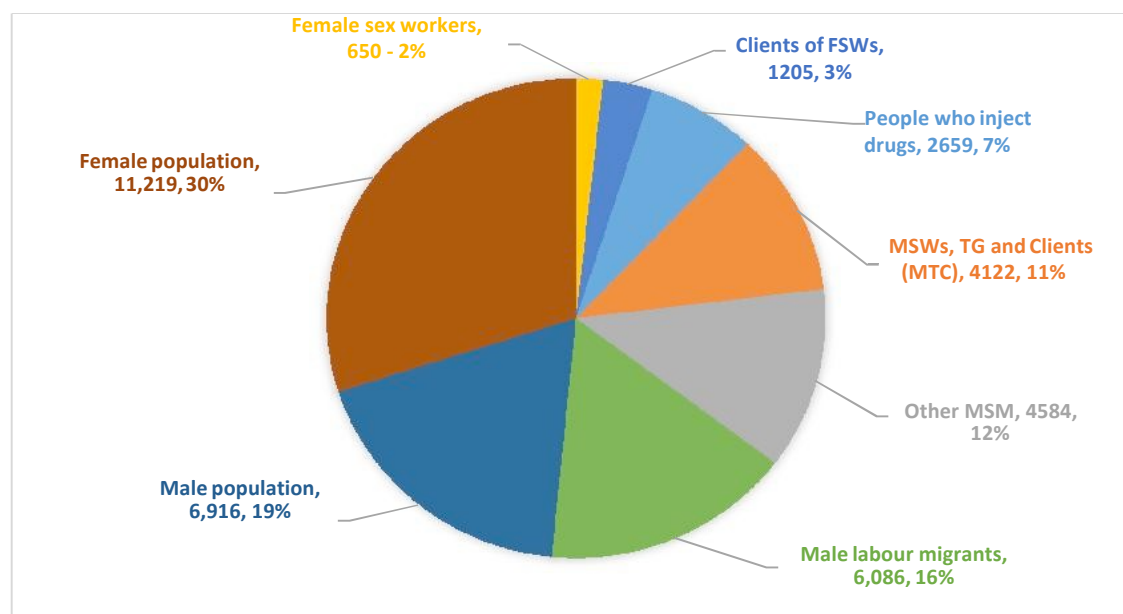


Figure 5: Estimated HIV infection among Key Populations in Nepal, 2013



Source: Country Progress Report on HIV Response Nepal, 2014⁽¹²⁾

Chapter 4: Overview of general and WLHIV specific SRHR, needs and challenges

This chapter focuses on the SRHR of all individuals/couples and particularly WLHIV. It further discusses the current challenges WLHIV are confronting regarding their SRHR and services.

4.1 Definition of human rights and SRHR

The Universal Declaration of Human Rights (UDHR) states that: "All human beings are born free and equal in dignity and rights" ⁽²⁹⁾. The ICPD Programme of action held in Cairo, Egypt in 1994, defined "Reproductive health including sexual health as the state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes" ⁽¹⁵⁾. It defined reproductive rights as "the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standards of sexual and reproductive health free of discrimination, coercion and violence" ⁽¹⁵⁾.

The International Covenant on Economic, Social and Cultural Rights (ICESCR 1966) in Article 12 recognized "the right to the highest attainable standard of health" of an individual ⁽³⁰⁾. The Committee for monitoring the ICESCR issued minimum core standards for health that ensures that health facilities, goods and services are available, accessible, acceptable and of high quality; reproductive, maternal (prenatal and postnatal) and child health care; education and information on health problems and the methods of prevention and control and the 'underlying determinants of health' are met like access to clean water, food and shelter ⁽²²⁾.

4.2 WLHIV specific SRH rights and needs

HIV is now more of a manageable chronic disease for WLHIV who have access to ART, which has provided an opportunity to focus on improving their quality of life. SRHR is one of the basic human rights of WLHIV that demand its recognition. There are no WLHIV specific SRHR related international declarations available ⁽³¹⁾. Hence, this paper discusses WLHIV specific SRH rights formulated by few organisations like ICW and GNP+ ^{(31) (32) (33) (34)} for advocacy purpose.

- WLHIV have the sexual right to have a consensual and pleasurable sexual relationship without being judged, to practise safer or protected sex, to start a new relationship, to be in control of their own sexuality, have access to information on sexual rights, sexual health information/counselling, comprehensive sexual health services and to be able to take legal action against sexual abuse or harassment.
- WLHIV have the reproductive rights to decide whom and when to

marry, whether and when to conceive without being judged, to decide on the number and spacing of children, to abort the child or get sterilised on demand or to keep the child, to get accurate information on labour, delivery, breastfeeding and child feeding options to make an informed decision about feeding the child, to quality antenatal, pre and post partum care, to have equal access to reproductive health care, family planning information and decision-making over the type and use of contraception, to have safe delivery how and where she wants, to access HIV and STI services such as voluntary HCT, ART that considers her possibility of a planned or unintended pregnancy, PMTCT, microbicides and PAP smear testing.

4.3 Current situation of SRHR violation among WLHIV

HCT and disclosure of status: The research undertaken by the FPAN in Nepal using the UNAIDS/GNP+ stigma index tool in 2011 ⁽¹⁴⁾, found that 41% of women were referred for testing when their partners were diagnosed with HIV. 34% of women went for testing when their partner/husband died of AIDS and they fell ill. 9% were tested under pressure, 5.4% without their knowledge and another 5.4% were coerced into HIV testing. To disclose their status, 14% WLHIV were pressurised from other PLHIV and 10% from other people. 12% reported that healthcare providers disclosed their status without their consent ⁽¹⁴⁾.

Contraceptive options: The APN+ quantitative study on reproductive and maternal health care in six countries ⁽¹³⁾ showed that condoms are the only contraceptive option promoted amongst WLHIV, including sero-concordant couples. 80% of Nepalese WLHIV preferred condoms as the method of contraception, 2.5% pills and 0% IUD ⁽¹³⁾. The FPAN study shows that 3% of WLHIV were denied family planning services and 2% for SRH services because of their HIV status by health care providers ⁽¹⁴⁾.

Counselling: The APN+ study showed that 35% of Nepalese WLHIV sought advice or counselling from a facility based medical practitioner regarding reproductive health options prior to their most recent pregnancy. It is the lowest compared to all other six countries ⁽¹³⁾. The FPAN study shows that 58% WLHIV did not receive any counselling regarding their reproductive options and 26% of WLHIV were advised not to have children by health care providers ⁽¹⁴⁾.

Pregnancy and delivery: The APN+ study showed that in Nepal, 27.5% of WLHIV's partners solely took the decision to have a child and mother in-laws around 2.5% in Nepal and 16% in India were also involved ⁽¹³⁾. The involvement of mother in-laws in pregnancy decision-making could be much higher as indicated by the Indian data as both countries have a similar social structure. In Nepal, 47.5% of recent pregnancies were unintended which clearly indicates the unmet need for contraceptive

methods. Out of the total pregnant WLHIV, 58% had either an abortion, miscarried or had stillbirth and 25% of that 58% aborted because of their HIV status. In Nepal, the caesarean section rate is quite high among WLHIV which is at 33.3% ⁽¹³⁾ in comparison to general women at 5%. ⁽²⁾

Coercion for sterilisation: The APN+ study ⁽¹³⁾ showed that from all six countries, around 30% of WLHIV were asked by health care providers for sterilisation and 4.6% of that did not have any children. Out of the total 30%, 40% WLHIV were not given an option to decline. In Nepal, only 16% had the chance to decline, which is the lowest among the six countries. Health care providers encouraged 43% of WLHIV who had caesarean section for sterilisation after delivery. The recommendation for sterilisation came from 61.4% gynaecologists and HIV clinicians, 9.6% outreach workers, 9.6% family members and 4.6% husbands/partners. 82.6% of respondents believed that it is because of their HIV status.

Maternal care: The APN+ study ⁽¹³⁾ showed that from all six countries, an average of 12.4% did not receive any maternal health services during pregnancy despite seeking them and 5.5% did not seek at all. Out of the 12.4%, 47.3% of pregnancies resulted in miscarriage or abortion. 58% WLHIV from Nepal lacked information on mother to child HIV transmission, which is highest in Nepal compared to all six countries. In Nepal, out of those who received maternal health services, 32.5% were not satisfied ⁽¹³⁾.

Self stigma: The FPAN stigma index report 2011 showed that out of 81% WLHIV who reported self stigma, 62% did not want to have (any more) children, 47% did not want to get married and 35% did not want to have sex again and 11% isolated themselves from family and friends. It also affected their health seeking behaviour such as going to local clinics, hospitals even when they needed medical care. This is also a reflection of their experiences of stigma and discrimination in healthcare settings ⁽¹⁴⁾.

Access to ART and its adherence: The 2011 FPAN study in Nepal reported that around 90% of the female respondents who were living with HIV at the time of their pregnancy did not receive ART to prevent mother-to-child transmission. 65% were not aware of their HIV status during pregnancy, 16% were not aware about PMTCT and 8% had no access ⁽¹⁴⁾. The APN+ study reported that in six Asian countries, 33% who received ARVs during pregnancy had difficulties staying on the ARV regimen due to side effects (85.7%), fear for baby (68.1%), illness (68.1%) and inability to access the clinic (53.8%) ⁽¹³⁾.

Violence against WLHIV: A study conducted with Nepalese married WLHIV by Aryal et al 2012 ⁽³⁵⁾ reported that violence rose up from 53.5% to 93.02% after being diagnosed with HIV. The emotional violence rose from 3% to 31% and economic violence from 0% to 40%. 100% reported physical violence of beating/ slapping/ kicking followed by strangling

72.7% and 40.9% stabbing. For psychological violence, 50% reported verbal abuse followed by threats of expulsion at 30.5% and community isolation at 38.7%. 83.7% contracted HIV from their husbands however, 45% of husbands were the main perpetrators followed by mothers-in-law at 42.5% and maternal relatives at 35%. As a result of violence, 90% suffered from self-humiliation and 77.5% from problems with their health and treatment while 50% were socially discriminated.

Chapter 5: Influencing factors for WLHIV to exercise SRHR and access SRH services

This chapter using the conceptual framework will identify and analyse influencing factors that could hinder or support WLHIV to exercise their SRHR and access of SRH related services.

5.1 Intrapersonal factors

In this section, evidence on WLHIV's individual level factors and its influence on the SRHR rights and services will be analysed.

5.1.1 Education

WLHIV on average have slightly lower education levels than women in general. The NDHS 2011 showed that among Nepalese women aged between 15-49 years, 40% had no education, 17% had primary-level education, 24% have some secondary education and only 18% have finished class 10 or higher levels of education⁽²⁾. The FPAN stigma index study conducted with 419 WLHIV in Nepal showed that 44% have no education, 15% had completed lower secondary/secondary education and only 4% completed class 10⁽¹⁴⁾. The use of maternal health care is higher among general Nepalese women who have at least secondary level education⁽³⁶⁾. The lower education could affect their health-related choices, seeking of health-related information and engagement in health-related communications⁽³⁷⁾.

5.1.2 Economic status

Both APN+ and FPAN studies showed that low economic status is also one of the reasons for WLHIV to seek abortion and also not to take legal actions when their rights are violated⁽¹³⁾⁽¹⁴⁾. Improving economic status of a WLHIV could play a role in the reduction of stigma, discrimination and rights violation. The International Labour Organisation (ILO) policy brief on Income generation and sustainable livelihoods for people living with and affected by HIV and AIDS 2010 stated that enhancing vocational skills and providing WLHIV with easily accessible employment/livelihood support is necessary to avoid treatment failure and transmission of HIV to their new born⁽³⁸⁾. The study conducted by Tsai et al⁽³⁹⁾ in Sub-Saharan Africa 2013 suggested that improving economic status of PLHIV through livelihood interventions (directly targeting poverty) could reduce stigma associated with HIV and has the potential to improve the well being of PLHIV⁽³⁹⁾.

"My family members who forced me out of the home are behaving well after I started working in a local NGO. I can survive on my own and even able to save money, thus the family members might have changed attitude towards me and my children." – WLHIV, Nepal⁽¹³⁾.

5.1.3 Knowledge about SRHR and services

It is the responsibility of duty bearers to ensure that citizens are well informed about their rights including SRHR. The knowledge about rights could provide an opportunity for WLHIV as rights holders to claim their legitimate rights ⁽²²⁾. Studies that measure knowledge or information level of WLHIV about their SRHR are not available. The APN+ study shows ⁽¹³⁾ that 65% of WLHIV in Nepal did not seek advice regarding reproductive health options prior to their most recent pregnancy from health care practitioners. WLHIV did not have much information on pregnancy prevention or birth spacing and family planning is a topic few women are comfortable to raise with their (mostly male) HIV doctors ⁽¹³⁾. Amongst those who did raise issues about their SRH, their doctor's responses varied and discouraged further discussion ⁽¹³⁾. WLHIV's stories on their silent endurance of SRHR violations at home and health care settings shows that their knowledge on SRHR is poor. Below mentioned is one of the stories from WLHIV who quietly tolerated the death of her twins.

"I went into labour prematurely and went to the hospital closest to my house. They asked me why I was having a baby and why I had not had an abortion. I was left alone for hours in labour. The first baby came out and fell directly into the rubbish bin under my feet. I could not do anything because the second baby was coming out so quickly. When someone finally came, the first baby was dead, and the second one was halfway out. They did not want to touch the baby because they did not want to touch my blood. I heard the second baby cry. They put him on oxygen for five hours, but he died. I saw him for five seconds only. I was so sad because I think my babies would have lived if they had gotten proper treatment. But I did not say anything because I did not want to hear more harsh words directed at me." - Navi, Cambodia ⁽¹³⁾.

5.1.4 Attitude and behaviour

Being diagnosed with HIV brings various changes in a WLHIV's general, sexual, reproductive attitude and behaviour. The FPAN Nepal PLHIV stigma index, 2011 ⁽¹⁴⁾ reported that 81% of WLHIV had experienced at least one feeling of self-stigma, such as shame, guilt, low self-esteem, suicidal thoughts and willingness to be punished. A literature review by Paudel and Baral in Nepal, 2015 reported that among WLHIV self-stigma might lead to isolation, hesitation to seek health services and ultimately deterioration of their health status. It also led to the fear of disclosure of HIV status leading to stress, depression, inferiority feelings, anxiety disorder, feelings of guilt and sometimes suicidal attempt ⁽⁴⁰⁾.

A qualitative study by Nguyen and Keithly in Vietnam, 2012 reported that living with HIV and its associated issues like stigma, depression, fear of transmission to negative partner, reinfection or cross-resistance and degrading health status dramatically affected their sexual health with reduced sexual desire, pleasure and frequency of sex ⁽⁴¹⁾.

A cross sectional study conducted by Mishra et al ⁽⁴²⁾ with 120 PLHIV (56 WLHIV) in Kaski, Nepal, 2012 reported that 93.3% had heard about family planning and 67.5% had received FP counselling. 65.8% were using condoms, 2.5% were using oral contraceptives and only 0.8% were using condoms and other FP method. Being female, single/de-facto widowed for male, having received FP counselling and not having regular sexual intercourse were positively associated with FP use.

A cross sectional study by Joshi et al among 300 currently married WLHIV in Mumbai, India, 2015 ⁽⁴³⁾ reported that above 90% knew about modern methods. 69% desired to use dual contraceptive methods for effective protection but believed that it is harmful because of their HIV status. Knowledge on dual protection was limited to condoms (75%), as a result condom use has increased from 5.7% before HIV diagnosis to 71.7% after diagnosis, with 89.6% reporting regular use. However, 16.6% reported abortions as they were unintended and also due to fear of transmitting HIV to the child. About 8.7% women expressed future fertility desire and 46.5% did not wish to have any children in future mainly due to their HIV status. 41% were aware about Emergency Contraceptive Pills (ECP) and 95% of them felt that it should be made available at PMTCT centres.

Another quantitative study in India among married PLHIV, 2011 by Chakrapani et al ⁽⁴⁴⁾ reported increased condom use from 11% to 92% among WLHIV and 15% to 92% among men after HIV diagnosis. The prevalence of use of condoms together with other pregnancy prevention methods (dual- contraceptive) increased from 5% before HIV diagnosis to 23% after diagnosis. Use of a dual contraceptive method is positively associated with being married, female, having received post test HIV counselling, women using contraception to prevent the risk of HIV transmission to their partner and using contraception due to a partner's preference. Results also showed that higher CD4 count was associated with less use of dual-contraceptive methods among both women and men.

All the above studies showed significant increase in condom use after being diagnosed with HIV ^{(41) (42) (43) (44)} which could be due to the reason that health care providers promoted mostly condoms as a part of the HIV preventive methods. Even with increased use of condoms, the unintended pregnancy is high; hence discussion on other contraceptives is essential and also showed need of proper information about PMTCT among WLHIV.

5.2. Interpersonal process and primary groups

In this section, the formal and informal social network and social support system will be analysed to identify its influence on WLHIV's accessibility of SRHR and services.

5.2.1. Immediate family members like husbands/partners and others like mothers-in-laws.

A cross sectional study by Adhikari and Tamang in Nepal, 2010 reported that every three in five i.e 58% of married women had experienced some form of sexual coercion by their husbands ⁽⁴⁵⁾. In a study conducted by the Office of the Prime Minister and Council of Ministers, 2012 ⁽⁴⁶⁾ reported that in Nepal, 69% of women who experienced spousal violence reported psychological problems and 6% had attempted suicide. Studies have shown that leading cause of death (16%) among women of reproductive age is suicide ⁽⁴⁷⁾ and it is the third-leading cause of death among pregnant women ⁽⁴⁸⁾ in Nepal. Above studies indicates Nepalese women in general are suffering from gender-based violence at home.

This situation is worse for WLHIV. Violence at home by husband, mothers-in-law has increased tremendously for WLHIV after HIV diagnosis as shown by the data provided in page 13 under the title "violence against WLHIV" ⁽³⁵⁾. A study on unsafe sexual behaviours of the Men living with HIV in Kathmandu, Nepal 2009 by Poudel et al ⁽⁵⁰⁾ showed that unsafe sex is common in seroconcordant, serodiscordant or sero-unknown relationships. Out of a total of 167 participants, 75% had sex in the past 6 months; 47% of that had multiple partners and 46% lacked consistent use of condoms. Only 41% knew about the possibility of re-infection or cross-resistance ⁽⁵⁰⁾. This is also supported by the national data which shows that nearly 80% of WLHIV got infected due to unprotected sex with their husband ⁽¹⁹⁾. Nevertheless WLHIV are stereotyped as having contracted HIV through immoral behaviour and blamed for spreading the infection in the family.

A cross sectional study among PLHIV in Nepal, 2014 by Amiya et al ⁽⁴⁹⁾ showed that 43% had ever thought about ending their lives and 17% had actually attempted suicide after being diagnosed with HIV. The family support can play an important role to lower PLHIV experiences of depression and suicidal thoughts ⁽⁴⁹⁾. However, family support is more available for men living with HIV in compare to WLHIV ⁽⁴⁹⁾ and situation become worse for WLHIV after death of the husband.

5.2.2 Peers (including other WLHIV and support groups)

A literature review by Paudel and Baral in Nepal, 2015 reported that support groups especially women led support groups empowers WLHIV, provides support to decrease isolation, feelings of shame and increases the network of friends as well as providing psychological intervention and guidance ⁽⁴⁰⁾. The APN+ study reported that around 23% WLHIV (46% in Cambodia) seek advice on reproductive and maternal health options from support groups and were viewed as most supportive ⁽¹³⁾. For the above reasons, researchers argue that support groups capacity should be enhanced to advocate for WLHIV's comprehensive SRHR and services, including family planning and raise awareness among peers on their rights and needs related to SRH ⁽⁵¹⁾.

5.3. Institutional factors

This section analyses the influence of institutions and organisation characteristics, their in/formal rules and regulations for operations on WLHIV's accessibility of SRHR and services.

5.3.1 Government structure - SRHR and services of WLHIV

Ministry of Health and Population (MoHP)'s department of Health services is responsible for delivering prevention, promotion and curative health services ⁽⁹⁾. The Family Health Division (FHD) under DoHS does not specifically target WLHIV to address their unmet need for FP ⁽⁵²⁾. FHD related services are integrated within the existing government health care facilities like HPs, PHCCs and hospitals at various levels.

The NCASC within DoHS has a vertical⁶ approach delivery system with nearly 90% funding from external development partners (EDPs) like the Global Fund to Fight AIDS, TB and Malaria (GFATM), bilateral agencies, namely USAID and GIZ, UN agencies and pool fund partners (the World Bank, DFID of UK, AusAID, Kfw) on HIV/AIDS ⁽¹²⁾. Due to the larger share of funding by international agencies, their internal policy does influence national decision-making and the delivery of health interventions ⁽⁵⁴⁾. For instance, a study in 2009 on "Sexual and reproductive health in HIV-related proposals supported by the Global Fund" by Lusti-Narasimhan et al reported that within PMTCT, issues like family planning, preventing unintended pregnancies and STIs through the promotion of dual protection, preventing unsafe abortion and preventing and managing gender-based violence are missing or were under represented ⁽⁵⁵⁾. As the Global Fund is the largest donor for Nepal's HIV programme, SRHR and related services for WLHIV is not much reflected in the current national HIV programme.

Integrated SRH/HIV programme

Both the revised national HIV policy and the current National HIV/AIDS strategy (2011-2016) stated integration of a PMTCT component in the reproductive health programme and child health services under FHD ⁽⁵⁶⁾ ⁽⁵⁷⁾. SRH related services for WLHIV is linked within the national target set to reduce new HIV infections in children by 90% by 2016 ⁽⁵⁸⁾. This target provides linkage between these two government bodies regarding WLHIV SRH services including family planning, abortion, antenatal care, delivery, newborn and postpartum care as well as HCT to pregnant women. The national guidelines on PMTCT 2011 elaborates on the dual protection with provision of modern contraceptives, pregnancy, HIV counselling for pregnant women during ANC visits, but guidelines for the provision of abortion services in the case of WLHIV is not mentioned ⁽⁵⁹⁾. The Nepal HIV investment plan (2014-2016) only mentioned, "training on rights-based sexual and reproductive health and HIV services for PLHIV, female

⁶ Vertical approaches tackle one specific health problem through targeted delivery, coordination, financing, or information mechanisms ⁽⁵³⁾

who inject drugs, FSW, TG, SWs”⁽⁶⁰⁾.

Integration or Linkage⁷ of SRH and HIV programme is gaining recognition widely. Linkages between SRH and HIV-related policies and programmes may lead to a number of important public health, societal and health systems benefits. It could improve coverage, access to and uptake of both SRH and HIV services for KP and PLHIV supporting stigma reduction⁽¹⁶⁾. A systematic review on linking sexual and reproductive health and HIV interventions in 2010 by Kennedy et al reported positive effects of linkages on HIV incidence, STI incidence, condom use, uptake of HIV testing and quality of services with some mixed effects on contraceptive use. Integrated services at family planning (FP) clinics, HIV counselling and testing centres and HIV clinics were considered beneficial and feasible⁽⁶²⁾. Another study conducted by Family Health International (FHI 360) 2013 shows that integrated services help meet clients’ desires and demand related to contraceptives, increases access to and uptake of contraception by WLHIV to prevent unintended pregnancy, reduce unmet need for SRH services, increase uptake of HIV testing, strengthen male involvement in FP and potentially reduce costs, while enhancing impact, for both the health system and for clients⁽⁶³⁾.

A systematic review in 2011 conducted by Gay et al⁽⁶⁴⁾ on interventions that works to meet the SRH needs of WLHIV, 2011 showed that the common implementation problems related to the SRH/HIV integrated programme include: delays or incomplete integration of higher level health systems functions; lack of coordinated leadership and unified national integration policies; separate financing streams for SRH and HIV services and inadequate health worker training, supervision and retention⁽⁶⁴⁾.

5.3.2 Health facilities

5.3.2.1 Availability

There is an acute shortage of doctors, specialists and nurses in district hospitals and PHCCs which reportedly affect service delivery in 88% of hospitals, 69% of PHCCs, 49% of HPs and 44% of SHPs⁽⁶⁵⁾. Currently government is providing contraceptives to 69% of the population i.e. more than two in three users⁽²⁾. Effect of staff shortage on FP services at the hospital is 14.3%) and at PHCCs is 11.1%⁽⁶⁵⁾. There are 776 listed sites that provide comprehensive abortion care (CAC) service⁽⁸⁾. The Family Planning Association clinics (part government and part private) and private clinics across Nepal, including Marie Stopes also provide abortion services. Pre-legalisation abortions were available at private clinics for a high-fee. The abortion services for WLHIV are available at government hospitals/clinics across Nepal⁽⁶⁶⁾. In Kathmandu, only one

⁷ The bi-directional synergies in policy, programmes, services and advocacy between SRH and HIV⁽⁶¹⁾

doctor is employed for WLHIV in a maternity hospital ⁽⁶⁶⁾. There were a total of 62 PMTCT sites in Nepal as of 2013 ⁽⁶⁷⁾.

5.3.2.2 Accessibility

Geographical access has been considered as a major constraint to access, however evidence shows that women are willing to travel great distances to facilities ⁽⁶⁸⁾. It is also supported by a study conducted with PLHIV in Nepal, 2014 where a reason for not using FP was the lack of knowledge about availability of FP services (20.0%), lack of resources to access (8.6%) and fear of stigma and discrimination (14.3%) but not travelling distance to health centres ⁽⁴²⁾. However, the issues of affordability of the transportation cost to reach the health centres do influence WLHIV health seeking practice as discussed below.

5.3.2.3 Affordability

A cross-sectional survey on out-of-pocket expenditure for reproductive and sexual health (RSH) care among the urban population in Nepal, 2008 ⁽⁶⁹⁾ showed that 1.1% of the total annual household expenditure was on RSH excluding HIV care and 2.9% on HIV care. 9% of the total health care expenditure was for obstetric care. Almost 50% were spent on maternal care (46%), STIs (27%) and RTIs (13%). Only 7% of overall RSH spending was on family planning as contraceptives and related services are supplied free-of-charge at public facilities.

The APN+ study ⁽¹³⁾ showed that for most WLHIV, affordability is the most important factor influencing utilisation of SRH and services due to their low economic status. Services related to SRH and HIV is not available at the same location so there are additional transportation charges. Most WLHIV are put in separate rooms during delivery, and must pay the cost of the private room. WLHIV pay more compared to other women for abortion, delivery if their HIV status is disclosed, for laboratory, doctor's fee, so-called preventive materials and expensive chemicals to sterilize instruments and most importantly for caesarean sections which cost more than the vaginal delivery ⁽¹³⁾. WLHIV are also not able to continue ART, adhere or have poor health-seeking behaviour due to the cost associated with transportation, administration and doctor's fees, laboratory tests and other procedures ⁽¹³⁾.

5.3.2.4 Acceptability of available services by WLHIV

The APN+ study showed ⁽¹³⁾ that 84% of WLHIV who were aware of their HIV status compared to 71% who were not had government facility-based delivery. Several women chose to seek SRH care services at private or NGO sponsored clinics, sometimes without disclosing their HIV status for fear of discrimination. Many WLHIV who knew their status travelled to Kathmandu for delivery because of the perceived good quality of service and also for confidentiality reasons even though the transport costs are very high.

5.3.1.5 Knowledge, attitude and behaviour of health care providers towards WLHIV seeking SRH services

Studies showed that some providers believed that PLHIV should not engage in sexual relationships or become pregnant ^{(70) (71)}. A quantitative study in India 2011 by Chakrapani et al showed that some providers are unwilling to engage in discussions about sexuality or any contraceptives (including condoms) with WLHIV because they do not want to convey the notion that they can be sexually active ⁽⁴⁴⁾ which severely limits WLHIV rights to fully exercise their reproductive rights. The major barriers for WLHIV to use contraceptive is lack of discussion by health care providers about contraceptives other than condoms and misconceptions about its side effects (which could be due to low counselling from health care providers) ⁽⁴⁴⁾. A study by Family Health International (FHI) in five-countries on family planning and HIV integrated services in 2010 showed that providers make a sharp distinction between contraceptive methods that are best for WLHIV and general women ⁽⁷⁰⁾. Some health workers have misconceptions about the appropriateness of other contraceptive methods for WLHIV ⁽⁷⁰⁾. Studies showed that WLHIV often face severe stigma and discrimination from health care providers when they express their desire to become pregnant ⁽⁷²⁾⁽⁷³⁾. Another study showed that coercive behaviour and stigmatizing attitudes from providers to abstain from sex, undergo tubal ligation or hysterectomy, have an abortion, refusing to assist deliveries has caused a loss of trust in them and WLHIV fear visiting these services ⁽⁷⁴⁾. This clearly shows a gap in knowledge/information about SRH rights of WLHIV among health care providers.

5.4.5 Non-Government sector

There are very limited organisations like the Family Planning Association of Nepal (FPAN) and USAID Nepal that are promoting SRH services for WLHIV ^{(75) (76)}. Civil societies (NGOs and CBOs) have been playing major roles in implementing preventive interventions, creating demand for services, advocating for the rights of the target groups and community mobilization in both HIV and FP field. However, Nepal has separate HIV and FP donors and programme. As the consequence of these separate programmes, WLHIV in Nepal are constantly referred back and forth between ART centres and maternal health care centres because nobody wants to deal with a pregnant WLHIV ⁽¹³⁾.

Both civil societies and media activists act as watchdogs to monitor rights violations that have become one of the important factors in combating HIV ⁽¹²⁾. The media's role in HIV prevention programmes is highlighted in the National HIV/AIDS strategy 2011 – 2016 ⁽⁵⁸⁾. 8% PLHIV of FPAN HIV stigma index study felt that the media was supportive when they disclosed their HIV status ⁽¹⁴⁾. A qualitative study by EngenderHealth/UNFPA, 2006 on SRH needs of WLHIV in Brazil, Ethiopia and the Ukraine showed that WLHIV preferred and relied on providers, outreach workers, community leaders than media as it is more relevant

for HIV prevention message dissemination ⁽⁷⁷⁾.

5.4. Community factors

This section will find and analyse the influence of informal networks within defined boundaries like gender, cultural norms and community groups on SRHR and services access of WLHIV.

5.4.1 Gender, culture and religion

Studies have shown that women's roles in patriarchal societies are often limited and restricted. As a consequence of lower social status, Nepalese women have poor access to health services, low involvement in decision-making regarding sexual relations and are much exposed to gender-based violence ⁽⁷⁸⁾ ⁽⁷⁹⁾. A study by Adhikari and Tamang on premarital sexual behaviour among male college students in Nepal on 2009 showed that sex, sexuality and reproductive health are taboo subjects and are linked with individual's morality ⁽⁸⁰⁾. From the religious, cultural point of view, sexuality is an extremely sensitive subject for discussion especially for girls and women. Widows are blamed for their husband's death and as per Hindu religion, they are expected not to remarry (implying abstinence from sex) and are considered to bring bad luck hence are neglected in family ⁽⁸¹⁾. WLHIV go through the same social phenomena but their stigma and discrimination is double due to social stigma attached to HIV. Issues around sexuality are more taboo for WLHIV, as often they are expected to abstain from sex ⁽¹³⁾.

"My mother in law didn't know my HIV status and pressurised me to have a child as she needs at least one grandson. I didn't want to get pregnant due to my HIV status. She told my husband to marry someone else if I didn't get pregnant. My husband also wanted to have a son and he said if I gave birth to a girl he would kill the baby. When I was six months pregnant I had an ultrasound to determine the sex of the baby and when we knew it was a boy I went ahead and gave birth." - Sunita, Nepal ⁽¹³⁾.

5.4.2 Social networks like community, co-workers

When WLHIV are rejected and forced to live in isolation by their family members it is further exacerbated by community members. A paper on Violence Against WLHIV by Hale and Vazquez in 2011 reported that WLHIV have left communities to escape from violence. The community location and size intersect to determine the types of violence WLHIV experience within the community ⁽⁸²⁾ however, there has been limited research conducted on the nature of community-level stigma against WLHIV ⁽⁸³⁾.

"I was infected by my husband but people accused me of being a sex worker and infecting men. The villagers banned from me from walking near their homes and using public taps. My mother-in-law then threw my daughter and me out of the house." - Jala, a widow WLHIV ⁽⁸⁴⁾.

5.5. Public policy

5.5.1 International, national law and policies on SRHR of WLHIV

Governments have three levels of obligation: to respect⁸, protect⁹ and fulfil¹⁰ every right⁽²²⁾. By ratifying international treaties like the Elimination of All forms of Discrimination against Women (CEDAW) 1979 and declarations like ICPD 1994, Beijing Platform for Action, 1995 and Millennium Development Goals (MDG) 2000, Nepal has committed itself to sexual and reproductive health rights of all Nepalese. Nepal has also endorsed international declarations related to HIV and AIDS like the Paris declaration 1994, United Nations General Assembly on HIV/AIDS (UNGASS) Declaration of Commitment on HIV/AIDS 2001 and UNAIDS three ones principle in 2003 and the Political Declaration on HIV/AIDS in 2006 which reaffirms the commitment to achieving universal access to reproductive health by 2015⁽⁸⁵⁾. The Interim Constitution of Nepal 2007 stated, "Every woman shall have the right to reproductive health and other reproductive matters"⁽⁸⁶⁾. However, it is always a challenge for policies to be translated into practice.

In 1988, the Government of Nepal launched the first National AIDS Prevention and Control Programme. The 12-point national AIDS policy developed in 1991⁽⁵⁵⁾ was revised in 2011 to ensure health as a right. However, sexual and reproductive health rights of PLHIV are not mentioned in the revised policy⁽⁵⁶⁾. Nepal drafted an HIV and AIDS (Treatment, Prevention and Control) bill which prohibits discrimination based on HIV status and supports privacy and confidentiality in health care settings protecting rights of PLHIV including WLHIV. Unfortunately, this legislation is still pending and has not yet been passed into law⁽⁸⁷⁾. In 2002, Nepal legalised abortion but HIV is not a reason for an abortion after 12 weeks⁽⁸⁸⁾. (See Annex 2 for details on the ratified International treaties, National law and policies that can protect SRHR of WLHIV).

Government is obligated not only to respect and protect rights of WLHIV but to fulfil it as well. The current situation of being forced for abortion, sterilization, not providing comprehensive sexual and reproductive information to WLHIV violates their SRHR as articulated in international instruments ratified by Nepal government, including CEDAW, the ICPD Programme of Action and the Beijing Platform for Action.

⁸ To respect the right means refraining from interfering with the enjoyment of the right⁽²²⁾.

⁹ To protect the right means enacting laws that create mechanisms to prevent violation of the right by State authorities or by non-State actors, and providing affordable and accessible redress. This protection is to be granted equally to all⁽²²⁾.

¹⁰ To fulfill the right means to take active steps to put in place institutions and procedures, including the allocation of resources to enable people to enjoy the right. The key is to create an enabling environment through all appropriate means, particularly through resource allocation⁽²²⁾.

Chapter 6: Interventions to improve WLHIV access to SRHR and services

Factors that influence WLHIV access to SRHR and related services were discussed earlier in the study. This chapter focuses mainly on interventions implemented in concentrated to generalized HIV epidemic to improve accessibility of WLHIV to SRHR and services.

A systematic review “What works to meet the sexual and reproductive health needs of women living with HIV/AIDS” 2011 by Gay et al ⁽⁶⁴⁾ has provided evidence based interventions that have proven to be effective in meeting SRH rights and needs of WLHIV. The interventions are largely from African countries and others like USA, Brazil and the Caribbean region. These countries have different HIV epidemics and factors affecting HIV compared to Nepal but as most of the SRH/HIV related programme has been conducted in Africa it is still worth taking note of these proven strategies since they can be transferred to the Nepalese context.

Table 3: Lists of evidence-based interventions

	Interventions	Outcomes
	Proven strategies	
1	Promotion of contraceptives and family planning counselling as part of routine HIV services and vice versa	Increased condom use, contraceptive use and dual method use, involvement of male partners in discussions of unintended pregnancies and support in integration of services
2	Early postpartum visits that include FP and HIV counselling, information and services	Increased condom and contraceptive use, HIV testing and treatment and reduced future unintended pregnancy
3	Providing information and skills-building support for PLHIV	Reduced unprotected sex and STIs among PLHIV by increased condom use.
4	Supporting disclosure	Increase safer sexual behaviours like asking partners to get tested, condom use among discordant couples, reduce number of sex partners,
5	Providing ARVs	Increase prevention behaviours, including condom use
	Promising strategies	
6	Cervical cancer screening integrated into HIV care	Reduce morbidity and mortality in WLHIV
7	Promoting condom use for contraception	Make condom use more acceptable and easier to negotiate

Source: What works to meet the sexual and reproductive health needs of women living with HIV/AIDS, 2011 ⁽⁶⁴⁾

Nepal:

USAID has launched a pioneer project “Saath-Saath” (2011-2016) ⁽⁷⁶⁾ ⁽¹²⁾ in Nepal to provide integrated FP and HIV services for FSWs and their clients, migrants and their spouses and PLHIV including WLHIV. Its key approaches is integration of FP services into existing HIV services at both NGO and government’s outreach and service delivery sites. It provides on-site orientation to service providers at government health facilities using the FP/HIV/STI integrated counselling toolkit to effectively provide FP information, counselling and services to the target populations. It provides capacity building support to its local NGO partners. In a community discussion forum a peer champion shares their experience on a FP method use and discuss misconceptions on existing FP method. Till January 2014, it had reached around 196,000 individuals from the target groups with FP and HIV messages. Around 13,000 have received FP counselling and 1,300 women had received non-condom FP methods like oral contraceptive pills, Depo (injectable) and implants ⁽¹²⁾. However, WLHIV are not largely covered under this project as it is more focused on the key populations. Separate data on the increased accessibility of SRHR and services by WLHIV is not published yet, which could be included in the project evaluation report after its completion in 2016.

International interventions:

In Nepal, civil society organisations of KP, PLHIV and WLHIV like National Federation of Women living with HIV (NFWLHA) have always led advocacy for rights and in implementation of HIV programmes. However, till now SRHR of WLHIV has not been reflected clearly in the organisational strategy of NFWLHA ⁽⁸⁹⁾. Hence, Nepal’s WLHIV national networks could learn from interventions implemented by HIV activists internationally to improve SRHR and services of WLHIV.

India:

The India HIV/AIDS Alliance launched Koshish (an Effort) programme from April 2011 to March 2014 ⁽⁹⁰⁾ to support advocacy and action to improve the SRH of PLHIV and key populations. An advocacy coalition was established that determines SRH advocacy priorities in each project state, designs and implements strategies to reach key decision makers to ensure better policies and programming responsive to the SRH needs of PLHIV and key populations. The project was to address critical challenges facing PLHIV, including social stigma and discrimination, limited accessibility to and availability of essential SRH services and lack of a comprehensive approach to the SRH needs of PLHIV, particularly of WLHIV. For instance, the programme increased access of WLHIV to Pap smear testing as they are five-times more susceptible to cervical cancer than other women. It advanced community-led advocacy initiatives that raised awareness of SRH challenges faced by PLHIV including WLHIV.

Malawi:

The Coalition of Women Living with HIV/AIDS in Malawi (COWLHA) in 2009 started documenting cases of gender-based violence against WLHIV. Based on the results of the findings, COWLHA challenged gender inequality and established a couple-centred approach (replacing male-centred approach) in which the SRHR and needs of both women and men are equally respected. It engaged senior traditional leaders to establish dialogue between community leaders and WLHIV. Through community dialogue meetings, WLHIV sought solutions to the social stigma and discrimination. The leaders denounced gender-based violence and discouraged practices that compromise WLHIV's SRHR and other human rights ⁽⁹¹⁾.

Namibia:

The Namibia Women's Health Network, a national organisation by and for women living with HIV in 2010 trained WLHIV and young people as SRHR advocates; conducted community workshops and organized local and national level advocacy on access to contraceptives, preventing coerced sterilization of WLHIV and promoting safe abortion. The trained SRHR advocates were mobilized through community dialogues, knowledge and skills building workshops on SRHR, including abortion and related issues. It resulted in positive attitudes to issues around WLHIV SRHR. It ensured access to post-exposure prophylaxis (PEP) and emergency contraception ⁽⁹²⁾.

Chapter 7: Discussion, conclusion and recommendations

This chapter discusses the findings from literature reviewed in previous chapters based on the conceptual framework.

7.1 Intrapersonal level

The findings show that comparatively WLHIV have slightly lower education levels than general women. However, the percentage of WLHIV with education above class 10 is much lower. Education in itself is a right and it also increases access to other rights and services so the lower education level indicates that WLHIV have limited health-related choices and health-related information. WLHIV should be informed, trained or sensitized about their SRHR rights, international treaties that Nepal has ratified to encourage them to claim it. This can be an empowering change when WLHIV are going through internalized stigma and denied sexual pleasure and parenthood desires.

The low education is linked with the low economic status, which could hinder WLHIV from taking legal actions against perpetrators and claim their legitimate rights as rights holders. Their poor economic condition is further worsened due to lack of skills. Government should provide vocational trainings and income generation packages to WLHIV to ensure that they can live a dignified life and take care of her children.

The limited information followed by misconception related with the existing FP method among WLHIV is a matter of concern. WLHIV should be given equal opportunity to have control over their reproductive health and not only depend upon their partners.

7.2. Interpersonal process and primary groups

Having good family support can lower WLHIV self-stigma, however violence against WLHIV is higher than general women in the family due to HIV status. Women in Nepal are vulnerable to HIV due to their unsafe sexual behaviour of their husbands. Hence, it is important to inform Men living with HIV about their unsafe sexual behaviour that could put their partner or wives at risk of HIV and be part to reduce gender based violence in the family. It is equally important that husband/partners and immediate family members like mother in laws of WLHIV are informed and educated about the SRHR of WLHIV to establish a favourable environment for WLHIV to access the SRHR.

WLHIV inability to recognise and demand for their SRH rights leaves them with no choice but to tolerate discriminatory behaviours from their family. Therefore, rights literacy should be delivered targeting WLHIV. The women leading support groups can be important actors to advocate and to empower WLHIV to understand, seek SRHR and related services.

7.3. Institutional factor

The Nepal Government is providing majority of services like ART, PMTCT, abortion, ANC and contraceptives. There is acute shortage of doctors, specialists and nurses in district hospitals and PHCCs, which is directly linked with WLHIV living in rural areas. On top of shortage of medical personnel in general, those who provide service and understand the need of SRH of WLHIV are severely insufficient. The Government needs to train more health care providers targeting WLHIV. Nepal has high out-of-pocket expenditure for maternal care, STIs and RTIs, which should be a major concern for the Government. WLHIV who has double burden of HIV and SRH, high out-of-pocket expenditure in health is inevitable. Government should intervene through livelihood support for income generating activities or social insurance to WLHIV to provide them some relief.

As HIV and FP service providers are different, WLHIV often do not have access to appropriate information on their reproductive choices. They do not want to reveal their HIV status to their SRH health care providers to avoid possible discrimination and HIV care providers lack information on contraceptives, family planning and mostly promote condoms and discourage other SRH needs. Health care providers cause major SRH related rights violation like performing coercive abortion, not sharing information about available contraceptives to avoid unintended pregnancy, sterilized WLHIV without their consent or give no space for their opinions. The low knowledge of SRHR and needs of WLHIV, discriminatory attitudes and practices towards WLHIV when they seek SRH related services emphasises the need for sensitization/training about the SRHR and needs of WLHIV among existing HIV care and treatment providers, obstetric and gynaecological service providers.

Nepal Government has subsequently increase PMTCT sites but it provides services only to already pregnant WLHIV so other WLHIV who do not wish to be pregnant are not currently reached under the HIV programme. The SRH/HIV integrated programme has been showing good results to advance the SRH rights and needs of WLHIV. Nepal has policies and strategies that mentioned integrated SRH/HIV services but actual implementation is limited. Both national strategies on HIV and FP should provide clear direction with budget allocation. Most of the problems related to SRH/HIV integrated programme is at policy and strategy level so this has to be facilitated from that level as well.

NGOs and CBOs that are delivering HIV services can be mobilised to advocate, provide FP services to WLHIV as the trust between the service provider and receiver has already been established. The national strategy could stress on the mobilization of WLHIV organisations at local and national level to raise awareness about SRHR and needs among their families, community, health care settings and policy makers.

7.4. Community factor

The gender norms, socio-culture values and religious practise that prevent WLHIV from accessing their SRH rights and services should be discouraged and punished by law. The social norms that expect WLHIV to abstain from sex are also observable among health care providers who are also part of the same society. Community sensitization is essential to reduce stigma and empower WLHIV to exercise their SRHR.

7.5. Public policy

Nepal has a long way to go to turn the international commitments like CEDAW, ICDP Programme of Action and the Beijing Platform for Action, the Political Declaration on HIV/AIDS in 2006 into practise. Policies that directly or indirectly support WLHIV's SRHR and related services should be effectively implemented such as the right to education and employment opportunities, the right to choose when and who to marry freedom from spousal, family member violence and promoting their legal rights.

The pending HIV bill can be an effective tool for WLHIV to seek any legal actions against rights violation. Hence, efforts should be done to pass it as soon as possible through the parliament. It can be a stepping-stone to address violation of SRHR of WLHIV in health care facilities. The national policy and strategies on FP and HIV should address SRHR of WLHIV. Participatory approaches should be applied to engage WLHIV during policies and strategies (re) formation.

7.6 Interventions

Currently there is only one programme providing integrated FP/HIV services in Nepal. However, it is more focused on key populations and is limited to specific districts. The project is implemented through WLHIV led CBOs (where it is available) at the local level and is training government staff on providing FP services to HIV key population and PLHIV. Its evaluation report can be used as evidence for designing, planning and implementing further SRH rights and related services targeting specifically WLHIV in Nepal.

Other international initiatives from India, Malawi and Namibia have shown the importance of WLHIV/women's networks leadership in advocating for SRHR and services at policy and community levels, engagement of men on issues of gender-based violence, strengthening of coordination between community leaders and support groups to increase dialogue around taboo issues and to challenge gender norms and cultural factors that are crucial for social change for women. Investment in capacity and leadership skills development of WLHIV is essential. The lesson learnt from such initiatives can be replicated to strengthen the national WLHIV network and organisations working to promote SRHR and services of WLHIV in Nepal.

7.2 Conclusion

The study established areas of rights violation (ranging from FP, proper FP counselling, safe abortion, safe delivery, to simply being able to talk about their SRH issues with health care providers and family members) that need immediate attention to improve the SRHR of Nepalese WLHIV. It also expressed a definite need to access SRHR related information, services and skills that will enable them to make informed choices. The Nepal Government needs to provide immediate attention from policy to grass root level on the issue in order to fulfil WLHIV's SRHR. It is the responsibility of duty bearers from lobbying for HIV pending bill to ensuring that WLHIV in the community and at home are informed about their rights and could take legal actions whenever and wherever it is violated.

Nepal needs a multi- and large-scale SRH and rights based approach and culturally sensitive programmes at the national, facility and community level targeting WLHIV that would significantly benefit the health of WLHIV and their partners, children and the national health system. The successful strategy to address SRHR and needs of WLHIV such as integration of SRH and HIV services, providing SRH and rights information and counselling to WLHIV and mobilizing women leading national network and support groups to reach WLHIV are key actions that can be taken. Future research is needed to compare the impact of such strategies more directly in the Nepalese context.

7.3 Recommendations

In order to advance the SRHR and services for WLHIV in Nepal, various actors should fulfil their roles actively. Based on the findings and discussion from the previous chapters, attention needs to be focused on the following recommendations;

For MoHP:

- Consult with NCASC and FHD to specify details for SRH/HIV integration such as which particular SRH and HIV services, to what extent (at the facility and/or community level) and set the priority interventions needed within the national health system to achieve the desired type of integration. Allocate budget for the SRHR and related services for WLHIV in the national HIV investment plan and national strategy of FP.

For NCASC:

- Provide strong support (position statements, funding) in coordination with UN agencies, EDPs to national networks and CSOs of WLHIV to advocate for the enactment of the pending HIV bill.
- Involve WLHIV in decision-making processes on SRH at all levels such as (re) formulation of SRH-related policy, programmes and resource allocation.

- Provide comprehensive SRH services and commodities for WLHIV (e.g., screening of cancer, STIs services, PMTCT, (emergency) contraception and psychosocial support) at HIV facilities.
- Develop national guidelines/training curriculum in consultation with FHD for health care workers to train them to provide SRH counselling and services to WLHIV.
- Train new and existing HIV health care workers to improve SRHR and services targeting WLHIV. Involve WLHIV in trainings of health care providers.
- Train and mobilize WLHIV to advocate for SRHR in the community.
- Involve men against gender-based violence (GBV) towards women particularly WLHIV through community campaigns.
- Establish mechanism for WLHIV to document and report stigma, discrimination and SRHR violations by HIV health care providers.
- Provide livelihood interventions to WLHIV to improve their economic status so that they can live a dignified life.
- Conduct future researches meaningful involvement of WLHIV on the impact of the change in law, policy, strategies and interventions on improving SRHR and services targeting WLHIV in Nepalese context. Based on the evidence, provide recommendations to MoHP, FHD to advance SRHR and services for WLHIV.

For FHD:

- In consultation with NCASC, develop national guidelines to provide comprehensive continuum of SRH services (beyond prevention of vertical transmission) for WLHIV throughout their sexual and reproductive age.
- Provide comprehensive SRH services, counselling and commodities for WLHIV (e.g., screening of cancer, STIs services, PMTCT, (emergency) contraception and psychosocial support) at SRH facilities.
- Train new and existing SRH health care workers to improve SRHR and services targeting WLHIV.
- Establish mechanisms for WLHIV to document and report stigma, discrimination and SRHR violations by SRH health care providers.

For health care providers

HIV care providers:

- Provide supportive environment for WLHIV who seek sexual and reproductive health information, ensure proper FP counselling, availability of contraceptives, information and services related to STIs.
- At HCT centres, inform WLHIV of the possibility of HIV transmission to their newborns, availability of PMTCT services and create linkages between WLHIV and STI, ART centre, PMTCT providers at the nearest health facilities.
- At ART centres, recommend ART regimens based on the desire of WLHIV for future pregnancy or current pregnancy. Provide SRH counselling, FP commodities, linkages with the STI, abortion, ANC or

delivery centres.

- At PMTCT sites, provide SRH counselling, FP commodities, linkages with the STI, abortion, ANC or delivery centres.

SRH care providers:

- Provide supportive environment for WLHIV who seek sexual and reproductive health information, ensure proper FP counselling, availability of contraceptives, information and service related to STIs, safe abortion, safe delivery and PMTCT.
- Provide informed family planning counselling and choices to WLHIV without any coercion.
- Provide safe, accessible and coercion-free abortion services and post-abortion care.
- Provide PMTCT and skilled care during pregnancy, child delivery, pre and postpartum care (including access to contraceptives) and infant health care.

For WLHIV national networks

- Advocate with government, donors for rights based approached SRHR policy, strategies, programmes and budget allocation for SRHR of WLHIV.
- Advocate for meaningful involvement of WLHIV in decision-making processes on SRH at all levels such as SRH-related policy, programmes and resource allocation.
- Design and implement interventions to improve SRHR and services of WLHIV including livelihood options.
- Amplify the voice of WLHIV by documenting stigma, discrimination and SRHR violations by SRH health care providers, family and reporting to the relevant authorities.

For support groups

- Inform WLHIV about SRHR and available services in their local settings to increase decision-making power of WLHIV.
- Involve particularly husbands/partners and mothers'-in-law for ensuring their acceptance and support for WLHIV SRHR and service utilisation. Inform them about the impact of SRHR violation on WLHIV, the family and community through community dialogues and public discussion.
- Document stigma, discrimination and SRHR violations by SRH health care providers, family and reporting to the local authorities.

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Annexes

Annex 1: Map of Nepal



Source: <http://ncthakur.itgo.com/map04.htm> ⁽⁹³⁾

Annex 2: Ratified International treaties, National law and policies applicable for WLHIV

Nepal signed "United Nations Convention on Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (CAT), 1975" in 1998.
Nepal signed "The convention on the elimination of all forms of discrimination against women (CEDAW), 1979" in 1991 and ratified the optional protocol to CEDAW in 2001.
Nepal signed "The International Covenant on Economic, Social and Cultural Rights (ICESCR), 1976" in 1991.
Nepal signed "The International Covenant on Civil and Political Rights (ICCPR), 1976" in 1991.
Nepal Treaty Act (1990) - Section 9: Monist approach which means that once Nepal has ratified an international treaty through its parliament and if there is a conflict between the treaty and current domestic law, then the latter shall be invalid.
The right to health: Nepal constitution Article 16 recognizes "the right to get basic health service free of cost from the State as provided for in the law."
The right to privacy: Article 28 of the Interim Constitution states that "except in circumstances provided by law, privacy in relation to the person and to their residence, property, documents, records, statistics and correspondence, and their reputation are inviolable."
The Civil Rights Act (1955) states at Article 3(a) "no citizen shall be denied equality before law and equal protection of law."
Medical Council Act, 1964: The Medical Council can remove a medical practitioner from the Medical Council Register when the practitioner is convicted and sentenced to a criminal offence involving moral turpitude, or on the basis of misconduct related to the profession if decided by two thirds of the members of the Medical Council.
Muluki Ain, Chapter 14: It defined rape as any act of non-consensual sex with a woman whether married or unmarried. It defined rape within marriage – regardless of the age of the wife – as rape, attracting the same penalties as rape of a non-spouse, 3–5 years imprisonment.
Muluki Ain, Chapter 10: The amended version states that abortion is not dealt under homicide. The paragraph 28 of the current law prohibits coercion or threat, lure or offer, to a pregnant woman, and retaining and strengthening the emphasis on consent.
HIV and AIDS (Prevention, Control, Treatment, Re-integration, and Protection of Rights), 2012 (pending) (HIV Bill): 1. Prohibition of discrimination: "No person shall be subjected to any form of discrimination because of his/her being HIV infected or on a suspicion that he/she is HIV infected." "No public or private enterprise shall discriminate against any person because of his/her being HIV infected or on a suspicion that he/she is HIV infected, in access or distribution of any facilities." 2. Privacy and confidentiality: "A person shall not be required to disclose HIV status unless otherwise required by the provisions of the HIV Bill of any other law in force."

Source: UNDP, WAP+, APN+ and SAARCLAW. 2013 ⁽⁸⁷⁾