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## Foreword

In response to call to submit national report by United Nations General Assembly Special Session on HIV and AIDS (UNGASS), we are pleased to present fourth country progress report. The report discusses about the HIV/AIDS status and progress on current policy, strategy, human rights status, involvement of NGOs and civil society's organization on prevention, treatment, care, and support.

Country has made significant progress on policy environment, resource mobilization and scaling up HIV and AIDS responses in recent years. Progress has also been made on data collection, analysis, and its uses to monitor and evaluate prevention, treatment and care programmes as well as HIV surveillance. These data and information indicate various positive trends in the response to the epidemic.

Nepal government is committed to activate the existing structures at all levels and harmonize their roles. Recent meeting of National AIDS Council (NAC) chaired by Prime Minister, further emphasized the importance of coordinated, multisectoral and decentralized actions to overcome the burden of HIV and AIDS in the country.

The fact that 90% of AIDS spending is being managed outside the public sector, calls for an attention to redress the balance in order for public sector to take increased role in HIV response.

As a result of collaborative efforts of national government entities, external development partners, civil society organizations, vulnerable groups, and PLHIV, HIV prevalence in some of the MARPS Group has declined or stabilized. Realizing the challenge to maintain this trend and achieve to MDG target by 2015, we should be committed for enhancing and expanding the services to population at risk and through engaging wider stakeholders.

It is pleasure to inform that continued support of EDPs has substantially contributed in scaling up the response along with the support in the areas like capacity building, supporting policy development, and international advocacy. However, it is also important to review the role of stakeholders in line with national policies and action plan particularly towards gradually shifting programme and fund management responsibilities to national entities.

It is very encouraging to express the active participation and contributions from government ministries, NGOs, PLHIV and their concerned networks in the process of preparation of this document. Government of Nepal would like to express its appreciation to our technical and programme partners for their expertise contribution to reinforce the content of this document.

We would also like to express our sincere thanks to UNAIDS for their technical and financial support for the preparation of this report. Finally, we would also like to thank all individuals for their contribution and active role played in prevention and control of HIV and AIDS.

Finally, we would like to express that the Government of Nepal is fully committed to address the vulnerability, risks, threats, and impact of HIV and AIDS and would like to extend its full support to halt the spread of HIV epidemic.

Honourable Minister Mr Umakant Choudhary
Ministry of Health and Population
and Chairperson – HIV AIDS and STI Control Board

Honourable member, Dr. Chet Raj Pant
National Planning Commission

Secretary, Dr. Sudha Sharma
Ministry of Health and Population
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Dr. Shyam Sunder Mishra, Vice chair & Chief
Executive, HIV AIDS and STI Control Board

Dr. Krishna Kumar Rai, Director
National Centre for AIDS and STD Control

**Date: 25 March 2010**

## Acronyms

| | |
|---|---|
| AED | Academy for Educational Development |
| AIDS | Acquired Immune Deficiency Syndrome |
| ANC | Antenatal Care |
| ART | Antiretroviral Therapy |
| ARV | Antiretroviral |
| AusAID | Australian Agency for International Development |
| CB-PMTCT | Community Based- Prevention to Mother to Child Transmission |
| DACC | District AIDS Coordination Committee |
| DDC | District Development Committee |
| DFID | UK Department for International Development |
| DIC | Drop-in Centre |
| DoE | Department of Education |
| EDP | External Development Partners |
| EHCS | Essential Health Care Services |
| EQAS | External Quality Assurance System |
| FHI | Family Health International |
| FNCCI | Federation of Nepalese Chambers of Commerce & Industry |
| FP | Family Planning |
| FSW | Female Sex Worker |
| GFATM | Global Fund to Fight AIDS, Tuberculosis and Malaria |
| HIV | Human Immunodeficiency Virus |
| HMIS | Health Management Information System |
| HP | Health Post |
| HSCB | HIV AIDS and STI Control Board |
| IBBS | Integrated Bio-behavioural Surveys |
| ICC | Information and Counselling Centre |
| IDU | Injecting Drug User |
| IEC | Information, Education and Communication |
| ILO | International Labour Organisation |
| INGO | International Non Governmental Organization |
| LGBTI | Lesbian, Gay, Bisexual, Transgender Intersex |
| LSBE | Life-skills based education |
| MARPS | Most at Risk Population |
| MCH | Maternal and Child Health |
| MOE | Ministry of Education |
| MoHP | Ministry of Health and Population |
| MSM | Men Who Have Sex with Men |
| MSW | Male Sex Workers |
| MTCT | Mother to Child Transmission |
| NAC | National AIDS Council |
| NACC | National AIDS Coordination Committee |
| NASA | National AIDS Spending Assessment |
| NCASC | National Centre for AIDS and STD Control |
| NCPI | National Composite Policy Index |
| NDHS | Nepal Demographic and Health Survey |
| NGO | Non-Governmental Organization |
| NHSP-IP | National Health Sector Programme Implementation Plan |
| NPC | National Planning Commission |
| OIG | Office of Inspector General (GFATM auditing mechanism) |
| OST | Oral Substitution Therapy |
| OVC | Orphans and Vulnerable Children |
| PHC | Public Health Centre |
| PLHIV | People Living with HIV |
| PMTCT | Prevention of Mother to Child Transmission |
| PMU | Programme Management Unit |
| PR | Principle Receipient (of Global Fund grant) |
| PRSP | Poverty Reduction Strategy Plan |
| RH | Reproductive Health |
| SAARC | South Asian Association for Regional Cooperation |

| | |
|---|---|
| SAE | Semi Autonomous Entity |
| SI-TWG | Strategic Information Technical Working Group |
| STD | Sexually Transmitted Disease |
| STI | Sexually Transmitted Infection |
| SW | Sex Worker |
| UNAIDS | Joint United Nations Programme on HIV and AIDS |
| UNDAF | United Nations Development Assistance Framework |
| UNDP | United Nations Development Programme |
| UNGASS | United Nations General Assembly Special Session |
| UNICEF | United Nations Children's Fund |
| UNTG | UN Theme Group |
| USAID | United States Agency for International Development |
| VCT | Voluntary Counselling and Testing |
| WHO | World Health Organization |

## Executive summary

The preparation of the UNGASS country report was widely participated in by a range of sectors like civil society organisations including PLHIV, government agencies; experts group (e.g. SI-TWG); external development partners and other stakeholders. A steering committee led by the National Planning Commission provided the guidance and oversight during the report preparation process. A desk review of a number of documents, studies (e.g. IBBS), and reports was carried out to extract necessary data and information. The UNGASS Nepal Country Progress Report Nepal 2010 covers the period 2008 -2009.

Nepal's HIV and AIDS epidemic which is concentrated amongst most-at-risk populations (MARPs) is not uniform but a mix of multiple types of epidemics in various regions/zones and districts. A high proportion of migrants with risk behaviour in the Far West has added a new dimension to the epidemic. According to the 2007 national estimates of HIV infection, about 70,000 people are infected with HIV in Nepal, 80% of whom are unaware of their status. As of December 2009 total reported HIV cases are 14320. The estimated adult HIV prevalence rate of Nepal was 0.49%, and nearly 50% of total HIV infections were recorded along the highway districts across the country. While the overall HIV prevalence among the labour migrants and rural/urban women is low, the labour migrants and low risk women (rural and urban) account for almost 40% and 26% to total infection respectively.

The data trends demonstrate a fluctuating epidemic amongst some of the high-risk groups, namely FSWs, MSWs, MSMs, labour migrants and Truckers while a steady decline in infection is seen amongst IDUs.

### National response

HIV and AIDS have been accorded high priority in many national policies and documents (National three year Interim Plan, National Health Sector Plan – II, UNDAF). Similarly, rights of minority and vulnerable group particularly those of 'third gender" had been recognised by an order of Supreme Court. Moreover, the National AIDS Policy (1995) is being revised vis-a-vis unfolding realities and challenges. Country has given continuity in developing multi year costed National Action Plan (2008 -2011) to operationalise National HIV and AIDS Strategy (2006 -2011). National M and E system and framework is evolving to meet the need for strategic information for policy and programme development.

National Policy Indices has been fairly similar to that of last reporting year. Continued political instability and frequent changes in government have been a challenge to staging consistent and focused advocacy initiatives. Civil society participation obtained high scores – which reflect the involvement of civil society in programme planning and implementation.

Institutional arrangements for better programme management were installed, The National AIDS Council, under the leadership of prime minister, HIV AIDS and STI Control Board (chaired by Minister of Health), National Centre of AIDS and STD Control (implementing wing of Ministry of Health), District AIDS Coordination Committee at the district levels are in place. Number of thematic groups and working groups are also in place.

Nepal's national programme targets the country-identified most-at-risk populations- IDUs, MSM, FSWs and MSWs, clients of FSW and seasonal male labour migrants and wives of migrants. The main thrust of the programme is need-based and tailored to the specific characteristics of the population group. Primary prevention is given a high priority. A large part of the prevention programme is currently supported by three major grants from USAID, DFID and the GFATM (Round 2, Round 7), with activities being implemented by a sizeable number of community based organisations and national NGOs including PLHIV.

The country was divided into four epidemic zones in 2003: 1) Kathmandu Valley; 2) Highway districts; 3) Far – western hills: (7 hill districts of the Far – western development region); 4) Remaining Hill Districts. There is a plan to conduct the first ever simultaneous mapping of all MARPs across the country in 2010. The – mapping is expected to inform the redefinition of the epidemic zones.

Financing wise, NASA (2007) reveals a total US$ 17 million AIDS spending in the country, with 97% from external sources and 3% from government despite an increase in allocation. Moreover, only 45% of resource is available (pledged by EDPs) for the three year National Action Plan (2008-2011) indicating large part of programme are not funded at all.

**Prevention**

Coverage data indicate wide variations among the groups between the 2008 and 2009 reporting period. Generally, there is increasing trend of coverage among MARPs except for clients of sex workers, where some decrease from the last reporting period was observed.

Knowledge among migrants appears to be the lowest: 15.8% in the Far Western region and 17.2% in the Western region (IBBS 2008). The knowledge level of clients of FSW (truckers) has decreased significantly, to half from the previously reported figure: from 50.5% to 25.8% (IBBS 2006, 2008). Combined with low coverage of ongoing outreach programmes on truckers (14% in 2009), this calls for more programmes to be launched targeting this particular group on the highways.

IBBS study indicated that comprehensive knowledge has well increased among MSM from 44.4% to 64.3% and even more so with MSWs and knowledge amongst IDUs has remained almost the same compared to last reporting period. Knowledge amongst female sex workers in Kathmandu has increased from 30.2% to 36.4%, but reported lower in other survey sites (14% in Pokhara, 26.7% in 22 Terai highway districts). Condom use in 2009 is reported highest among Truckers (93%) and lowest among IDUs (50%).

**Treatment, care and support**

Government service delivery outlets have increased - particularly on VCT, ART sites, sub ART sites and OI management sites - along with additional service sites implemented by various NGOs and INGOs. However, the uptake of services has only marginally increased. Detection of positive cases has almost remained constant and utilization rate per VCT centre has gone down. As of July 2009 there were 3236 people on ART (3540 as of December 2009). Despite increased uptake of ART from 11% in 2008 to 19% in 2009, the coverage is still low. This indicates the need of scaling up of ART services to reach though who are in

needs. Similarly PMTCT uptake is 3.29% calling for urgent attention for scaling up the programme.

The difficult geographical terrain, compounded by the lack of adequate information about existing services greatly limit the access and full utilization of available services.

**Monitoring and evaluation**

The Government recognises the need to improve monitoring and evaluation of the HIV response in a multisectoral manner and to significantly strengthen the systems that inform and shape the national response. Nepal has started putting in place the ingredients of a good M&E System, namely establishing an M&E Unit in the NCASC and HSCB and setting clear goals for the system, which include an M&E framework and national M&E guidelines, (in existence since 2006) and covering a range of indicators. The M&E Operational Plan (2008-2010), drafted in 2009, is currently being piloted in 6 districts.

Most of the surveillance activities carried in the past were project based. Discussions on the need to institutionalise and sustain surveillance are underway. Also, a major part of the human resource in the M&E system at all levels is supported by Global Fund/DFID. Though DACCs are keen on taking responsibility for monitoring and evaluating multisectoral HIV and AIDS programmes at the district level, inadequate capacity and support to DACC limits its functional role in M&E. There is need therefore to plan for building national capacity and ensure knowledge transfer from the national to downstream.

Despite having set up a national M&E system both at NCASC and HSCB conceptual clarity on how to link these two and operationalise one system that captures all the aspects of HIV and AIDS response (including those implemented by non state actors and non health actors) remains a challenge.

**Major challenges and remedial actions**

There is need for harmonisation and consolidation of the roles and functions of different bodies set up at various point in time for specific purposes, i.e. NAC, NACC, CCM, NCASC and DACC for better programme coordination. In addition, proper coordination and harmonisation of interventions implemented by various stakeholders (government agencies, multilateral and bilateral agencies, NGO and INGOs) to bring synergy and maximise benefits from these interventions are essential.

- The process of activating NAC and harmonisation of roles of different agencies will soon be completed as well as the endorsement of AIDS Bill by the parliament.

Global Fund did not allow the Ministry of Health/NCASC to become PR for Rd 7 until the OIG report is accepted by the Global Fund. Government body (neither NCASC nor HIV Board) not becoming PR has sent mixed messages and has affected the coordination of service delivery throughout the health care outlets.

- Capacity building process for two national entities (NCASC and HSCB) initiated by UNDP needs logical and strategic conclusion

along with UNDP preparing its exit plan to phase out from its current role as PR.

The delay in the approval/implementation of the no cost extension of DFID assistance caused sudden disruption or closure of activities implemented through more than 70 NGOs. The assistance was very crucial in expanding services in the areas of harm reduction, mobile population, care and support to PLHIV, service expansion (VCT) to MSM and the general population, and capacity building of national entities (NCASC and HSCB).

- The country to produce a quality proposal to the Global Fund for round 10 and explore funding opportunities with other EDPs. Speedy action to World Bank commitment is important.

Almost 90% of AIDS spending is managed by the UN and other international agencies (as a Financing Agent) outside the public sector. In other words, international partners have been engaging almost directly in programme management. The challenge therefore, is to increase the management responsibility of national institutions for long term sustainability of the programme in the country.

- External Development Partners who are handling the programmes need to critically review their role in the HIV response in Nepal and make an informed decision to gradually shift programme and fund management to national entities. However, continued support of EDPs, through technical assistance, will be required in areas like capacity building, supporting policy development and international advocacy

Seasonal labour migration, particularly between India and Nepal through an open border, will remain a major challenge for appropriate programmatic intervention. Ensuring access to prevention and other services across the border, calls for action at the SAARC level for a regional policy and programmatic framework.

- A number of SAARC level meetings and dialogues regarding HIV, trafficking, and drug issues in the past have created a strong basis to move towards more concrete action. A proactive move from those countries who share a common border would accelerate the process of developing an appropriate mechanism and for resource allocation

# I. Status at a glance

## A. Preparation of UNGASS progress report 2010

The HIV AIDS and STI Control Board (HSCB) was mandated by the Secretary, Ministry of Health and Population (MOHP), to lead the preparation of the UNGASS Progress Report 2010 in collaboration with National Centre for AIDS and STD Control (NCASC). Support was provided by the Strategic Information-Technical Working Group (SI-TWG), which is comprised by technical experts from government agencies, civil society, development partners. Other civil society organisations have also been engaged throughout the process.

As early as August 2009, a roadmap for UNGASS report development identifying activities, modalities, timelines and roles of the different actors has been prepared (*Annex 1: Roadmap of UNGASS 2010 country report* preparation). The roadmap outlined data needs and possible sources to generate and analyse information required to report on UNGASS indicators. The SI-TWG carefully reviewed the data and several consultations and meetings were held to discuss data quality, results and their implications.

Consultative processes undertaken included the following:

- A steering committee, led by honourable member from National Planning Commission (NPC) with members from the MoHP, HSCB, NCASC, UNAIDS, civil society, and other experts was formed, to oversee and finalise the UNGASS country report. A number of briefings and consultations with key stakeholders were conducted.
- HSCB, NCASC, UNAIDS and SI-TWG held sub-group meetings (1. Data Working team and 2. NCPI team) to review data needs and analyse existing data.
- Meetings with SI-TWG (with both sub-groups present) were organised to review methodology and refine and finalise data and indicators. Representatives from government, other development partners, civil society and specific MARP and vulnerable populations (i.e., IDUs, MSM, FSWs, and migrants) participated in the meetings.
- Two regional workshops with civil society and government officials were held (one in the capital and the other in Butwal) for NCPI and NASA.
- Data vetting workshop with technical partners and civil society organisations was held on 7 March 2010.
- A national consultation meeting was also held to share available data for UNGASS indicators, offer an opportunity for additional information to be shared, and to discuss and agree on data sources data quality.
- A sharing was organised for high level officials from Ministry of health and population, National Planning Commission, EDPs, Civil Society representatives and other before finalising the report.

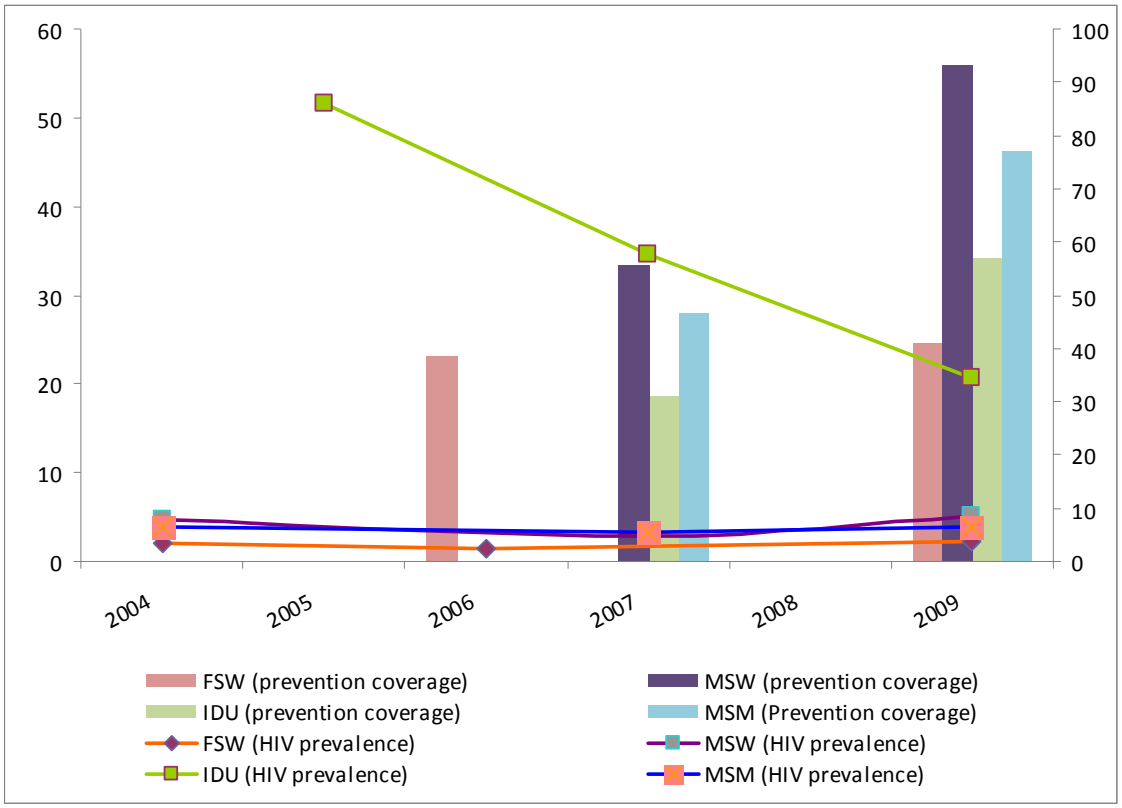
Feedback from the UNAIDS HQ on UNGASS Report 2008 provided the focus for improving the quality of the 2010 reporting and remained the guiding principle in defining the country action plan. Officials from HSCB, NCASC and Civil Society

also participated in the regional UNGASS workshop in Bangkok from 29 September, 2009 to 2 October 2009. A full report on the process is included (Annex 2: Process and steering committee for report preparation).

## B. Status of the epidemic (in summary)

Nepal's HIV and AIDS epidemic is concentrated amongst most-at-risk populations (MARP). However a high proportion of risky migration in the Far West might possibly add a new dimension to the epidemic. It is not a uniform epidemic but a mix of multiple types of epidemics in various regions/zones and districts. These groups include IDUs, FSWs and their clients, and MSM. Migrant males, uniformed service and transport workers have also been identified as at-risk groups in the NAP. However, the data demonstrate that in the case of migrants this is true only when they are clients of sex workers both in country and abroad. According to the 2007 national estimates of HIV infection, about 70,000 people are estimated to be infected with HIV in Nepal, most of whom are unaware of their infection. As of December 2009, there are only 14,320 HIV positive persons reported.

**Figure 1: Programme coverage and HIV prevalence (MARPs)**




The estimated adult HIV prevalence of Nepal was 0.49% in 2007 (2007, NCASC). The HIV prevalence among MARPs in 2009, as derived from IBBS studies are as follows: IDU, 3.4% in Pokhara to 20.7% in Kathmandu; MSM, 3.8% in Kathmandu; FSW, 2.3% in Terai Highway Districts; Truckers, 0% (AC Nielsen, SACTS, FHI, NCASC, 2009a, 2009b; New ERA, SACTS, FHI, NCASC, 2009a, 2009b, 2009c, 2009d, 2009e)). Similarly, the HIV prevalence in 2008 among

FSWs in Kathmandu was 2.2% and 3% in Pokhara; migrant males, 0.8% in Far Western districts and 1.4% in Western Districts; and spouses of migrant males, 3.3% in far western districts (IBBS, 2008). The epidemiological data trends demonstrate that the epidemic is fluctuating amongst some of the high-risk groups, namely FSWs, MSWs, MSMs and Truckers[1] with steady decline amongst IDUs.

**Table 1: HIV prevalence among MARPS (%)**

| | 2002 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 |
|---|---|---|---|---|---|---|---|
| **FSW** (Kathmandu) | | 2.0 | | 1.4 | | 2.2 | |
| **MSW** (Kathmandu) | | 4.8 | | | 2.9 | | 5.2 |
| **IDUs** (Kathmandu) | 68.0 | | 51.7 | | 34.8 | | 20.7 |
| **MSM (**Kathmandu**)** | | 3.9 | | | 3.3 | | 3.8 |
| **Clients of FSW** (Terai high way) | | 1.7 | | 1.0 | | | 0 |
| **Returned migrants** (West and Mid to Far West) | | | | West 1.1<br>F. West 2.8 | | West 1.4<br>F. West 0.8 | |
| **Wives of migrants** (4 districts far west) | | | | | | 3.3 | |

Source: IBBS (2002-2009)

## C. Policy and programmatic response

### Policy

Some of note-worthy initiatives (also highlighted in previous UNGASS report), are setting up of: (1) National Workplace Policy, (2) National Policy on Drug Control (2006), (3) Nepal Policy Advocacy Panel on HIV AND AIDS (4) HIV AND AIDS and STI Control Board (2007) as an expression of the commitment to move towards implementing the "Three Ones" principle in the country. National AIDS policy (1995) is also being reviewed taking into account of emerging challenges and new realities.

Nepal during this reporting cycle has also made significant progress in HIV and AIDS legal amendments. The Supreme Court of Nepal has ordered the government to promulgate laws to ensure confidentiality in the judicial process for cases involving people living with HIV, and recognized Lesbian, Gay, Bisexuals, Transgender and Intersexes (LGBTIs) as natural persons. The Court issued directives to ensure rights to life according to their own identities, introduce laws providing equal rights to LGBTIs and amend all the discriminatory laws against LGBTIs. Lastly, transgender (TG) individuals are legally recognised as the third gender and provisions have been made to include this category on the National Citizenship Cards.

[1] 2007, NCASC: National Estimates of HIV Infections Nepal 2007 Report Published by NCASC, Ministry of Health and Population 2009, IBBS: Final report on IBBS among IDUs, FSWs, MSM, Truckers conducted by New ERA/SACTS/FHI/USAID in 2009 (reports are to be disseminated by NCASC), 2008, IBBS: Final rep[orts on IBBS among FSWs, Labour Migrants and wives of conducted Labour Migrants by New ERA/SACTS/ FHI/USAID in 2008

HIV and AIDS have been accorded "priority 1" in the Three Year National Plan (2008 – 2010). It means that HIV and AIDS activities submitted by the line Ministries would receive high priority and funding. But despite efforts by a small number of line ministries, Ministry of Labour and Transport Management received funding support from Ministry of Finance. The Ministry of Labour and Transport Management received funding as a continuation from a previous programme jointly committed with ILO, for workplace HIV prevention.

**Strategic Plan**

The current National HIV and AIDS Strategic plan (2006-2011) is the third that the country had developed. The first effort towards developing a strategic approach to the epidemic was started in 1997 with Strategic Planning to HIV and AIDS (1997-2002).

The National HIV and AIDS Strategy 2006-2011 includes a Service Coverage Plan that established detailed activities in order to attain its coverage targets. The aim towards Universal Access to prevention, treatment, care and support has been central to setting these targets, considered the baseline situation, current available service facilities and the feasibility of expanding services.

To operationalise the National HIV AND AIDS Strategy 2006-2011, action plans were developed (National Action plan (NAP) 2006-2008 and NAP 2008-2011). The National Action Plan 2008-2011, developed through a multi-sectoral participative consultation process[2], articulates necessary actions to achieve universal access to prevention, treatment, care and support over the next three years. It highlights key programmatic needs and available resources indicating financing gaps in certain key areas.

The National Monitoring and Evaluation Framework will also track the progress of programme implementation outputs, outcomes and impact.

Besides the national strategy and action plan, Poverty Reduction Strategy Paper (PRSP) and United Nations Development Assistant Frameworks (UNDAF) continue to include HIV and AIDS as a key component of the plan. The National Health Sector Programme-Implementation Plan (NHSP-IP 2005) was revised and updated to include among others HIV and related programmes as one of the priority programmes in Phase II (2010-2015) plan.

**Programme focus**

Nepal's national programme is well-targeted at most-at-risk populations, and in Nepal's context these are: IDUs, MSM, FSWs and MSWs, clients of FSW and seasonal male labour migrants and wives of migrants. The main thrust of the programme is need based and tailored to the specific characteristics of the population group. Primary prevention is given a high priority. A large part of the prevention programme is currently supported by three major grants from USAID, DFID and the GFATM (Round 2, Round 7), with activities being implemented by a sizeable number of community based organisations and national NGOs including PLHIV.

[2] included non-health sectors and traditionally non-health partners

There are a number of service delivery points providing a variety of services including clinical management of Sexually Transmitted Infections (STI), Voluntary Counselling and Testing (VCT) and ART centres. I/NGOs are offering services for key target groups such as FSWs and clients, MSWs, MSM, IDUs and migrant workers (or clients of sex workers abroad) as well as for PLHIV. Government service delivery outlets have increased - particularly VCT, ART sites, sub ART sites and OI sites - along with additional service sites implemented by various NGOs and INGOs. The difficult geographical terrain, compounded by the lack of adequate information about existing services greatly limits the access and full utilization of available services.

**Financing**

As for the financing of the programme, NASA (2007) revealed that total of US$ 17 million was spent in the country on HIV and AIDS programme, of which 97% comprised funding from external source. Despite increase in government allocation to HIV and AIDS, it is still 3% of total spending on AIDS.

The total cost NAP 2008-2011 in USD is 128 million: for the first year 36 million, the second year 42.8 million and for the third year 49.2 million. The pledged resource commitment from EDPs and national sources is only 45% of the total need for three years.

Financing of the national response has been dominantly led by EDPs, which contribute over 97% of total spending. Therefore sustainability of the national response remains a colossal challenge.

**Leadership and coordination structure**

Nepal has expressed strong political commitment through the National AIDS Council (NAC), convened under the leadership and chaired by the Rt. Honourable Prime Minister. Formed in 2002, the NAC provides the highest level of leadership, multi-sectoral policy and overall guidance to the HIV AND AIDS response in Nepal. The multi-sector composition of the council is expected to allow for greater involvement of different ministries, the private sector and civil societies in the response to the HIV epidemic. The Prime minister in the meeting held on August 2009 had articulated a clear directive towards this end.

Likewise, there is the National AIDS Coordination Committee (NACC) chaired by the Minister of Health to execute NAC decisions.

The National AIDS and STI Control Centre (NCASC) was set up in 1992 after the completion of a two year AIDS Prevention Project that had started in 1988. Since then, NCASC has remained the key institution in the national response to HIV.

Similarly, keeping in view of changing needs within the institutional arrangement, HIV AIDS and STI Control Board (HSCB) was set up under the chair of the Ministry of Health along with representation from civil society organisations to further, among other activities, policy development, multisectoral coordination and monitoring the national response.

**An overview of National AIDS Council**

The National AIDS Council formed in 2002 is the highest level body to provide the highest level of leadership, multi-sectoral policy and guidance to the HIV/AIDS response in Nepal. This body is chaired by the Rt. Honourable Prime Minister and represented by the concerned line ministers. The multi-sector composition of the council is expected to allow for greater involvement of different ministries, the private sector and civil societies including PLHIV in the response to the HIV epidemic. Though this body was expected to meet at least once a year to review and guide the national response to HIV epidemic in Nepal, because of political turmoil and changes in the government leadership the Council was not able to meet since October 2002. In 2008 former prime minister during World AIDS Day had announced a Council meeting to be held shortly. The 2nd NAC meeting was organized in August 2009, after 7 years. A total of 95 people attended the meeting including different ministers, representatives from political parties, and high level officials from different sectors of the government, civil society heads and representatives, EDPs, Division Chiefs from the Department of Health Services, HSCB members, NCASC personnel and Media persons.

**The major outcomes of the meeting included:**

- The decision to proceed further to strengthen, empower and make HSCB more effective for multi sectoral coordination in line with the "Three Ones" principle.
- The decision to provide increased support to the NCASC for expansion of services and quality for increased access to HIV and AIDS and STI treatment and care services.
- The decision to authorize HSCB to lead and speed up the process of finalising the draft bill of "National AIDS ACT -2066". This comprises of the rights of the HIV infected and affected people and vulnerable populations as well as the provision of an appropriate institutional arrangement for a strong, sustainable, autonomous national entity. All concerned parties were urged to support the process.

## D. UNGASS Indicators: Data Overview

The data overview table shows the values reported in 2008 and current value from main sites as well as short explanation for values not reported. Analysis of the reported value and findings from routine reporting are also explained in the report.

### Table 2: Data overview by indicator

| UNGASS Indicator | Value reported in 2010 | Value Reported in 2008 |
|---|---|---|
| **Data reported is from main sites as follows: Kathmandu (FSW, MSW, IDU, MSM); Terai Highway (Clients of FSW-Truckers); Mid-Far West (Migrants)** | | |
| **IMPACT Indicators** | | |
| **Indicator 22:** Young women and men aged 15-24 who are HIV infected | Subject matter not relevant | Subject matter not relevant |
| **Indicator 23:** Most- at- risk populations who are HIV infected | **FSW -** 2.2%:<br><25 0.7; >25 4.7<br>**MSW** - 5.2%:<br><25; 1.4 >25 9.1<br>**IDU -** 20.70%:<br><25 7; >25 33.4<br>**MSM** - 3.8%: | **FSW-** 1.4%<br>**MSW**- 2.9%<br>**IDU-** 34.7%<br>**MSM**- 3.2%<br>**Clients of FSW (Truckers)-**1.0%<br>**Migrants**-<br>West – 1.1% |

| UNGASS Indicator | Value reported in 2010 | Value Reported in 2008 |
|---|---|---|
| **Data reported is from main sites as follows: Kathmandu (FSW, MSW, IDU, MSM); Terai Highway (Clients of FSW-Truckers); Mid-Far West (Migrants)** | | |
| | <241.3; >25 6.8<br>**Clients of FSW (Truckers)**-0%[3]<br>**Migrants**:<br>West: 1.4%<br>Far West: 0.8%) | Far West – 2.8% |
| **Indicator 24:** Adults and children with HIV still alive and known to be on treatment 12 months after initiation of ART | 90.56% | 84.86% |
| **Indicator 25**: Infants born to HIV infected mothers who are infected | Relevant but data not available | *(missing data cannot be reported accurately<br>*Loss to follow-up is high |
| **PROGRAMME COVERAGE** | | |
| **Indicator 3:** Donated blood units screened for HIV in a quality assured manner | 38.00%[4] | 100% |
| **Indicator 4:** Adults and children with advanced HIV infection receiving antiretroviral therapy | 11.75% (2008)<br>19.03% (2009) | 6.46% |
| **Indicator 5:** HIV positive pregnant women who received antiretroviral to reduce the risk of mother-to-child transmission | 1.94% (2008)<br>3.29% (2009) | 1.61% (2006)<br>1.44% (2007) |
| **Indicator 6:** Estimated HIV-positive incident TB cases that received treatment for TB and HIV | Relevant but data not available | 5.80% |
| **Indicator 7:** Women and men aged 15-49 who received an HIV test in the last 12 months and who know the results | Subject matter not relevant | Subject matter not relevant |
| **Indicator 8:** Most-at-risk populations that have received an HIV test in the last 12 months and who know their results | **FSW -** 32.4%<br><25 29.3; >25 37.3<br>**MSW**- 65.2%<br><25 62.3; >25 68.2<br>**IDU -** 21.5%<br><25 19.3; >25 23.3<br>**MSM** - 42.0%<br><25 35.7; >25 50<br>**Clients of FSW (Truckers) -** 13.80%<br>**Migrants**-<br>Western: 3.34%<br>Far West: 6.70% | **FSW-** 36.8%<br>**MSW**- 51.8%<br>**IDU-** 21.0%<br>**MSM**- 30%<br>**Clients of FSW (Truckers)**- 11.1%<br>**Migrants**- 3.2% |

[3] Client of sex worker data is based on sero study among Truckers. Among the clients of sex workers (12 different categories) truckers contributed only approximately 50 %. This suggests that the sampling may not represent all categories of clients of sex workers, as sampling was taken only from truckers' category. Therefore, from the programmatic point of view it is difficult to conclude that there is no prevalence among truckers hence no intervention required. This explanation applies to Indicator 9 also.

[4] Whereas all collected blood are tested for HIV, only blood transfusion centre at capital city participated in External Quality Assurance System with reference laboratory in Australia, hence the figure 38% reported in 2010. In 2008 all tested figure were reported irrespective of participating in EQAS.

| UNGASS Indicator | Value reported in 2010 | Value Reported in 2008 |
|---|---|---|
| **Data reported is from main sites as follows: Kathmandu (FSW, MSW, IDU, MSM); Terai Highway (Clients of FSW-Truckers); Mid-Far West (Migrants)** | | |
| **Indicator 9:** Most-at-risk populations reached with HIV prevention programmes | **FSW -** (40.8%<br><25 37.1; >25 46.6<br>**MSW -** 93.30%<br><25 89.9;>25 97<br>**IDU -** 56.9%<br><25 53.6; >25 60<br>**MSM -** 77.25%<br><25 71.9; >25 84.1<br>**Clients of FSW (Truckers) -** 14.0%<br>**Migrants**<br>West: 5.60%<br>Far West: 8.30% | **FSW-** 38.6%<br>**MSW**- 55.56%<br>**IDU-** 31 [5]%<br>**MSM**- 46.75%<br>**Clients of FSW (Truckers)-48.5%**<br>**Migrants**- 13.9% |
| **Indicator 10:** Orphan and vulnerable children whose households received free basic external support in caring for the child. | Subject matter relevant indicator not relevant | Subject matter relevant indicator not relevant |
| **Indicator 11:** Schools that provided life skills-based HIV education in the last academic year | 7.56% | 5.67% |
| **KNOWLEDGE AND BEHAVIOURS** | | |
| **Indicator 12:** Current school attendance among orphans and among non orphans aged 10-14 | Subject matter not relevant | Subject matter not relevant |
| **Indicator 13:** Young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and reject major misconception about HIV transmission | **Female:** 27.6%[6]<br>15-19 yrs: 29.1%<br>20-24 yrs: 25.8%<br><br>**Male:** 43.6%<br>15-19 yrs: 45.3%<br>20-24 yrs: 41.1% | 31.8% |
| **Indicator 14:** Most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission | **FSW-** 36.4%<br>25 35.3; >25 38.3<br>**MSW-** 80.7%<br>25 75.4; >25 86.4<br>**IDU-** 67.6%<br><25 64.4; >25 70.6<br>**MSM-** 64.3%<br>25 58.9; >25 71<br>**Clients of FSW (Truckers)-** 25.8%<br>**Migrants**<br>West: 17.20%<br>Far West: 15.80% | **FSW-** 30.2%<br>**MSW**- 40.7%<br>**IDU-** 66%<br>**MSM**- 44.5%<br>**Clients of FSW(Truckers)-**50.5%<br>**Migrants**- 19.2% |
| **Indicator 15:** Young men and women who have had sexual intercourse before the age of 15 | Subject matter not relevant | Subject matter not relevant |
| **Indicator 16:** Adult aged 15-49 | Subject matter not relevant | Subject matter not relevant |

[5] This data was revised following a national level consensus reached in consultation with SIT WG, civil society organization and MARPS community to report programme coverage data as basis for calculating coverage as against the IBBS survey findings (78.33%).
[6] DHS (2006)

| UNGASS Indicator | Value reported in 2010 | Value Reported in 2008 |
|---|---|---|
| **Data reported is from main sites as follows: Kathmandu (FSW, MSW, IDU, MSM); Terai Highway (Clients of FSW-Truckers); Mid-Far West (Migrants)** | | |
| who have had sexual intercourse with more than one partner in the last 12 months | | |
| **Indicator 17:** Adult aged 15-49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse. | Subject matter not relevant | Subject matter not relevant |
| **Indicator 18:** Female and male sex workers reporting the use of a condom with their most recent client | FSW- 75.0%<br><25 77.5; >25 71.0<br><br>MSW 37.8% | FSW- 77.2%<br><br>MSW- 93% |
| **Indicator 19:** Men reporting the use of a condom the last time they had anal sex with a male partner | 75.3%<br><25 74.6;>25 76.1 | 73.5% |
| **Indicator 20:** Injecting drug users reporting the use of a condom the last time they had sexual intercourse | 50.8%<br><25 49.3; >25 45.3 | 58.0% |
| **Indicator 21:** Injecting drug users reporting the use of sterile injecting equipment the last time they injected | 99.1%<br><25 98; >25 100 | 96.3% |

Sources: IBBS Survey (different years), NCASC/FHI/New Era
for indicators 3,4,5,24 NSASC routine programme data
for Indicator 11, MOE/UNICEF
for indicator 13, NDHS 2006 (MOHP)

# II. Overview of the AIDS epidemic

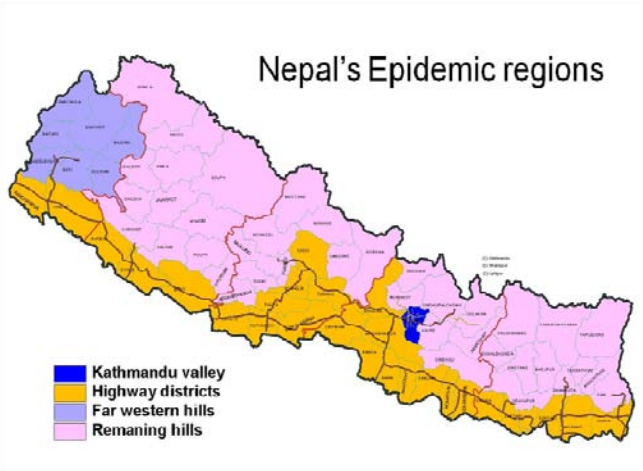
Since the first AIDS case was reported in 1988, the HIV epidemic in Nepal has evolved from a "low prevalence" to a "concentrated epidemic". As of 2008, national estimates indicate that 69,790 adults and children are infected with HIV in Nepal, with an estimated prevalence of about 0.49% in the adult population (15-49 years old). As of December 2009, only 14,320 cases of HIV and 1,755 AIDS cases had been reported to the National Centre for AIDS and STD control (NCASC). The sex ratio is 2.9:1 (male: female). Despite rapid increase of VCT and other service outlets, of the national estimate only 20% were identified as HIV positive.

## A. Epidemic zoning

Administratively, Nepal is divided into five development regions, 14 zones and 75 districts. The country has three ecological zones classified as mountain, hill and terai (flat-lands). The distribution of key populations at higher risk and HIV prevalence are distribution of key populations at higher risk and HIV prevalence is not uniform within a particular administrative or ecological region but rather associated with the extension of highways, mobility trends and urbanization.

As Nepal is geographically diverse, access to districts via roadways also varies between districts. For example, many districts (particularly those lying in the southern parts of the country) are linked by highways while there are others (particularly those that belong to hill ecological zone) that are very far from the highways and are less accessible. Kathmandu valley (comprising three districts) is different from highway and hill districts in terms of key populations at higher risk of HIV infection, and HIV prevalence. Commercial sex and sharing of unclean needles by injecting drug users were found to be the major drivers of the HIV epidemic in the highways and major towns, while migration of people to India and other countries is the risk factor in selected hill districts. There are other districts where all of these risk factors occur, but to a lesser extent.

**Figure 2: Epidemic zoning (2003)**




To better understand the epidemic of the country, based on available information on risk behaviours, HIV prevalence, and other factors contributing to transmission of HIV, the country was divided into four epidemic zones in 2003: 1) Kathmandu Valley; 2) Highway districts: Mahendra, Prithvi and Pokhara – Butwal highways; 3) Far – western hills: 7 hill districts of the Far – western development

region; 4) Remaining Hill Districts.

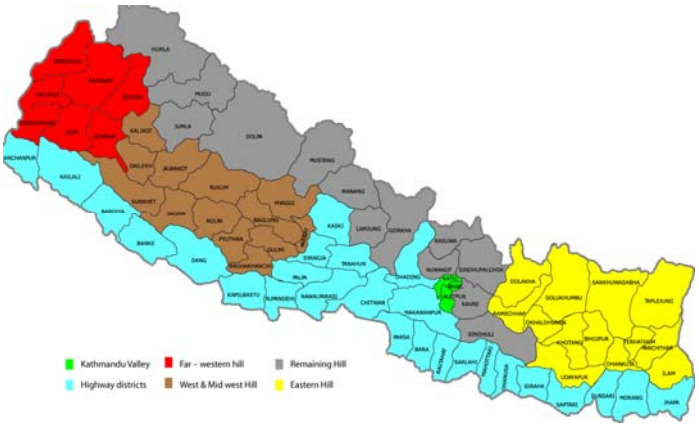
During the 2005 estimation, the need to redefine these regions was noted. However, this was not done then in the interests of comparability with the original study and to fill in the gaps from previous estimates. For the same reason, the 2007 estimates also follow the same definition of HIV epidemic zones as the 2003 and the 2005 estimates.

The present epidemiological zoning has 39 districts clubbed as remaining hills that account for a high proportion of the country. The country is planning to conduct its first ever simultaneous mapping of all MARPs across the country this year and while planning for the mapping the working group looked into the socio economic similarities between the districts within these remaining districts and based on the discussion the hypotheses of having three sub categories within this remaining districts was formed ( as shown by the map below ) which will be corroborated and refined following the completion of mapping and size estimation of MARPs exercise this year.

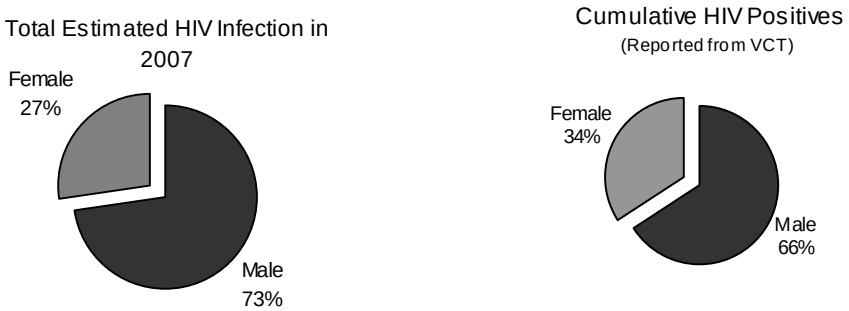
Proposed zoning for mapping of MARPs can be found in

*Annex 6: Proposed mapping zone and districts.*

## Figure 3: Proposed Zoning used for mapping MARPs




## Figure 4: Total estimated and reported HIV (%)




Nearly 50% of total HIV infections are recorded along the highway districts across the country. In the rest of the country (by epidemic zone), distribution of HIV infection ranges between 16 and 19%. Various new spots have emerged in other parts of the country showing concentrated MARPs presence, therefore while continuing the focus on the Terai belt, there is the need to explore risks and vulnerability in the remaining districts to understand the dynamics and to retain the low prevalence status of those areas. Similarly there are indications that more women IDUs exist than initially reported, calling for a revision in the strategy addressing women IDUs. Addressing the issue of prevention amongst migrants (client of sex workers abroad) and their spouses (prevalence 3.3% - IBBS 2008) especially in the far west, remains a challenge.

## Table 3: HIV infection estimate by sub population

| Population | Estimated infection 2007 | % |
|---|---|---|
| Children (0-14) | 1,857 | |
| Adults (15-49) | 64,585 | 0.49% |
| Adults (50+) | 3,348 | |
| **Total** | **69,790** | |
| Women | 19,061 | 29% |
| **Population sub groups (adults)** | | |

| Population | Estimated infection 2007 | % |
|---|---|---|
| IDU | 4,781 | 7.4% |
| MSM | 2,321 | 3.6% |
| Female Sex Workers | 449 | 0.7% |
| Male clients of female sex workers | 9,282 | 14.4% |
| Labour migrants* | 25,049 | 38.8% |
| Former IDUs | 1,776 | 2.8% |
| Former FSW | 689 | 1.1% |
| Former Clients of FSW | 722 | 1.1% |
| Former Migrants* | 1,422 | 2.2% |
| Former MSM | 171 | 0.3% |
| Trafficked return to Nepal** | 798 | 1.2% |
| **Population at low risk** | | |
| Urban female low-risk population | 3,514 | 5.4% |
| Rural female low-risk population | 13,611 | 21.1% |
| **Total** | **64,585** | **100%** |
| *Male: ** female | Source: NCASC 2007 | |

As of December 2009, the cumulative reported cases since 1988, are just over 14,340 (Table 4). The majority of reported HIV infections in the country are found among the most productive members of society, which is the 25 to 39 age group.

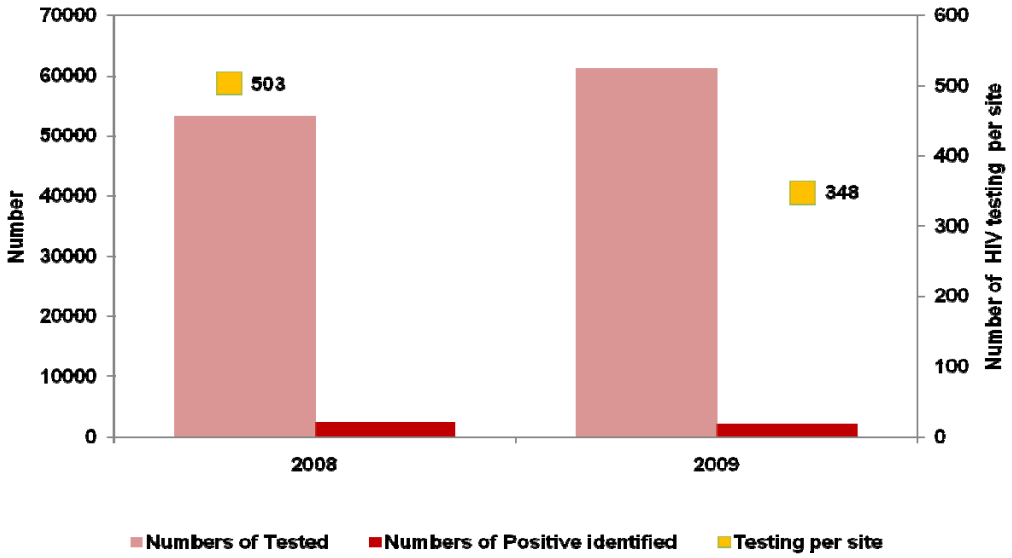
### Table 4: Cumulative reported cases from 1988 to Dec 2009

| | Male | Female | Total |
|---|---|---|---|
| HIV Positives (Including AIDS) | **9418 (65.7%)** | **4902 (34.3%)** | **14320** |
| AIDS (Out of total HIV) | **1755** | **738** | **2403** |

The large gap between estimated cases and detected cases raises question about programme reach, situation of stigma and discrimination, and other factors that limit access to testing and counselling services. In other words, only about 20% of estimated case knows their HIV status. The significant gap between estimated and tested size poses programmatic, epidemiologic as well as public health challenges as about 80% of HIV infected individuals are unaware of their HIV status.

If we consider the trend of increase in uptake of testing services, we notice that uptake is going up but detection of positive cases remains stagnant with 4.4% and 3.4% in 2008 and 2009 respectively (Figure 5 and Figure 6).

### Figure 5: Number of people tested and number of HIV

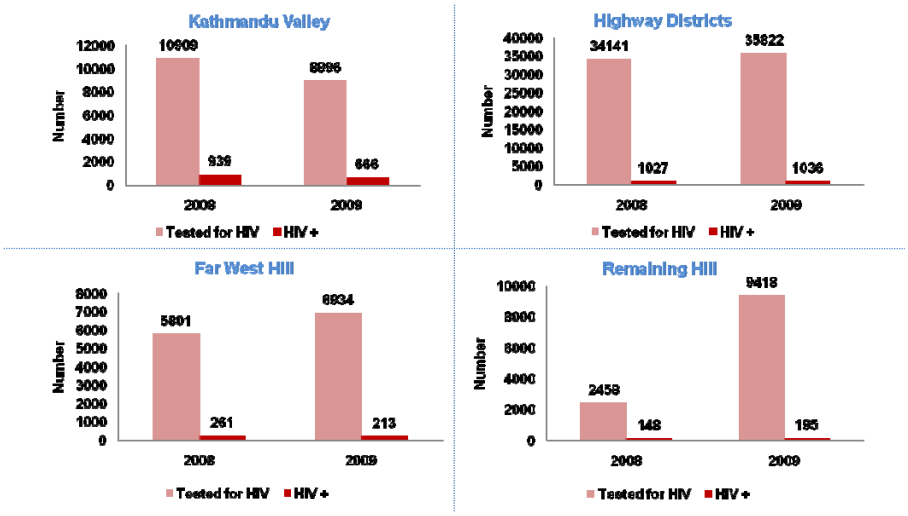



Source: NCASC 2008, 2009, Routine Programme Data

Despite increase in number of testing facilities the uptake of services has only marginally increased. Detection of positive cases has almost remained constant. Utilization rate per VCT centre has gone down and so has the cost effectiveness: 10 to 7 per week between 2008 and 2009. The low detection of positive cases from VCT sites raise number of questions. Whether the expansion of VCT sites have been strategic both in terms of location and timing, have VCT been appropriately targeted to reach the MARPs, are people using private clinics and hospitals for such test, is it cost effective to have stand alone VCT when uses per week is very low, are there still barriers and stigma and discrimination that discourage people to access the service. Besides, significant geographic overlap of test and increased possibility of double count should not be undermined.

**Figure 6: Number of people tested vs HIV positive by epidemic zones**

Number of people tested for HIV vs HIV positive in 4 epidemic zones, 2008-2009




Source: Routine reporting data (NCASC, HSCB)

## B. HIV prevalence among MARPs

Nepal's HIV epidemic, driven by unprotected sex, sharing of unclean needle by injecting drug users and sexual transmission, is characterized by higher HIV prevalence concentrated among groups. Prevalence among IDUs though declining steadily over the period is still well above 5% in some areas (Figure 17) while among FSWs and their clients, MSWs, MSM and returning migrants, it remains above 1.5% *(see detailed breakdown in* Table 5*)*

**Table 5: HIV prevalence among MARPs % (indicator 23)**

| MARP | Location | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 |
|---|---|---|---|---|---|---|---|---|---|
| FSWs | Kathmandu | | | 2.0 | | 1.4 | | 2.2 | |
| | Pokhara | | | 2.0 | | 2.0 | | 3.0 | |
| | 22 Terai Districts | | | 2.0 | | 1.5 | | | 2.3 |
| Client of FSW (Truckers) | Terai Districts | | | 1.8 | | 1.0 | | | 0.0 |
| IDUs | Kathmandu | 68.0 | | | 51.7 | | 34.8 | | 20.7 |
| | Pokhara | | 22 | | 21.7 | | 6.8 | | 3.4 |
| | E. Terai | | 35.1 | | 31.6 | | 17.1 | | 8.1 |
| | W. Terai | | | | 11.7 | | 11.0 | | 8.0 |
| MSM | Kathmandu | | | 3.9 | | | 3.3 | | 3.8 |
| MSW | Kathmandu | | | 4.8 | | | 2.9 | | 5.2 |
| Migrants | Mid- and Far West | | | | | 2.8 | | 0.8 | |
| | Western districts | | | | | 1.1 | | 1.4 | |
| Spouses of migrants | Far west districts | | | | | | | 3.3 | |

*Source: IBBS (2002-2009)*

# III. National response to the AIDS epidemic

## A. National Programme and Achievements

There have been some gains and progress made with respect to national commitment and strengthening the national response in this reporting period (2008 - 2009).

Major achievements in the reporting period (2008 – 2009) are:

- Recognition of HIV and AIDS as a priority in the country's latest development plan (National Interim Plan, National Planning Commission 2008 – 2010).
- Inclusion of HIV and AIDS as one of key programme areas in the NHSP phase II for the period 2010-2015
- Significant progress made towards adopting the "Three Ones" principles:
    - One strategic plan: National Strategy 2006-2011 and National Action Plan 2008-2011 to operationalise the, national strategy;
    - One coordinating authority: Setting up of the HIV AIDS and STI Control Board under the leadership of the Ministry of Health, with representation from civil society and other vulnerable communities
    - National AIDS Council meeting
    - One monitoring and evaluation framework: a National M & E framework is under development ensuring harmonization of national and global indicators (i.e. UNGASS indicators). A system and institutional arrangement has also been set up to collect, collate, and disseminate the information. The above are initial steps to set up the country monitoring and evaluation system that will allow use of strategic information to support decision-making, planning and implementation.
- Strengthening of institutional arrangements to support the national HIV and AIDS response, such as SI-TWG and CHBC etc. More technical working groups or thematic groups (MSMs, FSWs, and IDUs) were formed in the areas of treatment and care like on management of logistics and supplies, ART working group.
- Securing increased financial resources for HIV and AIDS:
    - commitment by government for increased budget
    - successful application to the Global Fund, Round 7 which amounts to US$ 36.6 million and covers gaps identified in the response.
    - DFID committed to continue funding up to 2011
    - USAID committed to continue its funding
    - World Bank has now agreed fund HIV and AIDS through a pooled funding mechanism.
- Progress made in strengthening capacity on HIV of national leaders and policy makers, women and youth leaders.
- Formation and registration of networks of MARPs, (e.g. sex worker organisations, network of positive persons, organisations of women living with HIV, networks for MSM, etc).
- Implement a comprehensive legal framework on HIV and AIDS to promote human rights and establish HIV and AIDS as a development agenda

The national strategy includes six key programme areas and strategic outcomes namely:

**a). Prevention**

- Improved knowledge and safe behavioural practices of all target groups (safer sex and injecting practices);
- Increased availability of and access to appropriate and differentiated prevention services;
- Increased acceptance of HIV and AIDS and enhance non-discriminatory practices affecting marginalized and most at risk populations, and;
- Reduced risk and vulnerability to HIV infection of all target populations.

**b). Treatment care and support**

- Increased national capacity to provide quality diagnostic, treatment and care services;
- Increased availability of appropriate and differentiated care and support services to infected, affected and vulnerable populations;
- Increased involvement of private sectors, civil societies, communities and family for treatment, care and support to infected, affected and vulnerable groups;
- Increased importance of the role of support groups of infected, affected and vulnerable people in treatment, care and support;
- Established and monitored continuum of prevention to treatment, care and support,
- Standardised clinical care, ART, treatment for opportunistic infections and Post Exposure Prophylaxis both in the public and the private sectors, and;
- Impact mitigation strategies and programs in place, adequately resourced and accessed equitably by the infected, affected and vulnerable groups.

**c). Advocacy, policy and legal reform**

- HIV AND AIDS prioritised as part of the national development agenda and included in the 11$^{th}$ Five Year Plan as a programme under the social sector;
- Rights of infected, affected and vulnerable groups insured through an effective legislative framework;
- Operationalised networks of PLHIV and most-at-risk-populations;
- Decentralised and coordinated HIV response, and;
- Strengthened and expanded multi-sectoral response to HIV and AIDS.

**d). Leadership and management**

- Operationalised national strategy through the National Action Plan;
- Active champions and leaders at the societal, institutional and individual levels for the HIV and AIDS response;
- Mainstreamed HIV and AIDS programs in selected development sectors;
- Enhanced social inclusion, equitable access and gender equality to AIDS services, and;
- Coordinated and decentralized response to HIV and AIDS.

**e). Strategic information**

- Trends and changes in HIV prevalence and HIV and STI related risk behaviours among different risk groups tracked over time and across regions in Nepal;
- Effectiveness of HIV prevention and care interventions and activities monitored and evaluated;

- All aspects of key programme service delivery areas effectively monitored and evaluated;
- Programme coverage and service delivery assessed by target group; and
- Resource inputs and outputs contributing to the programme monitored.

### f). Finance and resource mobilisation

- 100% of funding mobilized for the implementation of the multi-year National Action Plan from the Government, development partners, NGOs and private sector organizations;
- By 2009, government investment in AIDS activities will be at least 5% of the total HIV AND AIDS program budget, and by 2011, at least 10%;
- Appropriate multi-sectoral resource allocation under the relevant line ministries,
- An efficient and coordinated financial management system;
- Timely and improved resource flow, and;
- Improved accountability at all levels.

## B. Institutional arrangement

Since the first AIDS case was reported in 1988, the government of Nepal under the leadership of Ministry of Health initiated the 1st National AIDS Control Project in 1988. By 1992, the project has evolved into a more formal structure with the then newly-formed National Centre for AIDS and STD Control under the Ministry of Health. NCASC is tasked to set up the system, scale up national response and coordinate the interventions despite structural limitations, limited budget and human resources. NCASC in past led policy and strategy development, provision of direct services and monitoring the responses in collaboration with national and international stakeholders and donors.

In order to manage an effective and sustained national response while keeping in view emerging challenges and overcoming some structural limitations, the Government of Nepal established the "HIV/AIDS and STD Control Development Board" (2007 AD) also referred to as a Semi-autonomous Entity" (SAE) as the national AIDS coordinating authority. This body, chaired by the Minister of Health and Population has enhanced the status and authority, with its multisectoral remit and financial authority.

The most recent meeting of the National AIDS Council held on August 2009 (chaired by the Prime Minister) demonstrated further commitment to strengthen the national response and institutional arrangement.

However, keeping in view the changing scenario and in the context of where HSCB currently stands, the challenges include, the need for defining the 'Three Ones', and the consolidation and harmonisation of the functions of different bodies set up at various points in time for specific purpose, i.e. NAC, NCASC, NACC, CCM, and DACC.

Continued effort from the previous reporting period (2006-2008) has further contributed in progressing towards achieving of the "Third One" – one agreed country level Monitoring and Evaluation system. The *Monitoring and Evaluation Guidelines for HIV and AIDS in Nepal* and M&E system was developed by two national institutions, namely NCASC and HSCB.

As a result of the standardisation of indicators in 2006, a number of surveys now include questions that generate data required by the country to report on UNGASS. These include knowledge indicator in the DHS, coverage and behaviour indicators in Integrated Bio-Behavioural Surveys, multisectoral indicators (e.g. life skills based education) from the education sectors. A detailed implementation plan has been developed in collaboration with the HSCB and NCASC to operationalise the M&E system. Pilot testing of the M&E system has been done in six districts.

## C. National Composite Policy Index (NCPI)

### 1. Strategic Plan

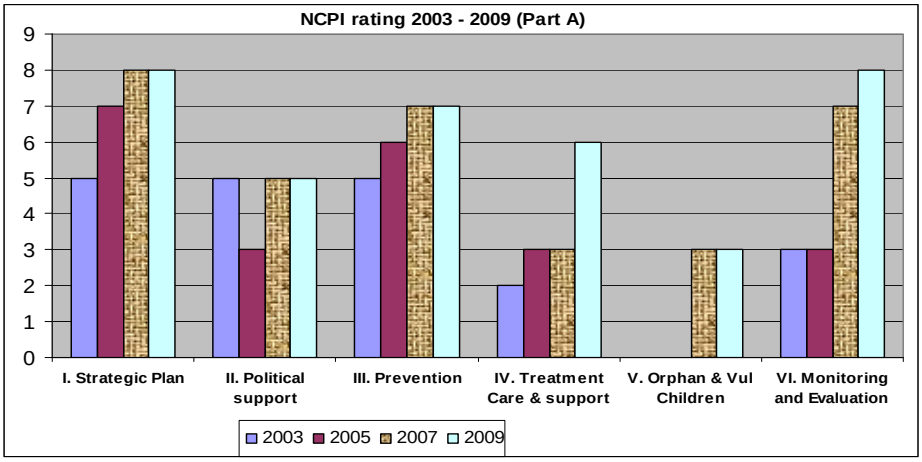
Nepal is on its third National HIV/AIDS Strategic Plan (2006-2011) with a corresponding National Action plan 2006-2008 and another for 2008-2011.

Based on the national strategy, the multi year costed national action plan (2008-2011) and budget was developed where programme targets and strategic outcome indicators have been defined including the funding requirement, pledged commitments and funding gap in implementing the plan.

### 2. Political support

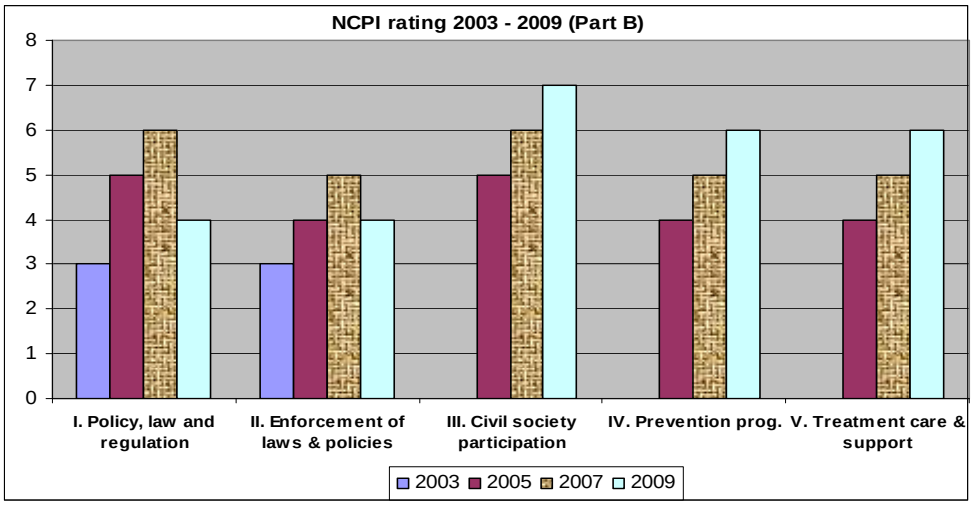
Policy advocacy and political support has been fairly similar to that of last year. The continued political instability and frequent changes in government have been a challenge in staging consistent and focused advocacy initiatives. Changes in government have also meant turnover of bureaucrats and officials, resulting in disruption of advocacy initiatives and programme implementation. The overall NCPI scoring has remained the same as or scored lower than last reporting period by CSOs.

**Figure 7: NCPI rating 2003 – 2009 (Part A)**




The overall rating from civil society in part B appeared higher for prevention, treatment and care. Here, the scoring in part A and part B is fairly consistent. However, in other sections like policy and law enforcement, civil society's scoring is either lower or the same as the last report. Civil society participation obtained high scores – which reflect the involvement of civil society in programme planning and implementation.

## Figure 8: NCPI rating 2003 - 2009 (Part B)




It is noteworthy that despite political instability and during the height of political conflict, the health sector was least affected and continued to deliver at its maximum level. Some of the policy initiatives undertaken over the period were as follows:

- National AIDS Council, being the highest-level policy forum, held a meeting on October 2009 and took key decisions. Leading from this, NCASC, Ministry of Health and HSCB have now initiated a revision of the HIV Policy (1995) so as to reflect HIV as a development issue.

- Among the Nepalese leaders of the Asia Pacific Leadership Forum on HIV and AIDS and Development (APLF), four are members of the Constitution Assembly. During a meeting in 2009 with HSCB, the APLF leaders were introduced to the current HIV and AIDS Bill and addressed how they could support the endorsing process. Besides this, some other events where advocacy has taken place are World AIDS Day, Condom Day, TB Day, 16 day long march on violence against women, Breast feeding day and so on. During the 2009 World AIDS Day, two Goodwill Ambassadors were nominated.

- A multisectoral sub-committee within HSCB comprising representatives from the Ministries of Local Development, Home Affairs, Women and Children, Labour and Transportation, Education and the National Planning Commission (2009), have initiated working on an agenda to mainstream HIV and AIDS.

- National Action Plan, National Advocacy Plan on HIV/AIDS and National AIDS Spending Assessment were disseminated to over 100 different stakeholders, which also provided an opportunity to bring forth the advocacy issues (2009).

- The global Code of Good Practice has been translated into Nepali for NGO's working on HIV sector and is now under process of implementation (2009-2010).

### 3. Human rights and civil society participation

While the official state mechanism to monitor human right violations of MARPs and PLHIV is not very specific, civil societies, media, activists and professionals regularly collect and share cases related to human rights violation. Networks of PLHIV and other MARPs groups also publish such cases regularly in their newsletters.

**Voices from field: UNGASS process and CSO needs**

It is important to note that AIDS could have a severe impact in migrant population over the coming decade; however separate indicator for this population is not included in the UNGASS guidelines.

Although CSOs have a vital role to play in the preparation of the country report, their capacity to effectively respond to the UNGASS process could be hindered due to the lack of capacity. CSO needs extensive support to build their capacity for engagement in the future.

There is great demand from various MARP groups and networks to clarify national figures on coverage and other programmatic indicators. CSOs strongly urged to have a regular follow up of the data gaps identified in this year's UNGASS report preparation. Most of the surveillance information comes from project specific objectives and is not representative of the country as a whole. Also, because the programmatic data comes from various donor supported programmes, CSOs felt the need to coordinate these reports into one national system so that they can get national and regional level data to support their resource mobilisation and programme management efforts. Demand for region specific UNGASS reports was also expressed by CSOs, to continue the process beyond UNGASS report submission. More linkages with CSO networks and SI-TWG were suggested, so that the CSO data needs are addressed by SI-TWG, including Third Gender disaggregation for all UNGASS indicators.
Despite a thorough plan of action built upon evidence-informed recommendations, the country is still facing a shortage in resources that could jeopardize the national response and can put the country one step behind the epidemic. Therefore, more resources are needed to curb the epidemic, with increased investment by the government towards HIV and AIDS.

Civil society participation in all aspects of HIV related activities is well established. MARPs representatives or their networks are regularly involved in all activities ranging from policy development, proposal writing and implementation, and monitoring of the implementation. MARPs are represented in policy bodies such as NAC, HSCB and DACC at the district level. All CSOs are not equally capable in terms of programme implementation and providing inputs at strategic level. Strong advocate gets higher share (participation and access to resources).

In an effort to move towards a rights-based approach and ensuring equity of services, National HIV/AIDS Strategy and National Action Plan have clearly recognized the need for specialized approaches of service provision so that those who are not reached by the general programme can be reached.

Most obstacles have remained the same as those within the 2008 UNGASS Report. No major changes were observed during this reporting period except that the Supreme Court legally recognizes TGs as the third gender. The National Citizenship Card will now have three options to choose from in the "sex" column i.e. Male, Female, and Third Gender (TG).

## D. AIDS Spending in Nepal

Nepal conducted a National AIDS Spending Assessment for the year 2007. This exercise was the first of its kind and has revealed much critical information with implications for HIV policy and programmes in the country.

In 2007, Nepal received US$ 22,681,199 for HIV and AIDS-related initiatives and spent US$ 17,661,653 on activities supporting these initiatives. Overall, the absorption rate was almost 80%.

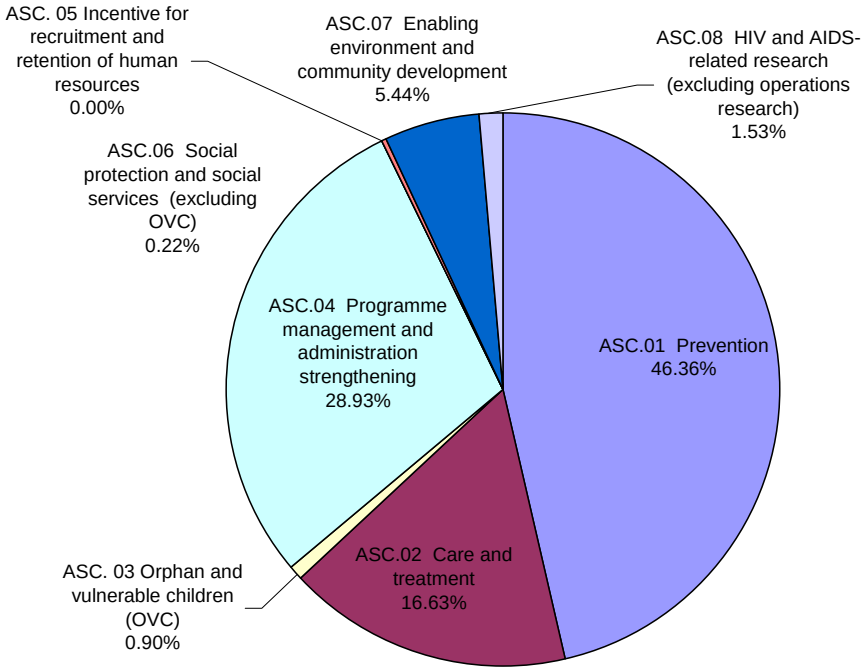
Of the total spending for HIV-related activities in 2007, US$ 8,187,202 (46%) was spent on a prevention programme, and US$ 2,936,452 (17%) on care and treatment related activities. Over 28% (US$5 million) was spent on programme management and administration. More information and analysis are necessary to be able to detail expenditure on programme management in the context of strengthening the national spending capacity for programme interventions.

Partners committed about US$ 33 million for the two-year period 2006-2008, or about US$17 million a year compared to the US$64 million budget plan of the National Action Plan (2006- 2008). Some US$ 17.5 million was actually spent, indicating a fairly consistent pattern of commitments and actual spending. However, this spending is only 50% of total requirement according to the NAP 2006-2008.

### Table 6: Spending by AIDS Service Category 2007

| Major AIDS Spending Categories | Expenditure | (%) |
|---|---|---|
| ASC.01 Prevention | 8,187,202 | 46.36 |
| ASC.02 Care and treatment | 2,936,452 | 16.63 |
| ASC.03 Orphans and vulnerable children (OVC) | 158,739 | 0.90 |
| ASC.04 Programme management and administration strengthening | 5,109,801 | 28.93 |
| ASC.05 Incentive for recruitment and retention of human resources | 0 | 0.00 |
| ASC.06 Social protection and social services (excluding OVCs) | 39,673 | 0.22 |
| ASC.07 Enabling environment and community development | 960,359 | 5.44 |
| ASC.08 HIV AND AIDS-related research (excluding operations research) | 269,427 | 1.53 |
| **Total** | **17,661,653** | **100** |

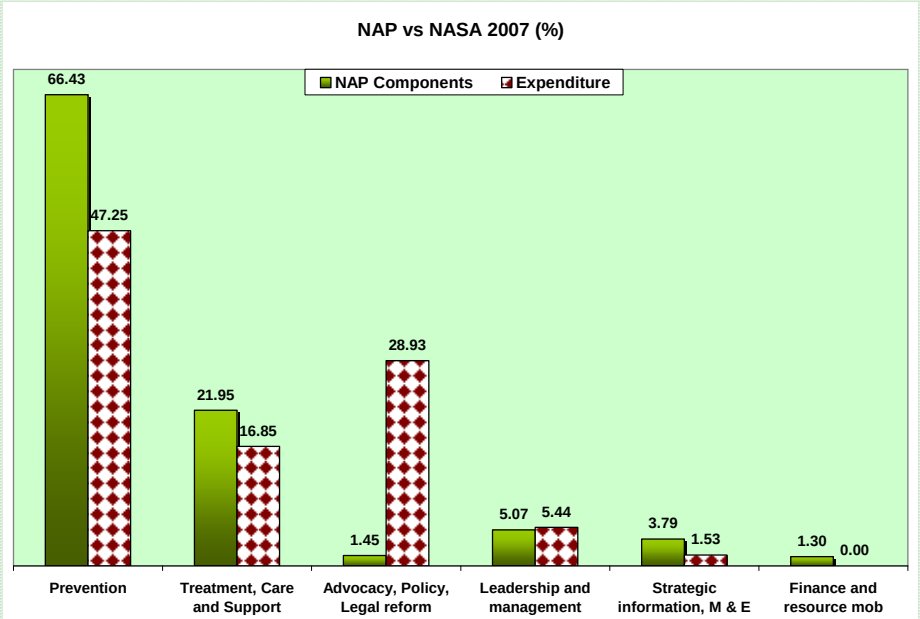
### Figure 9: Spending by major programme category (2007)




**Spending by intervention**

Spending for the six major strategic components of the programme was less than budgeted for (Figure 10). On the other hand, spending for advocacy and policy reform was much higher than what was planned.

### Figure 10: NAP 2006-2008 and NASA 2007 Expenditure



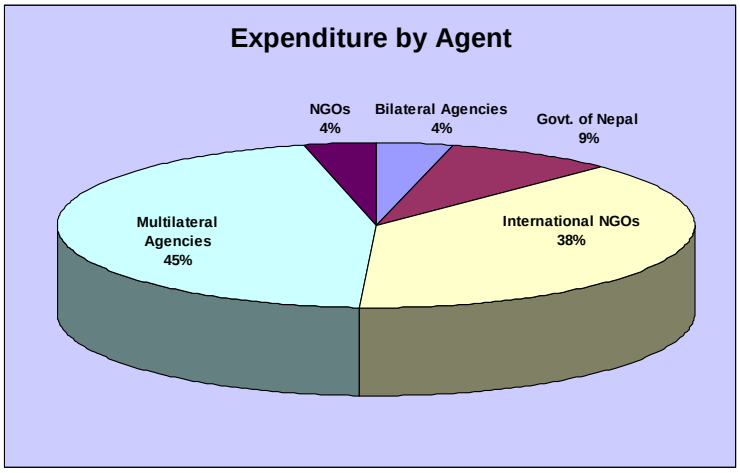

Of the total spending of US$ 17,661,653 for HIV and AIDS in 2007, 67% was financed by bilateral donors, followed by multilateral sources including the Global Fund (24%). Government financing for the programme was 3%. International not-for-profit sources, mainly international non-governmental organisations, used up about 6% of total spending

## Table 7: Function by source of fund

| AIDS Spending by Source of Fund (in US $) | Total (2007) (100%) | Public Sub-Total (3.5%) | International Sub-Total (96.5%) | Private Sub-Total (0%) |
|---|---|---|---|---|
| 1. Prevention (sub-total) | 8,187,202 | 251,169 | 7,936,033 | 0 |
| 2. Care and Treatment (sub-total) | 2,936,452 | 100,734 | 2,835,718 | 0 |
| 2.01 Outpatient care | 1,826,957 | 100,734 | 1,726,223 | 0 |
| 2.02 In-patient care | 29,393 | 0 | 29,393 | 0 |
| 2.03 Patient transport and emergency rescue | 0 | 0 | 0 | 0 |
| 2.98 Care and treatment services not disaggregated by intervention | 537,061 | 0 | 537,061 | 0 |
| 2.99 Care and treatment services not-elsewhere classified | 543,041 | 0 | 543,041 | 0 |
| 3. Orphans and Vulnerable Children (sub-total) | 158,739 | 0 | 158,739 | 0 |
| 4. Program Management and Administration Strengthening (sub-total) | 5,109,801 | 240,038 | 4,869,763 | 0 |
| 5. Human resources (sub-total) | 0 | 0 | 0 | 0 |
| 6. Social Protection and Social Services excluding OVC (sub-total) | 39,673 | 25,746 | 13,927 | 0 |
| 7. Enabling Environment (sub-total) | 960,359 | 0 | 960,359 | 0 |
| 8. Research (sub-total) | 269,427 | 0 | 269,427 | 0 |
| **TOTAL** | **17,661,653** | **617,687** | **17,043,966** | **0** |

Different financing sources seem to have their specific functional focus, but all sources have consistently spent highest on prevention (ASC 01.01), and programme management and administration (ASC 04.01). Spending on programme management and administration needs careful and cautious interpretation; detailed breakdown of expenditures is necessary to be able to draw conclusions. As the financing of national response is heavily reliant on international funding so is the management of fund. In other words, large proportion of available fund is managed (or spent) by or through multilateral agencies and INGOs. Only 9% to total fund is managed by public sector (Figure 11).

## Figure 11: Expenditure by Agent



## E. Prevention

Given the nature of Nepal's concentrated epidemic, the focus of the response is on prevention programmes for most-at-risk (IDUs, MSM, FSWs and MSWs, clients of FSWs, and seasonal labour migrants, with an emphasis on adolescents within these groups) and at-risk populations (young people, uniformed services and prison populations). Efforts are focused on primary prevention, while the secondary prevention programme is implemented for those who are already infected and their partners.

The National Action Plan and budget show that targeted interventions for most at risk populations have grown from 44% in last period (NAP 2006 -2008) to 65% over this period (NAP 2008-2011). A large part of the prevention programme is currently supported by four major grants from GFATM (Round 7), USAID, UN agencies and DFID. Activities are being implemented by over 200 national NGOs, NGOs networks and community-based organisations.

Epidemiologic and modelling data suggest that growth of the HIV epidemic may have stabilized in Nepal in recent years for some groups. This declining trend, parallel to several other epidemics in the region, suggests that current prevention efforts are having impact and should be strengthened. Evidence supporting this view comes from triangulation of HIV, STI and behavioural data (although geographically limited) from several sources, and from coverage data of targeted interventions[7].

### a. Positive prevention

The NAP (2008-2011) has included some activities on positive prevention mainly focusing on manual and guideline development, trainings and procurement of CHBC kit for a limited number of PLHIV. Besides, the PLHIV networks and groups are engaged in positive prevention at the field level while at the same time advocating for increased national attention.

The positive prevention is led by a team of PLHIV initiated as part of USAID/ASHA project encourages others to access VCT, ART and other services through experience sharing. Positive Prevention programs activities have included training and mobilization and development of a Positive Speaker's Bureau (PSB) for sharing real life experiences. This has been a cornerstone in promoting disclosure of PLHIV. It has increased PLHIV's access to various services and evoked stigma reduction in the communities. PLHIV themselves are highly effective outreach educators and community mobilizers. They work through interpersonal approaches with a confidential manner, encouraging for individual behaviour change and reaching more easily PLHIV who do not wish to disclose their status.

The approach has produced good results for concordant and discordant couples as well as for the general population. It has brought families together, promoted safer sex and developed good understanding between discordant couples as well as with the communities.

[7, 5] External Assessment Report 2008

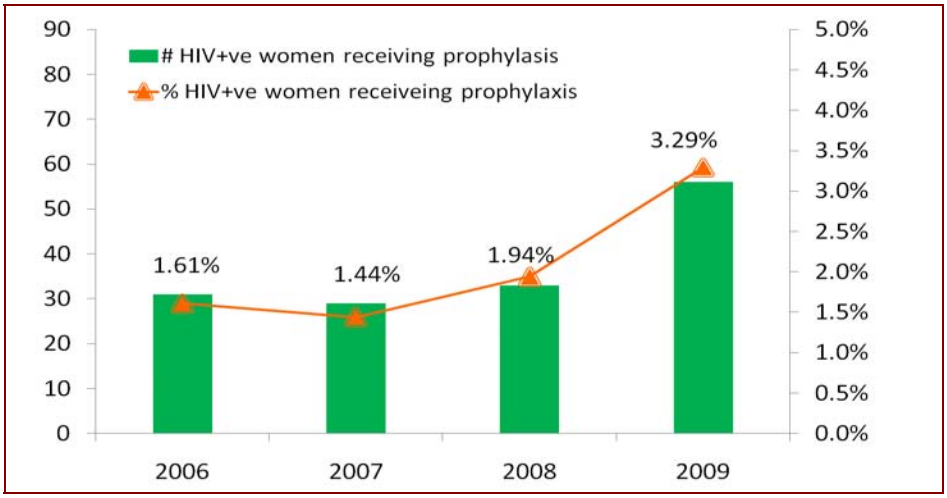
Groups comprising of HIV positive individuals have formed loose networks in different parts of the country with the aim of supporting each other, advocating for the access to ART and other services and running crisis care centres next to ART sites to help access ART and ensure ART adherence. Some support groups had received DFID civil society challenge funds through the National Association of PLHA – Nepal (NAP+N) to strengthen their CBOs and networks.

Stigma and discrimination to HIV is still high in rural areas. Scaling up stigma and discrimination reduction programmes is required to achieve better results of positive prevention.

### b. PMTCT

It is estimated that some 1700 pregnant women are in need of PMTCT, of which only 56 mothers received ARV Prophylaxis from 17 PMTCT sites. In 2008, 33 mothers received single dose Nevirapine (sdNVP). Looking at the disaggregation by regimen in 2009 (English calendar) 41 received sdNVP, 21 received expanded regimen, and 15 were on ART. Despite increasing trend on uptake of the PMTCT services on Prong 3, overall uptake rate is very low, indicating need of rapid scaling up of services including through integrating/strengthening it to other MCH and RH services within ministry of health also focusing on Prong 1 and 2. Based on the National PMTCT Review 2007, NCASC, UNICEF and FHI have piloted CB-PMTCT in three districts, and the services has started from 14 PHC/HP sites in Achham district from May 2009 to increase the access the of PMTCT services.

**Figure 12: PMTCT up take**



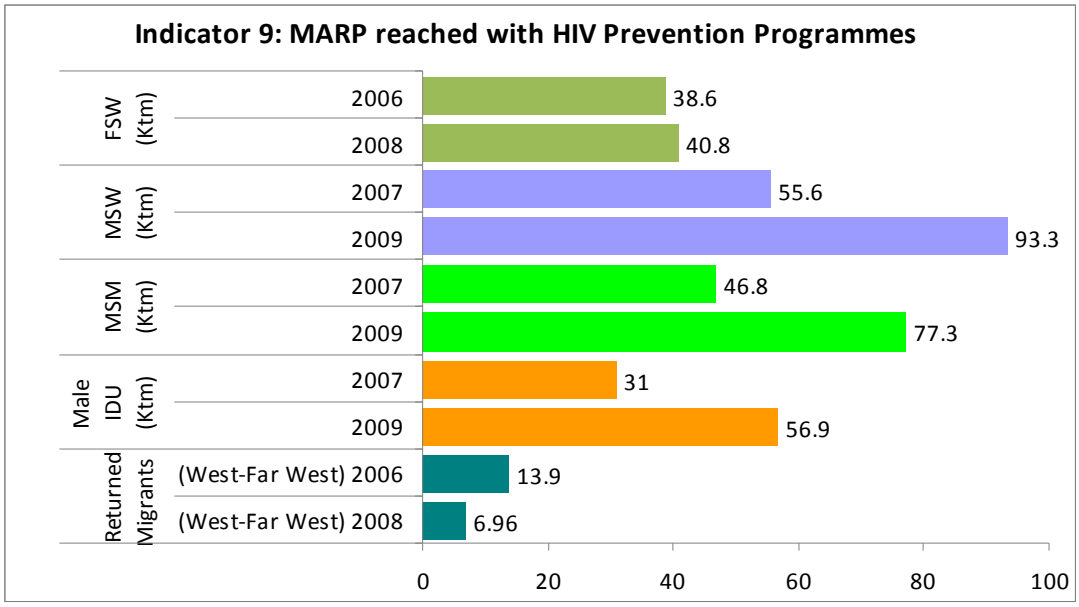

Source: NCASC 2006-2009, Routine Programme Data

### MARPs reached with prevention programme

Programme coverage data (source: IBBS) indicate wide variations among the groups and between the 2008 and 2009 reporting period (Figure 13). Generally, there is increasing trend of coverage among MARPs except for clients of sex

workers, where some decrease from the last reporting period was observed. Similarly, coverage for female sex workers has slightly increased to 40.8% in the 2009 IBBS in Kathmandu.

### Figure 13: MARPs reached (Indicator 9)

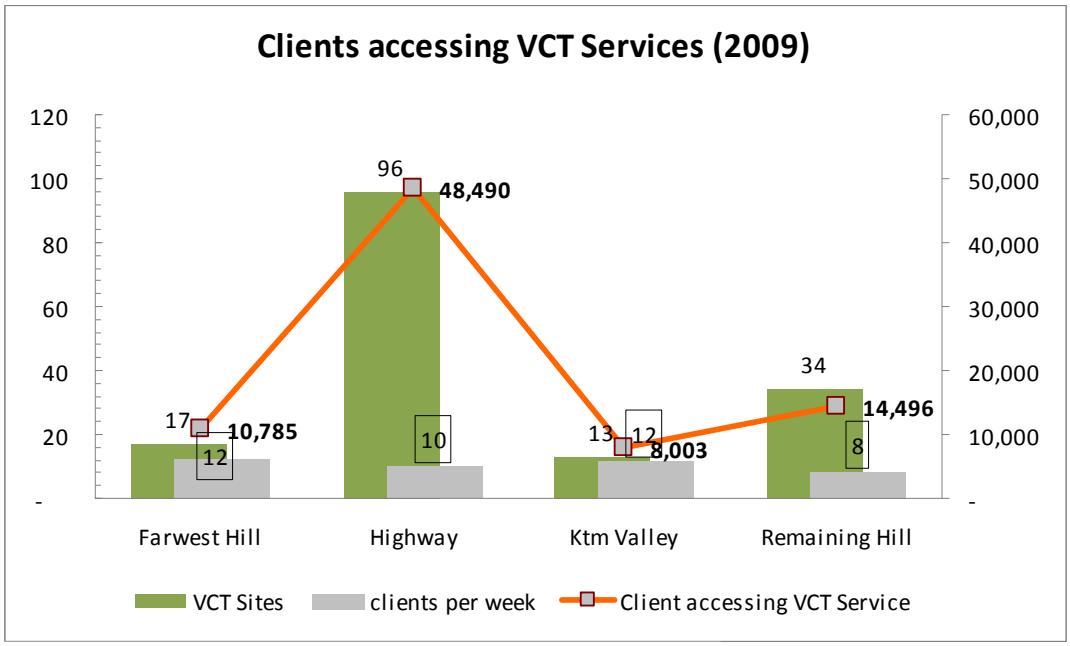



Source: IBBS-NCASC,FHI

Migrants show lower coverage compared to some of the more mature programmes. Despite increased number of service sites in high migrating districts (DFID/UNDP and GFATM Rd 7), the 5.6% (West) and 8.3% (Far West) coverage among migrants highlights the need to significantly expand prevention and develop better strategies to reach larger numbers of Nepali migrants travelling to India for work. Coverage for MSM however, shows a significant increase in recent years as per the IBBS, which shows 46.7% in 2007, and 77.3% in 2009. Figures derived from routine reporting showed national coverage ranging from 12% to 35.9% for the same group. It is noteworthy that the coverage among MSWs was higher (55.7%) than of MSM (46.75%).

MARP reached by VCT services has increased remarkably (Table 8). The availability of VCT centres has increased throughout the country. There is a 12% increase in coverage for MSM and over 2.7% for clients of sex workers. Coverage for FSWs in Kathmandu has slightly decreased, while the first IBBS conducted among FSWs in 22 Terai districts shows a twice-as-large coverage as compared to FSWs in Kathmandu. Coverage for IDUs has remained the same in Kathmandu. The increase is expected to be more visible among well-defined population groups targeted by the response such as FSWs, IDUs or MSWs and MSM. Despite increase in service sites and prevention programmes rolled out in high migrating districts, the lower percentages among migrants (3.3% West, 6.7% Far West) and wives of migrants (0%) highlight the considerable challenges of reaching individuals in larger, less well-defined groups. This necessitates more effective strategies to reach them.

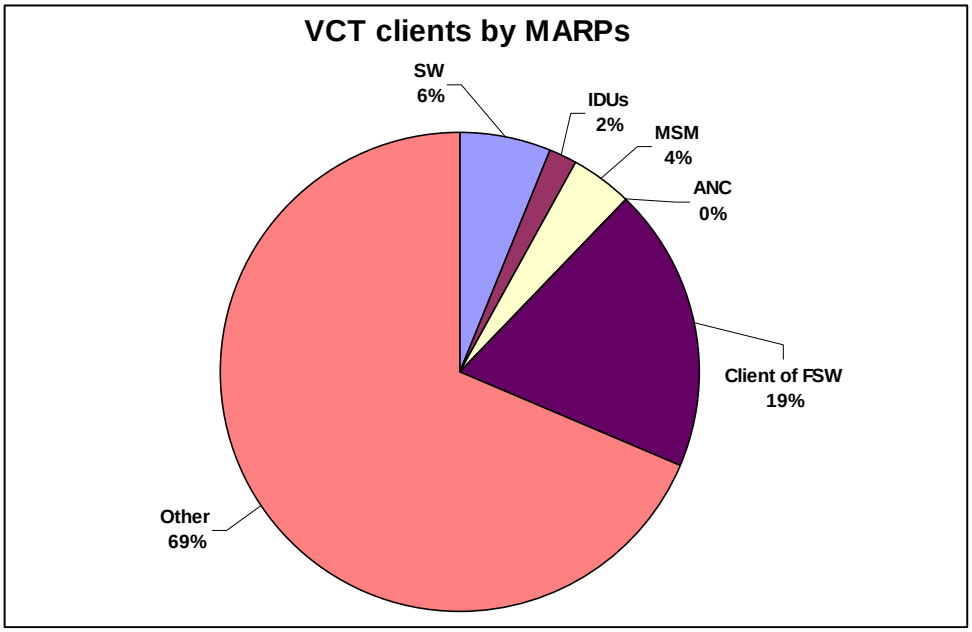
**Figure 14: VCT utilisation**




Source: Routine Programme Data, 2008-2009 (Program Implementers)

Routine programme data shows that almost 70% of users of the VCT (Figure 14) are non specific groups (or general population including migrants) and utilisation varies greatly by regions (Figure 15). Although no specific data is available, it can be assumed that since most VCT sites are located in strategic places to reach a large number of migrants, the "other" includes a substantial number of migrants accessing VCT services. On the other hand, the lower VCT utilisation by certain MARPs group (i.e. among the lowest attendees of VCT were IDUs accounting for 2%) and MSM 4%) indicates the existence of barriers in accessing VCT service among that population.

**Figure 15: VCT clients by MARPs**




Source: Routine Programme Data, 2008-2009 (Program Implementers)

### c. Injecting Drug Users

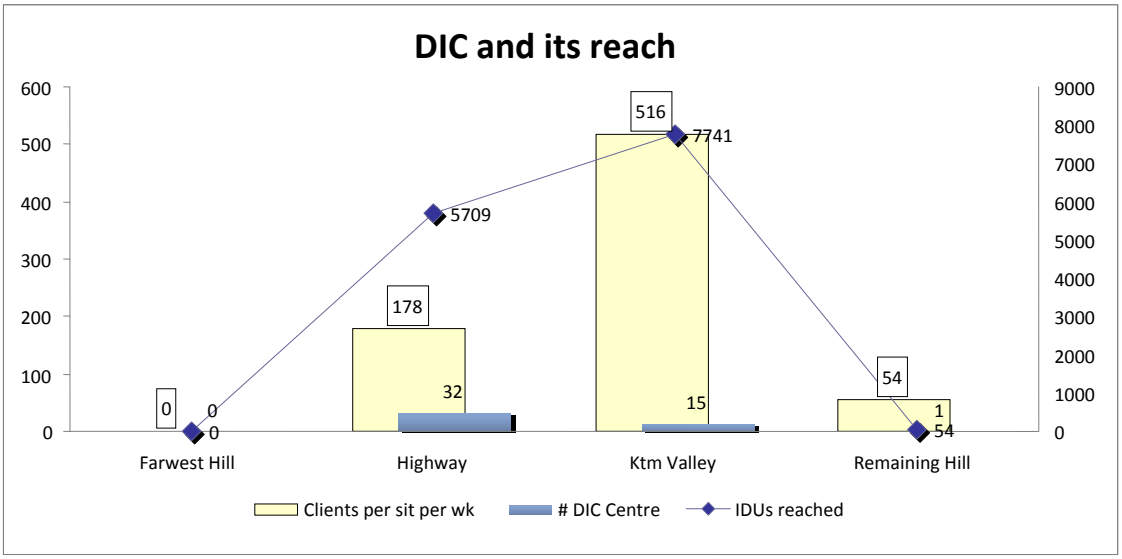
Nepal was the first country in the region to initiate needle syringe programme as early as the mid 1980s. The IDU harm reduction programme is probably the oldest targeted intervention in Nepal but the systematic programme was initiated only from early 2000 as a component of Nepal Initiatives (funded by DFID). With notable increase in technical and financial support, a stronger focus on harm reduction, and oral substitution was instituted. Also, coverage target in Kathmandu was readjusted and reported accordingly to UNGASS from 78% in 2007 (IBBS 2007) to 31%. This adjustment was in consideration of the views of CSO who thought the 78% coverage as recorded in IBBS was too high. New IBBS studies from other regions (Pokhara, Far-West and East Terai) show the coverage to be higher in these sites.

The National Action Plan (2008-2011) includes a comprehensive harm reduction programme that includes needle/syringe exchange programmes, oral substitution therapy with methadone and buprenorphine, rehabilitation, detoxification and after care. The present Plan aims to achieve service coverage to 80% of IDUs by July 2011. Special focus is given to targeting female IDUs.

Over 30 rehabilitation centres in different districts in Nepal through community-based organisations and NGOs provide free detoxification. Quite a few were supported through UNDP/DFID during 2007-2009. In 2006, oral substitution therapy was re-introduced in Nepal, first with buprenorphine in two community settings and in September 2007, with methadone substitution re-started at the Teaching Hospital in Kathmandu and the Western Regional Hospital in Pokhara in May 2009. As of December 2009, a total of 125 IDUs were on methadone and 40 on buprenorphine. Clinical services are supported by social services and counselling. There is a need to adjust the balance between drug rehabilitation services and harm reduction in favour of effective public health approaches such as NSP. Post Rehabilitation Care will roll out soon in 8 districts through the Global

Fund grant. Manual preparation, partner selection and other preparatory work have now been completed.

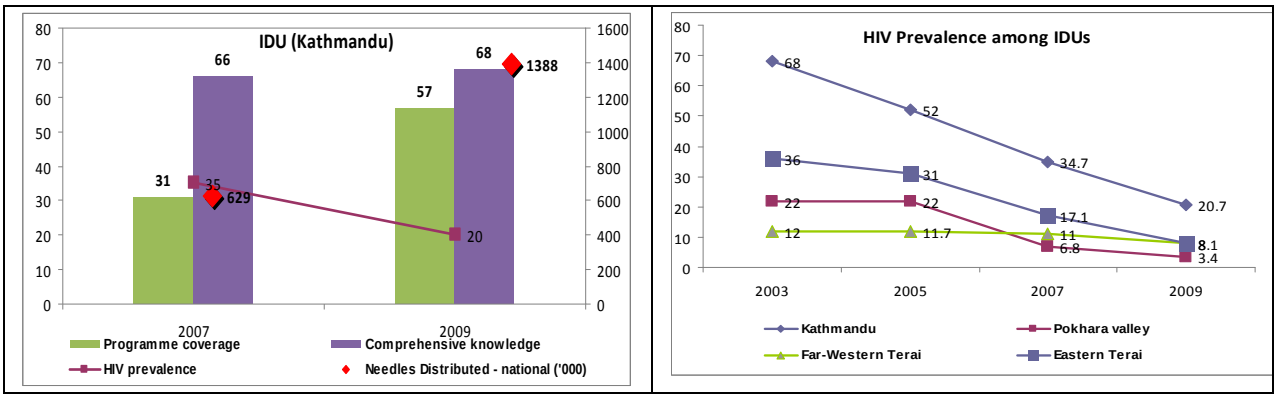
### Figure 16: IDU reached through DIC




Source: Routine Programme Data, 2008-2009 (Program Implementers)

Routine programme data shows that over 13,000 IDUs were reached through DIC with BCC, STI and other prevention services (Figure 16). Given the total size of IDUs (28,000) the reach is almost 46% of total IDUs. This finding is not too far from the finding of IBBS (56.9% in 2009) if likelihood of reporting bias and double counting errors are taken into consideration. With the increase in service expansion including needle syringe exchange programme, the cumulative effective is seen in reduction in HIV prevalence among the IDUs (Figure 17).

### Figure 17: HIV Prevalence trend among IDUs




Source: IBBS, NCASC,FHI

## Table 8: MARPs tested and who know their result (Indicator 8)

| | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 |
|---|---|---|---|---|---|---|
| FSW (Kathmandu) | na | na | 36.80% | na | 32,4% | |
| FSW (Pokhara) | | | | | 31,0% | |
| FSW (22 Terai Highway Districts) | | | | | | 61,2% |
| MSW | 13.50% | na | na | 51.85% | | 65.2% |
| IDUs (Male, Kathmandu) | na | 5.23% | na | 21% | | 21,5% |
| IDUs (Male, Pokhara) | | | | | | 39,9% |
| IDUs (Male, Far-Western Terai) | | | | | | 23,3% |
| IDUs (Male, Eastern Terai) | | | | | | 33,3% |
| MSM | 7% | na | na | 30% | | 42% |
| Clients of sex workers | na | 0.21% | 11.10% | na | | 13,8% |
| Returned migrants (West, Mid & Far West) | na | 0.00% | 3,2% | na | | |
| Male labour migrants (West) | | | | | 3,34% | |
| Male labour migrants (Far West) | | | | | 6,7% | |
| Wives of migrant labour in (Far West, 4 districts) | | | | | 0% | |

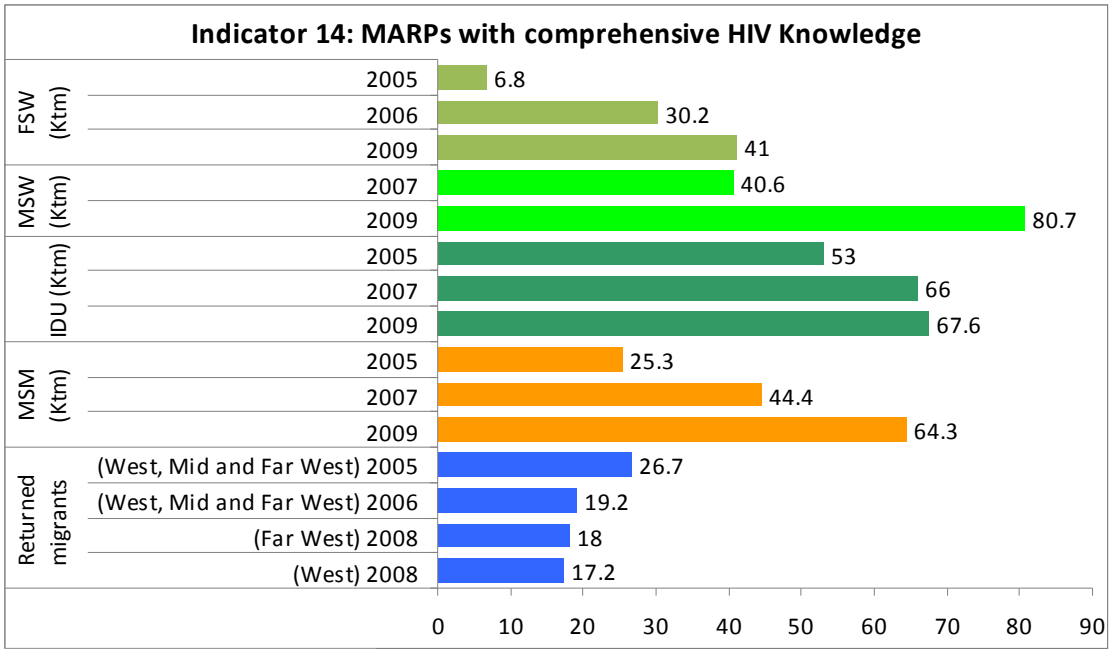
### d. Men having sex with men

Progress in reach and behavioural change is very encouraging with comprehensive prevention programmes among MSM and transgender implemented by a CBO federation and partner organisations in many districts of Nepal with the support of DFID/UNDP and GFATM/FPAN. CBO health centres provide health services along with counselling and screening. MSM groups are still hesitant to refer individuals for HIV related services to other health providers due to stigma and discrimination. There are estimated 135,000 (68,000 to 202,000) MSM in Nepal. A national size estimation of MSM is being conducted currently, as part of the Action Plan.

The expansion of services during the past years has resulted in better coverage, especially in urban areas. During the past five years, the coverage for MSM in Kathmandu has increased significantly: from 10% in 2004 and 46.75% in 2007 to 77% in 2009. A recent IBBS study shows that comparatively more MSWs than non-MSWs are exposed to HIV and STI prevention programmes. Larger numbers of men who have occasional MSM contact are harder to reach with interventions.

Prevalence for MSM appears to have stabilised. However, coverage of prevention needs to be expanded to improve knowledge and to respond to the special service needs of MSM.

## Figure 18: Comprehensive knowledge among MARPS




Source: IBBS, NCASC,FHI

Progress on STI treatment has improved over time. This is corroborated by the fact that there has been increasing attention from various partners, particularly from USAID/ASHA, DFID/UNDP, Global Fund Rd 7 and other partners. Besides, routine reporting has also improved from implementing partners, as have the efforts in reporting STI treatment through HMIS.

### Table 9: STI Gaps and Progress

| | Programmatic gap and progress | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Actual | | Anticipated/Targets | | | | | |
| | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 |
| **TOTAL UNMET NEED: STI** | | | | | | | | |
| Projection | 15,629 | 152,535 | 54,730 | 77,964 | 136,010 | 164,540 | 192,980 | 196,280 |
| Progress | | 8,896+HMIS | 60,096 | 42,000 +HMIS | 117, 959 | | | |

*Source: Anticipated/Targets = GFATM Round 7 Proposal (successful proposal) June 2007*
*Progress = programme data (NCASC, NGO partners)*

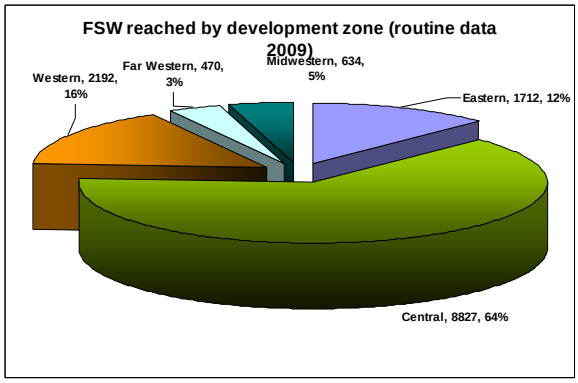
Whether noticeable improvement against targets is because of improvement in case reporting or as a result of expanded activities, has yet to be ascertained. Similarly, there is no mechanism to avoid double reporting as the implementing partners may have reported through HMIS as well as directly to the national M and E hub.

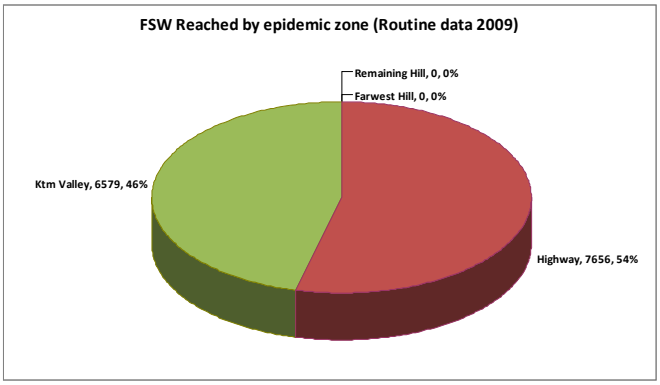
### e. Female Sex Workers

Programmes targeting FSWs are more established and developed than other targeted interventions for MARPs. The main components of FSW interventions in Nepal are peer-led education, behaviour change communication, STI service management, condom provision and promotion and providing an enabling

environment. Of the total size of FSW (30,000) more than 46% are reported to have been reached by the programme (Figure 19). This year some consistency noticed between IBBS data (UNGASS indicator 9) coverage (40.8%) and programme coverage (Figure 13) for FSWs.

### Figure 19: FSW reached (programme data)

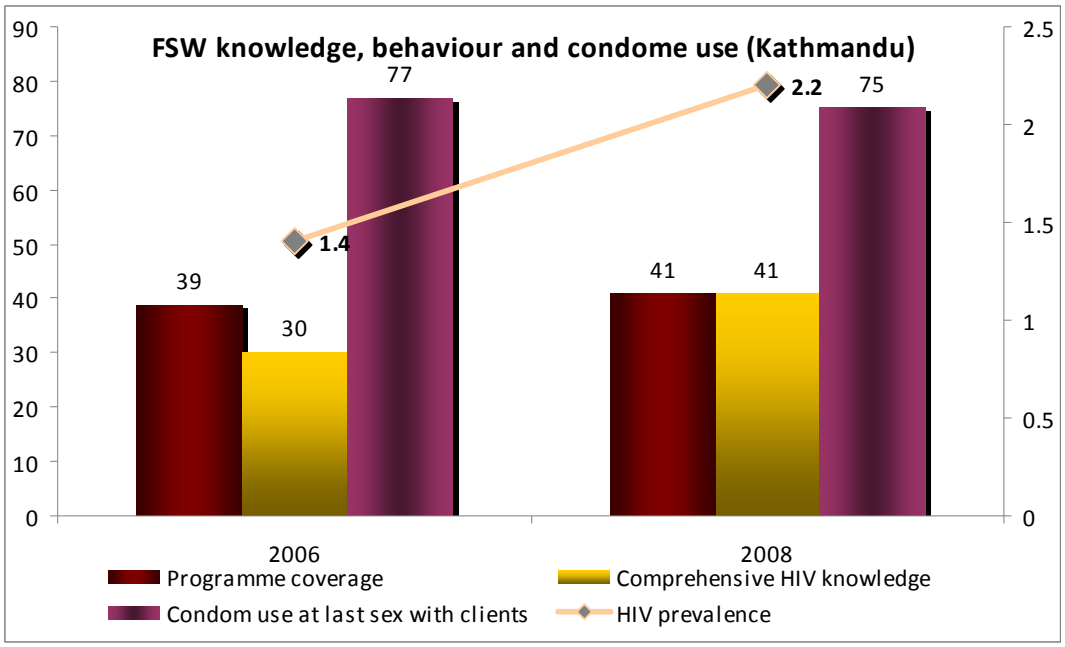



Source: IBBS, NCASC,FHI

There are an estimated 30,000 female sex workers in Nepal. Most of them are either establishment-based or home-based. Also about 52% of the FSWs are illiterate or have no formal schooling. This poses a challenge for prevention programmes that need to be designed keeping in mind that the larger proportion of FSWs who cannot read or write properly need special ways of communication. The focus of intervention is high in two epidemic zones (Kathmandu valley and Highway districts) and other two zones (Far west hill and remaining hill) have no programme for FSW.

### Figure 20: FSW: Knowledge, behaviour and condom use




Source: IBBS, NCASC,FHI

Despite some fluctuations, a low HIV prevalence has been maintained for FSWs along with improvements in awareness, condom use and health seeking practices, at least among surveyed populations. However, the challenge is to maintain these achievements on knowledge, behaviour and sero-prevalence. Since most FSWs are hidden, illiterate, very poor, highly stigmatised and often harassed by the police, ensuring expansion to newly emerging markets and towns and increasing access to services is crucial. Moreover, sustaining the level of programmes for FSW will remain a challenge when considering the relatively high numbers of young sex workers entering the trade each year and their highly mobile nature.

**Voices from field: FSWs voices and actions**

Female sex workers (FSW) are one the Most-At-Risk- Population sub groups in Nepal's HIV epidemic. Other groups include IDUs, MSM, transgender, and migrants. Injection drug use also overlaps with commercial sex. Another important factor is the high number of sex workers who migrate or are trafficked to Mumbai, India, to work, thereby increasing HIV transmission among the sex workers and through clients to other population in Nepal more rapidly. For more than decades FSW are facing the problems of stigma and discrimination from the society itself and also, in all the programs of government, their issues have been not been recognized and taken into consideration in policy and programmes. FSW lack comprehensive programs for themselves and as well for their children.

Many organizations like SWAN and Greater Share of Network of FWS - initiated by the female sex workers themselves, are working for issues of FSW. Also the loose network Jagriti Mahila Sangh has been working through its 9 CBOs partners since last three years.

Jagriti Mahila Sangh has helped communities to start the services by themselves and for themselves, and started services like condom promotion, and BCC activities. Through these programs, many female sex workers have come forward to know more about their health and rights, and have truly become aware of these issues. Today FSWs are giving pressure to the government for their rights, and doing awareness programs through rallies. They themselves have started initiation in many activities.

Men who buy sex are considered to be the single-most powerful driving force in Asia's HIV epidemics. In Nepal truckers, drivers and transport workers are taken as the major identifiable, and therefore reachable, client groups of FSWs. In 2009, IBBS study of truckers claim that the coverage of ongoing HIV programme is relatively low (14%). The estimated size of clients of FSWs will be reviewed during the current National Action Plan period (2008-2011), to more accurately design and estimate the cost of services.

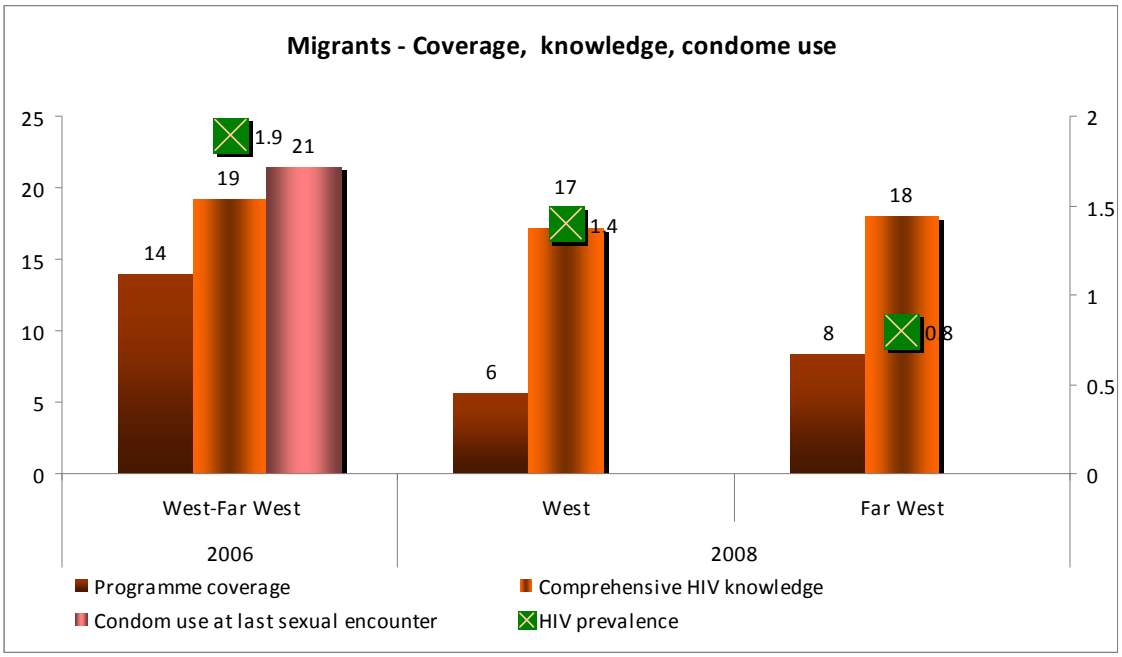
Other clients such as men in uniform services, IDUs, youth, high-risk migrants and industrial labourers are to be reached under their respective programmes.

### f. Labour migrants

Both internal and international short and long term migration of young men, including seasonal labour migration, is becoming increasingly common and occurs regularly from districts of Far West, Terai and hilly regions, to mostly the urban areas of Nepal, India and other countries of the Persian Gulf and Southeast Asia. This phenomenon has programmatic implications as reaching migrants across the border is a complex and challenging task.

Integrated Bio-Behavioural Survey data show that 67.8% of young males in the West and 57.9% in the Mid-Far West migrate before the age of 20[8]. Recent data also shows that around 20% 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 numbers of HIV cases also increasing among wives and partners. Improvements in strategies to prevent secondary transmission from infected migrants are crucial.

**Figure 21: Migrants – coverage, knowledge and condom use**




Source: IBBS, NCASC,FHI

HIV prevalence of migrants has remained relatively low in 1.4% (West) and 0.8% (Far West), although prevalence in wives of migrants is 3.3%. The prevention coverage is the lowest among all key populations, both for migrants and their wives. Comprehensive knowledge and condom use also not very high compared to other MARPS (Figure 21). The programme for migration has now been intensified through the Global Fund Rd 7 grant being implemented by Save the Children and Nepal Family Planning Association, reaching migrants in 18 districts with high migration or high transit districts.

### f. Blood transfusion

Nepal Red Cross Society (NRCS) has the sole responsibility for blood collection, safe keeping, screening for HIV and making it available to hospitals when needed. It runs 58 blood banks (blood transfusion centres) in 43 districts in Nepal include 17 hospital units attached to major hospitals and in 41 districts as stand alone blood transfusion centre. In order to respond during emergency situations, 15 emergency blood transfusion service centres have been set-up through- out the country. NRCS performs HIV screening for all collected blood

[8] Reference IBBS 2009 among Male Labour Migrants in 11 Districts in Western and Mid to Far-Western Regions of Nepal.

samples in the country and for External Quality Assurance Scheme(EQAS) – Central BTS has participated in EQAS National Reference Laboratory Australia. Last year in 2009 some 136, 580 units of blood were collected and central blood transfusion service in Kathmandu participated in EQAS that accounts for 38% only. National Guidelines for EQAS is being drafted by National Public Health Laboratory.

### g. Life skills based education

Ministry of Education has expanded the life skills based education programme in the past two years with support from UNICEF. While 3.1% (880/27,888) of all schools provided LSBE in 2006, this has increased to 5.6% in 2007 and now in 2009 has further increased to 7.56%. LSBE is being implemented over 20 districts in the country through formal curricula or extra curricular activities (as peer education), the coverage and expansion is slow (Table 10).

**Table 10: Life Skills based HIV education**

| **Schools that provided life-skills based HIV education within the last academic year** *(Indicator 11)* | No. of schools | | No. of schools with LSBE | | % of schools with LSBE | |
|---|---|---|---|---|---|---|
| | 2007 | 2009 | 2007 | 2009 | 2007 | 2009 |
| Number of schools (all schools combined) | 29,448 | 32,120 | 1,670 | 2,427 | 5.67 | 7.56 |
| Number of Primary Schools | 13,833 | | 1,035 | | 7.48 | |
| Number of Secondary Schools | 15,615 | | 635 | | 4.07 | |

Source: MoE/UNICEF

### Challenges in reaching key populations at higher risk

- Defining MARP specific package for prevention services, coordinating and monitoring the inflow of resources and the lack of a standard operating procedure and guidelines at the national level to ascertain quality. (e.g. definition of MSM includes all subgroups (MSWs and LGBTI) with different risk behaviours while the service package remains similar for all.)
- Determining an appropriate strategy to reach people moving across the open border between India and Nepal and displaying high risk behaviours
- Reaching the un-reached: hidden populations including people in prison and low-profile MSM
- High turnover and mobility of both FSWs and MSWs
- Geographically mountainous terrain makes physical access difficult
- Defining programme coverage indicators and monitoring the results avoiding duplication and double counting. For MSM, IBBS data are mainly from Kathmandu, therefore not nationally represented, but service is being accessed in other regions as well. 46,000 out of 135,000 have accessed the services from various outlets in the country but IBBS data have not been able to capture all those differences.
- Most of the HIV programme interventions are under resourced

## F. Knowledge and behaviour change

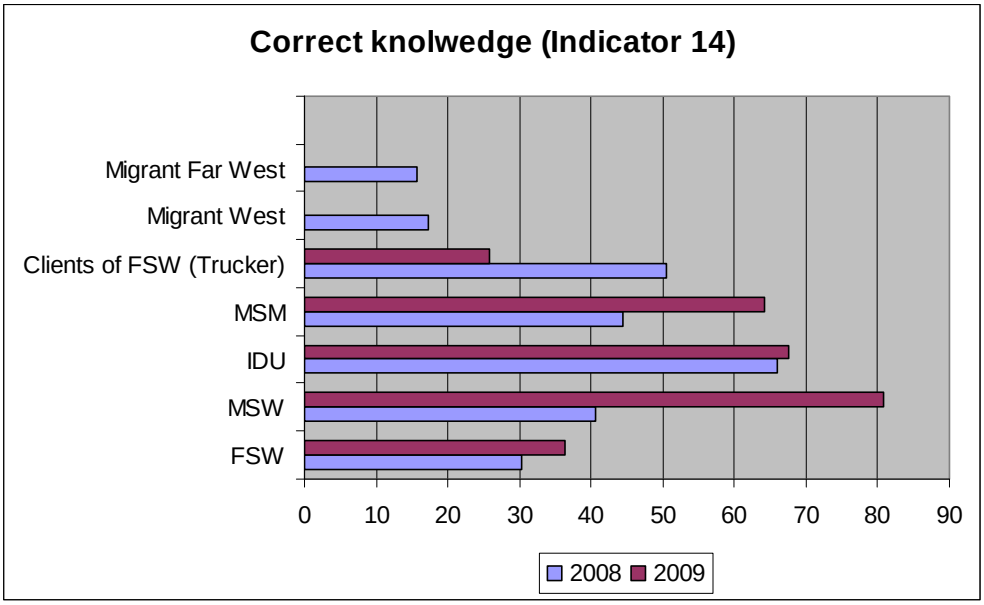
Integrated Bio-Behavioural Surveys have been carried out in alternate years since 2003 to support the evaluation of the national response. Most knowledge and behavioural data for most-at-risk populations is generated from these surveys for which indicators and survey tools have been fully harmonised (e.g.

UNGASS). Although general awareness of HIV and AIDS is relatively high, comprehensive knowledge on HIV and AIDS, as defined by the UNGASS indicator, remains comparatively low among populations groups, especially some of those most-at-risk.

Knowledge among migrants appears to be the lowest: 15.8% in the Far Western region and 17.2% in the Western region (IBBS 2008). The knowledge level of clients of FSW (truckers) has decreased significantly, to half from the previously reported figure: from 50.5% to 25.8% (IBBS 2006, 2008). Combined with low coverage of ongoing outreach programmes on truckers (14% in 2009), this calls for more programmes to be launched targeting this particular group on the highways (Figure 22).

Comprehensive knowledge has well increased among MSM from 44.4% to 64.3% and even more so with MSWs, amongst whom the previous figures have doubled from 40.6% to 80.7% (both IBBS 2007, 2009). Knowledge amongst IDUs has remained almost the same, increasing slightly from 66% to 67.6% (IBBS 2007, 2009). Knowledge amongst female sex workers in Kathmandu has increased from 30.2% to 36.4% (IBBS 2006, 2008), although it is still low among FSWs in other survey sites (14% in Pokhara, 26.7% in 22 Terai highway districts).

**Figure 22: Correct Knowledge among MARPs**

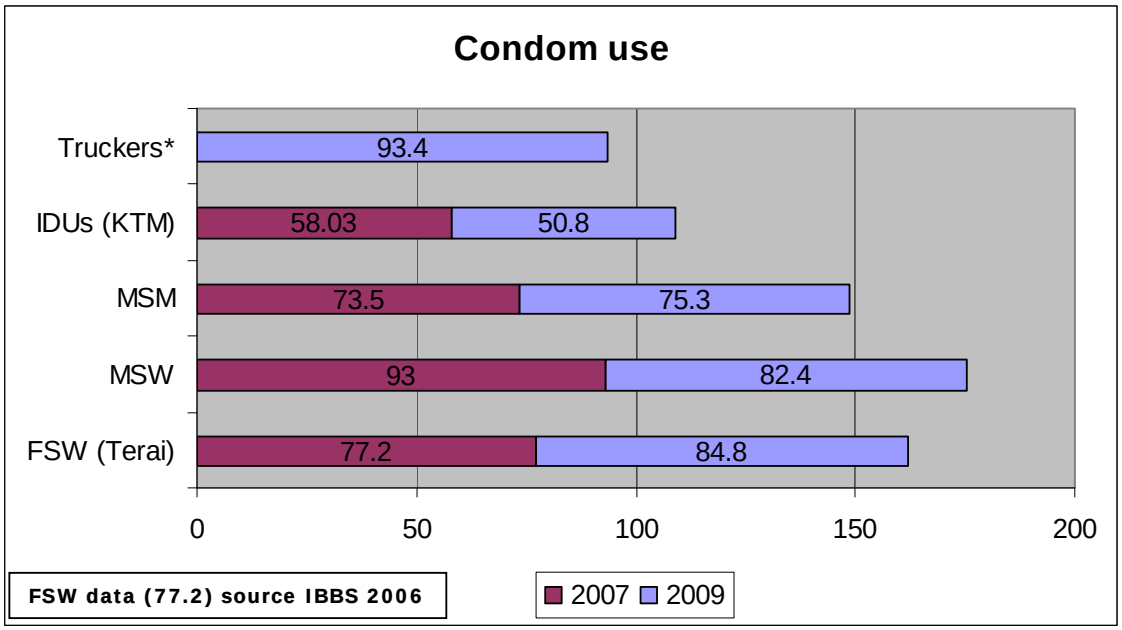



Source: IBBS, NCASC,FHI

### Behaviour change

Condom use amongst female sex workers has increased from 77.2% to 84.8% in 22 Terai districts (IBBS 2006, 2008). In Kathmandu condom use amongst FSW has decreased from 77% to 75%. According to the 2008 IBBS study, only 22% of the FSWs were reported to carry condoms regularly. Almost half of FSWs had heard about the female condom, but only a small number of them had ever used it. Condom use amongst clients of FSW (truckers) is as high as 93.4% according to the 2009 IBBS study.

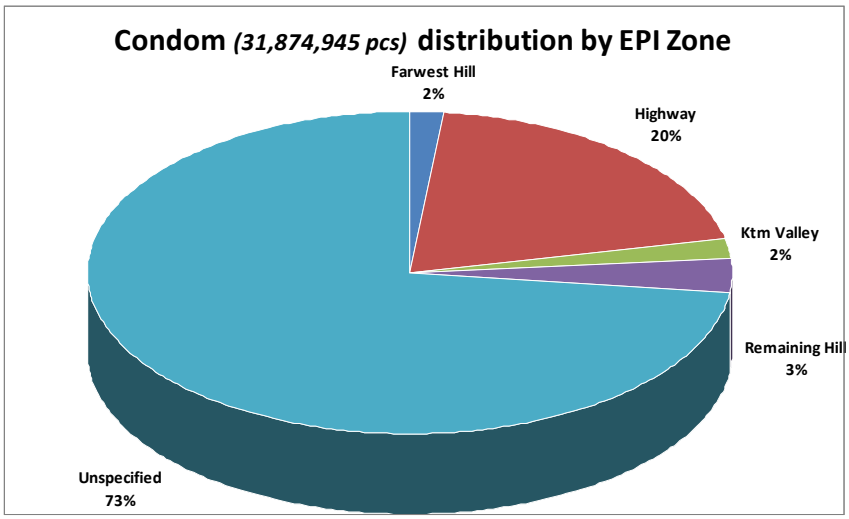
### Figure 23: Condom use (MARPs)




Condom use amongst IDUs has declined from 58.03% to 50.8% (this value is an average of condom use with all partners) (IBBS 2007, 2009 and for FSW IBBS 2006). Disaggregated data reveals differences in condom use according to the type of partner at last sex. Condom use is still highest with female sex workers, highlighting some awareness of the risk of sexual transmission. Over 50% also use condom with non-regular sex partner. Condom use with regular sex partners has, however, remained almost the same. Although this trend is not unusual, it highlights the emphasis on self-protection versus protection of a spouse and the need to use condoms regularly and consistently. A similar trend is found in all IBBS sites: in Kathmandu, Pokhara, Far-Western Terai and Eastern Terai.

For MSWs who have shown good comprehensive knowledge, the figure for condom use has somewhat dropped from 93% to 82.4% (IBBS 2007, 2009). Condom use by MSM has remained almost the same during last two years, increasing slightly from 73.5% to 75.3% (IBBS 2007, 2009). The IBBS study states that consistent use of condom amongst MSM is low especially with non-paying female and male sex partners.

### Figure 24: Condom distribution by Epi Zone



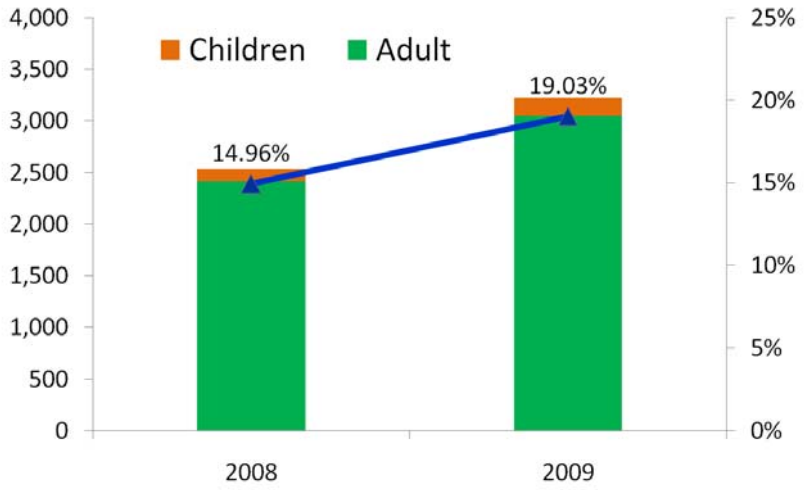

Condoms are distributed through numerous channels and outlets and above figure represent condoms distributed under all programmes like reproductive health and HIV/AIDS etc. Condoms are available in all health facilities up to VDC level through Sub Health Post. Besides, AED, CRS Company also distribute condom through social marketing networks. A total of 31 million pieces of condom was distributed free or socially marketed (Figure 24) in 2009. Unspecified distribution which accounts for 73% of total distribution is largely through social marketing where disaggregation by Zone was not available.

## G. Treatment, care and support

Of the total estimated numbers of people who are in need of ART (16,000 adult, 950 children), some 19.03 % (3048 adult, 178 children) are accessing ART from 23 ART sites throughout the country. Last year only 6% had accessed ART services. Considering all those who are registered for ART at the moment (13, 143), 5198 ever started ART.

Keeping in view of the current rate of ART uptake against total people who are in need of ART (Figure 25), achieving the Universal Access target of 80% in the next few years is highly unlikely unless the ART strategy is changed and services are scaled up. Out of the total individuals tested for HIV, 20% of males and 26% of females have accessed ART services (Figure 26)

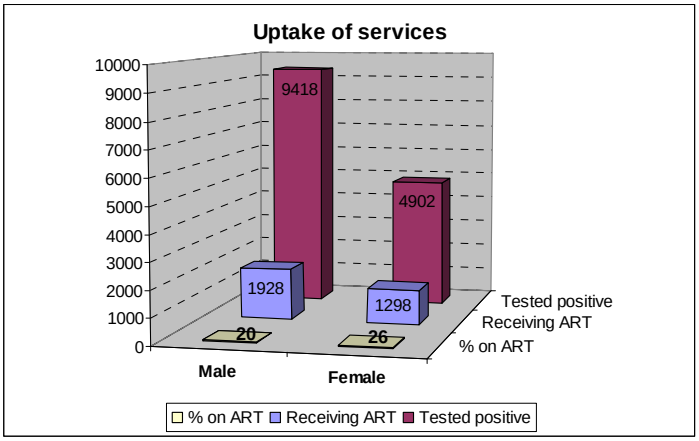
**Figure 25: ART uptake trend**




Source: NCASC 2009

As of Nov 2009, data shows that 450 of those on ART have died, and a total of 198 have been lost to follow-up. Similarly, 23 people have stopped treatment and 17 people have switched to 2nd line treatment of ART. It has been projected that by 2011, 40% of the estimated individuals in need of ART will be on 1st line anti-retroviral drugs and 5% of those will move to 2nd line ART. There are currently 23 sites around Nepal that provide ART, 21 of which are run by public hospitals, with the remaining two, by national NGOs. CD4 count service is available in 13 sites.

### Figure 26: ART up take (male: female)




Source: NCASC 2009

### Challenges in scaling up treatment, care and support

- Currently the cost of HIV commodities are funded through Global Fund Grant 7 and the calculation of commodity requirements was based on 2006 data and price. With introduction of the new WHO guideline, the CD4 cut-off point of 350 will double the ART eligibility, which will have huge implications on cost of drug, programme management, and other support systems.

- Loss on follow up is still high - accounting for 198 people. A more careful follow-up is required to understand and examine ART adherence and barriers to ART services.

- Although 2nd line treatment preparation has begun, a more conscious effort is required to scale up 2nd line treatment.

## H. Impact alleviation

The National Strategy (2006-2011) expects some strategic results regarding impact alleviation focusing on micro credit or linkages to such activities. Infected or affected housewives, husbands or widows in many parts of the country are doubly disadvantaged because of their low socio-economic status and have limited access to preventive and curative services. Besides, children are also discriminated barring them to get into schools. In addition, housewives have increasingly emerged as the sole care provider in many rural settings. Some small scale efforts are being made to provide income generating support to PLHIV and their families like trainings, seed money, saving and credit groups and so on.

A number of small, isolated and localised interventions were initiated by different organisations, INGOs, NGOs and positive networks in different parts of the country with varying degree of focus on nutrition, income generation activities, community care, promoting access to services and so on.

National CHBC guidelines and training manuals were prepared by NCASC/FHI to ensure proper rollout of the CHBC programme and to ensure the quality of intervention. Government leadership would be helpful to monitor and standardise services provided by NGOs.

# IV. Best practices

Best practices are reported in the main body of the report. The following best practices are reported in this report:

## Best practice 1: PLHIV Friendly Hospital

**PLHIV Friendly Hospital**

National NGO's Network Group Against AIDS, Nepal (NANGAN) promotes safe and friendly health facilities for PLHIVs by aiming to decrease stigma and discrimination from service providers' side. During the project's 1.5 years duration, NANGAN had organized Training of Trainers (TOT), who then gave orientation training about safe and friendly health facilities in three hospitals (in Kathmandu, Pokhara and Nepalgunj). Overall 346 members of hospital staff were trained. Training methods emphasised using simple language, practical exercises and demonstrations, and open discussion. A system of regular review meeting was set up with all level of staff in the hospital – who look into barriers and weakness in the system and behaviour of the staff that discourage the PLHIV in accessing the services.

Base line studies have demonstrated that the trainings have successfully increased hospital staff's know-how about safe and patient friendly practices, reduced communication gaps among staff members and increased application of safety measures. PLHIVs treatment has improved after trainings: Clients Satisfaction Surveys conducted in the aforementioned hospitals have shown improving results. Applying the right kind of methods in hospital staff's training has thus decreased discrimination against PLHIV's.

## Best practice 2: GIS mapping and tracking condom use

**Using GIS mapping to track condom use**

Recognizing the national need to have a focused response to the concentrated HIV/AIDS epidemic in Nepal, the Academic for Educational Development (AED), the implementing agency for the USAID-funded Nepal Social Marketing and Franchising Project for AIDS, Reproductive Health and Child Survival (N-MARC), embarked on a pioneer research project to use Geographical Information System (GIS) to measure and monitor condom coverage, the quality of condom coverage and access to condoms for females working in and around designated hot-zones. The objective has been to facilitate more targeted marketing and distribution of condoms in these risk areas.

In the beginning, hot spots or places where sex negotiation or sexual activity usually takes place were identified in 24 districts of Nepal. From each hot spot a 100 meter catchment area was measured – or the average distance a person might walk to get a condom - and overlapping hot spots were connected, thus creating 'hot zones'. The hot zones were layered over the geographical map of the 24 districts. After this, condom selling outlets in 19 randomly selected 'hot zones' were identified. Enumerating all the outlets in these zones, the research developed a clear picture of relationship between condom-selling outlets and the "hot spots".

Through GIS mapping the research project now possesses a clearer picture of the status of condom coverage and access in high-risk areas. Results have been promising: condom coverage (the % of hot zones with one condom-selling outlet per 5 high-risk meeting places) has increased from 69% in 2007 to 90% in 2009. Similarly, access to condoms (the percentage of hot spots with a condom-selling outlet within 100 meters) has increased from 63% in 2007 to 75% in 2009. Research using GIS mapping allows for targeted interventions focused on these specific geographic areas, and helps monitor programmatic performance objectively over time. While research has thus far focused on private sector condom marketing and distribution, it is possible to expand the focus of the study to include other interventions. Thus, GIS mapping is contributing to driving a coordinated, focused national response.

## Best practice 3: Recognition of Third Gender

**Social Methadone: Model Methadone Maintenance (MMT) Program**

Methadone is accepted, safe and cost effective type of oral substitution therapy that can be used in prevention of HIV and other blood borne infections among people who inject drugs. Nepal re-started Methadone programme in 1994.

Currently Nepal has been implementing a holistic Methadone treatment in three government hospitals. The combination of Social Support Unit (managed by NGOs, ex users) and Clinical Unit (managed by hospital) constitutes a unique blend of intervention providing psycho-social counselling, clinical dispensing and medical services. This approach is considered to be a model in the region for OST. Social support is a part of wider services for HIV and AIDS prevention, treatment, care and support for IDUs, aiming to establishing a continuum of care between psycho-social and bio-medical support for people who use drugs. Located in the same premises as the dispensing/clinical component, it promotes synergies between the civil society partners and the clinical professionals.

Effectiveness of the MMT lies in making links with other programmes focused to IDU/DUs. The linkages has been key in averting some harmful consequences of drug use in Kathmandu, Lalitpur and Kaski districts in Nepal. Lessons from the past pilot projects have been has been the basis of expansion of OST programmes in the country. The MMT program is supported technically and financially by UNODC/USAID/GTZ, and is under the supervision of the Technical Working Group on OST led by the Ministry of Home and the Ministry of Health and population, with representation of civil society, users and other relevant partners. Within the UN system this project is also a good example of joint programming, as various UN agencies (including WHO, UNDP and UNAIDS) are involved in the design, funding, technical assistance and implementation of the project.

## Best practice 4: National harmony in OST programme

**Recognition of Third Gender**

Sexual and gender minority groups (lesbian, gay, bisexual, transgender and intersex -LGBTI) face a multitude of discriminations including access to health and prevention services related to HIV and AIDS, human rights violation and legal protection. Blue Diamond Society - the only organization in Nepal working to raise awareness about the health and human rights of SGM - has achieved considerable success in terms of grassroots community outreach and legal advocacy.

One of Blue Diamond Society's most significant efforts has been a petition to Supreme Court of Nepal, demanding the rights of LGBTI individuals of Nepal to enjoy equal protection and standing before the law. In December 2007 the Supreme Court responded to the petition by issuing a directive order to the Government of Nepal to ensure that all individuals have the right to live according to their own identity and to correct those discriminatory laws that violates the constitutional rights of LGBTI individuals. Identifying all SGMs as "natural persons" under the law, the Supreme Court ordered the government of Nepal to reform all legislative provisions referring exclusively to men and women only and include the Third Gender. Furthermore, the decision ordered the issuing of legal documents, including citizenship cards and passports, with an identity category for Third Gender, and confirmed the right to same-sex marriage under Nepal's legal framework.

This was a major breakthrough in the process of rights recognition for sexual minorities in Nepal. In the whole process BDS was able to obtain support from human rights activists, lawyers and civil society leaders.

## Best practice 5: Positive prevention

**Positive Prevention – PLHIV at the forefront of HIV prevention in Nepal**

HIV counselling and testing sites have increased throughout Nepal over the past two years. However, further scale-up of HIV counseling and other services are needed with special attention to reach those most-at-risk. Many people are still reluctant to seek services due to HIV-related stigma and discrimination. Family Health International Nepal's ASHA Project, supported by USAID, has worked with eight PLHIV-led organizations on Positive Prevention programs since November 2007. The project has reached nearly 850 new PLHIV, their partners and families. The ASHA project related programmes are an excellent example of full and meaningful involvement of PLHIV in the HIV response to increase knowledge and access to prevention, care and support services.

Positive Prevention programmes and activities have included training and mobilization of Positive Speakers and development of a Positive Speaker's Bureau (PSB) for sharing real life experiences. This has been a cornerstone in promoting disclosure of PLHIV. It has increased PLHIV's access to various services and evoked stigma reduction in the communities. PLHIV themselves are highly effective outreach educators and community mobilisers. They work through interpersonal approaches in a confidential manner, encouraging for individual behaviour change and reach PLHIV who do not wish to disclose their status more easily. Positive Prevention programmes have also addressed the needs of couples that face difficulties after a positive test result, including partner disclosure and risk reduction strategy planning not addressed thus far by other HIV programs.

Meaningful involvement of PLHA in various HIV programme management areas, such as communication and presentation, technical knowledge on HIV and AIDS, organizational development, leadership, documenting and reporting, has strengthened the ownership of Positive Prevention programmes by PLHIV communities. This demonstrates that all HIV programmes from prevention to care, support and treatment should incorporate Positive Prevention component led by PLHIV themselves to fully address their distinct needs.

# V. Major challenges and remedial actions

## *I. Policy and coordination*

To better coordinate the programme, keeping in view the changing scenarios and the current context of the position and role of HSCB, there is need for harmonisation and consolidation of the functions of different bodies set up at various point in time for specific purposes, i.e. NAC, NACC, CCM, NCASC and DACC

**Remedial actions:**

i. National AIDS Council, the Ministry of Health and Population along with other ministries need to accelerate the already initiated process for harmonisation of functions of different entities and additional efforts are required to get the HIV Bill endorsed by the parliament soon.
ii. While the role of the Ministry of Health and its delivery outlets at various levels is central to the national response and has the challenging responsibility of expanding the health sector response, the non-health sector responses and the activities outside the purview of MOHP are also crucial for expanded response to HIV.

2. Multiple donors and vertically run programmes with varied emphasis on MARPS and geographical coverage with little or inadequate coordination and harmonisation of interventions. Currently there are a number of major interventions managed and implemented by Government agencies, multilateral and bilateral agencies, NGOs and INGOs in the country. Proper coordination and harmonisation of such interventions for maximising the benefits and bringing the synergy of interventions, has not been fully achieved.

**Remedial actions:**

i. A coordinated and multisectoral NAP (2008-2011) has been one of the mechanisms adopted by many. A proper coordination and harmonisation effort is required by the national entities like NCASC and HSCB.

## *II. Financing and resource mobilisation*

3. Completion of Rd 2 implementation in 2007 and delayed Rd 7 grant signing with GFATM created a gap for almost one year. The Rd 7 grant was signed only in November 2008. Global Fund did not allow the Ministry of Health/NCASC to become PR for Rd 7 until the account, performance and capacity is thoroughly examined by OIG (Office of Inspector General for GFATM) and the report accepted by the Global Fund. Any Government body (neither NCASC nor HIV Board) not becoming PR has sent mixed messages and has affected the coordination of service delivery throughout the health care outlets.

**Remedial actions**:

i. Capacity building of the national entities has begun with support from UNDP (DFID and Global Fund grant). Steps are being taken so that a national entity can assume the position of PR in phase II of GF Rd 7 grant implementation, with UNDP handing over its current responsibility to the relevant national entity. UNDP to prepare its exit plan to phase out from current PR role in phase II of GFATM Round 7.
ii. Reponses to OIG findings and recommendations have been forwarded. The country is proactively pursuing the matter with the Global Fund.

4. DFID assistance, managed by UNDP, was initiated in 2005 and concluded in mid 2009. DFID assistance was very crucial and instrumental in expanding services in the areas of harm reduction, mobile population, care and support to PLHIV, service expansion (VCT) to MSM and the general population, and capacity building of national entities (NCASC and HSCB). The delay in the approval/implementation of the no cost extension caused sudden disruption or closure of many activities implemented through more than 70 NGOs.

**Remedial actions:**

i. The country to produce a quality proposal to the Global Fund for round 10 and explore funding opportunities with other EDPs. Speedy action to World Bank commitment is important.
ii. Additional advocacy is needed to get increased budget allocation from the government coffers, including the use of pooled funds under NHSP – II.
iii. Continued high level dialogue with EDPs like DFID and USAID for sustaining bilateral assistance for HIV and AIDS is needed.

5. Almost 90% of AIDS spending is managed by the UN and other international agencies (as a Financing Agent) outside the public sector (NASA 2007). In other words, international partners have been engaging themselves almost directly in programme management. The challenge therefore, is to increase the management responsibility among the national institutions for long term sustainability of the programme in the country.

**Remedial actions:**

i. External Development Partners who are handling the programmes need to critically review their role in the HIV response in Nepal and make an informed decision to gradually shift programme and fund management to national entities. However, continued support of EDPs, through technical assistance, will be required in areas like capacity building, supporting policy development and international advocacy.
ii. Government and other national implementing partners also need to reflect and strengthen their role, capacity, and approaches, in order to take on increased responsibility in managing the funds and programmes in the country.
iii. Domestic allocation, including Government and private sectors allocation, has remained less than 3% of the overall HIV spending in the country. For sustainability and to minimise the

projectised mode of implantation of HIV and AIDS activities in the country, there is a need for increased national allocation.

iv. Furthermore, additional efforts are required for strengthening the health system in order to expand service coverage and ensure quality.

v. Additional efforts are required for strengthening the health system in order to expand service coverage and ensure quality.

### *III. Strategic Information, and M & E*

6. Strategic Information collection, analysis and dissemination have improved a lot over the period. The reformation of SI-TWG is nearer to completion.

### *IV. Implementation related difficulty*

7. Seasonal labour migration, particularly between India and Nepal through an open border, will remain a major challenge for appropriate programmatic intervention. Ensuring access to prevention and other services across the border, calls for action at the SAARC level for a regional policy and programmatic framework.

    i. A number of SAARC level meetings and dialogues regarding HIV, trafficking, and drug issues in the past have created a strong basis to move towards more concrete action. A proactive move from those countries who share a common border would accelerate the process of developing an appropriate mechanism and for resource allocation.

# VI. Support from the country's development partners

As highlighted in NASA 2007 and through the analysis in NAP 2008-2011, many external partners have provided support in different forms and magnitude. Since EDPs have endorsed the National Strategy and NAP, their support has largely been within the broad framework of the strategy.

**Global Fund**

Nepal was successful in securing two grants (out of 9 rounds) from the Global Fund to Fight AIDS, TB and Malaria (GFATM). The first grant from Round 2 (2002) was $11 million over 5 years (2002-2006). The actual implementation was delayed and was initiated only in 2004 which lasted up 2007. The fund was managed by United Nations Development Program (UNDP) and the NCASC/MOHP as PRs. The country was successful in securing US$ 36 million through Round 7 (2007) to further support HIV and AIDS programming over the next 5 years covering mainly IDUs, MSM, migrants and ART drugs. The Family Planning Association of Nepal (FPAN), Save the Children, and UNDP are the PR's for this grant. Nepal is also one of the recipient countries of approved Regional MSM proposal of Global Fund round 9.

**Bilateral agencies**

DFID's five year support began in 2004, focusing on IDUs, migrants, support to PLHIV and strengthening of local NGOs capacity in implementing HIV interventions at the grassroots level. Most of its HIV and AIDS funding was channelled through the UNDP and some through NCASC for strengthening DACC at the district level. So far, DFID has spent £9.12 million in HIV and AIDS support in Nepal. An additional £3.38 million has been pledged by DFID for HIV and AIDS activities from 2010 to March 2011.

USAID assistance is guided by its strategy developed in 2001 with three result areas: 1) Increased national capacity to provide HIV and AIDS services; 2) Increased access to information and prevention services for HIV and AIDS and other sexually transmitted infections; 3) Increased access to care and support. The USAID programme also emphasised on national impact and building on the technical strengths of the national entities by working closely with the GON to achieve the objectives of Nepal's National HIV/AIDS Strategy. The total budget (Jul 2006- Sept 2011) of US $ 21.7 million is channelled through FHI/ASHA project.

**UN agencies and UNAIDS secretariat:**

The UN system has supported numerous activities towards combating the HIV and AIDS epidemic in the country. The nature and scope of UN support ranges from policy development and capacity building at the national and regional level, to service delivery and social mobilisation at the grass roots level. The overarching framework of the UN support has been the national HIV strategies and UNDAF as well as Common Country Assessment. Most importantly, the UN system has fully recognised both the impact of the decade long conflict and the

new opportunity it has created for development and social transformation. UNAIDS, as secretariat of the joint UN programme, supports the GON and works with all stakeholders to coordinate a variety of activities with the NCASC and the HSCB. UNAIDS is coordinating the development of the national monitoring and evaluation framework along with other stakeholders.

**World Bank**

Based on numerous assessments and mission visits in 2007, 2008 and 2009 in Nepal, the Bank has committed to fund a range of HIV and AIDS activities over the next few years. The World Bank has expressed interest in supporting the Pooled Funding mechanism under the Ministry of Health with a provision for rapid and efficient fund flow mechanism.

**Other stakeholders**

There are number of other funding partners, channelled through INGOs and NGOs, like Big Lottery Fund, Elton John Foundation, and some private sector organisations contributing as part of their Corporate Social Responsibility. Detail of such funding sources will be available only after completion of the 2nd round of NASA exercise.

# VII.Monitoring and evaluation environment

The Government recognises the need to further improve monitoring and evaluation of the HIV response in a multisectoral manner and to significantly strengthen the systems that inform and shape the national response. Nepal has started putting in place the ingredients of a good M&E System, namely establishing an M&E Unit in the NCASC and HSCB and setting clear goals for the system, which include an M&E framework. National M&E guidelines have been in existence since 2006 that cover a range of indicators and in 2009 an M&E Operational Plan (2008-2010) was drafted, It is currently being piloted in 6 districts.

Merging the M&E technical group with the Surveillance working group in 2007, to create the Strategic Information-Technical Working Group (SI-TWG), under the chairmanship of National Centre for AIDS and STD Control (NCASC), has been valuable, as it has resulted in the creation of guidelines to establish a functional M&E system.

The M&E plan is part of the costed National Action Plan. The process of establishing and strengthening M&E functions at the DACC level have gained momentum in the last years, which have allowed for improving, quality of data and analysis coming from the field to ensure evidence-informed decentralised programming. Over the last two years, significant strides have been made in establishing coordination among M&E and Surveillance to strengthen national systems. With support from UNAIDS, USAID/ FHI, DFID, Global Fund, WHO and other development partners, HSCB and NCASC have led the following major activities in a collaborative manner and the results of which will guide the thinking for reviewing the National Strategic Plan:

- The country has produced regular infection size estimates and a national surveillance plan is under formulation, aiming at second-generation surveillance in 2010 with the country aspiring to use the Asian Epidemic Model. The country will use Modes of Transmission Model to identify new infections.
- Size estimation of all MARPs groups through a participatory mapping method is underway through collective support from WB/DFID, UNDP, UNODC, UNAIDS and FHI/USAID that will allow the country to produce geographic prioritisation to inform prevention planning.
- A national database is being rolled out at NCASC and HSCB that will allow management of information coming through various implementing agencies and service delivery points. Training programmes are regularly rolled out to strengthen the capacity of field level functionaries to improve the quality of reporting.
- A full National AIDS Spending Assessment was completed by HSCB with technical assistance from UNAIDS for 2007. The country is currently preparing to move to the 2$^{nd}$ round of NASA. A national research agenda is also in place and is led by NCASC under the technical guidance of SI-TWG.
- The country has produced guidelines on STI treatment, VCT, ART and PMTCT and is now strengthening its system of routine data collection through various service delivery sites.

- HIV AIDS and STI Control Board and National Centre for AIDS and STD Control are the focal points to collect and analyze data for national HIV response in the country. The HSCB has M&E unit comprising fulltime M&E officer and M&E Assistant with having overall responsibilities to establish and to make national monitoring and evaluation system functional at the national level. Similarly, The NCASC has Strategic Information Unit comprising full time M&E focal point, M&E Officer, surveillance officer, M&E associate and M&E Assistant with responsibilities of monitoring, analysis, and synthesis of the national HIV related health program and contributes to the national response of HIV AIDS.

**Challenges in Monitoring and Evaluation**

- Despite having a set up a national M&E system both at NCASC and HSCB, conceptual clarity on how to link these two and operationalise one National M&E system that captures all the aspects of HIV and AIDS response (including those implemented by Non State Actors) remains a challenge. There is need to integrate fragmented data collection and to strengthen the national capacity in coordinating and monitoring the NGO implemented activities, especially the non-clinical prevention services.
- Most of the surveillance activities carried in the past were project based. Now it has been realised and being discussed with various stakeholders that there is a need to sustain these activities and make them representative of the country as a whole and inbuilt as part of the national programming. The country also needs to mobilise resources to revitalise its sentinel surveillance activities that have been discontinued for the last 9 years due to lack of funding. This will allow achieving the minimum support requirement to graduate to second-generation surveillance.
- Routine data collection of HIV programmes like VCT, STI, OI, etc, are improving over time, yet they are underutilised and neglected, due to the lack of dissemination beyond the centre.
- A major part of the human resource in the M&E system (at all levels) is funded and supported by Global Fund/DFID. To ensure its sustainability, there is a need to plan for building national capacity with knowledge transfer, in a phased manner and also plan for integration of the HIV database into HMIS in the long run.
- Though substantial achievements have been made over the last two years, such as increasing human capacity at the central level, developing a national HIV and AIDS M&E Operational Plan, developing a national database, it appears that many weaknesses in the system, mainly in terms of quality and timeliness of reporting still remain. There is a need to build the capacity of NGOs and other field level functionaries in M&E so the quality of data improves, allowing for better understanding through more rigorous analysis.
- District-level data is limited and fragmented and often reported by those partners who implement specific components of the programme. Along the same lines, programmes implemented by various partners do not use the same package definition and monitoring tools. There is a need to develop quality assurance mechanisms that allow tracking of the coverage and its quality at the national level in an integrated and holistic manner.
- Though DACCs are keen on taking responsibility for monitoring and evaluating multisectoral HIV and AIDS programmes at the district level, inadequate capacity and support to DACC limits its functional role in M&E.

- IBBS provides prevalence and behaviour data of MARPs groups at different study sites and different points of time; however, these data are not easily applicable to the entire country. Moreover behaviour and HIV prevalence among general male and female population in the country is lacking. Need to initiate efforts to add components in NDHS or collect data through other mechanism. Though the country is rich in data on MARPs, and a unique process exists in Nepal to track the prevalence, knowledge and behaviour of wives of migrants, there is still limited data on migrants and spouses of migrant, as well as other groups like prison inmates, HIV co-infection with other diseases like TB, hepatitis etc.

# Annexes

## Annex 1: Roadmap of UNGASS 2010 country report preparation

| SN | Activities for Country Process and Report Submission | Sep-09 | | Oct-09 | | Nov-09 | | Dec-09 | | Jan-10 | | Feb-10 | | Mar-10 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | W 1-2 | W 3-4 | W 1-2 | W 3-4 | W 1-2 | W 3-4 | W 1-2 | W 3-4 | W 1-2 | W 3-4 | W 1-2 | W 3-4 | W 1-2 | W 3-4 |
| 1 | Partnership Forum acts as a steering committee to defines and agree the process of UNGASS report preperation | | | | | | | | | | | | | | |
| 2 | Prepare Roadmap for indicator to reported by country, data types, data collection methodology, timeline and responsibility (UNAIDS/HSCB) | | | | | | | | | | | | | | |
| 3 | Identification of Consultant for overall support for entire process including report writing | | | | | | | | | | | | | | |
| 4 | Comparison of indicators in 2010 guideline with that of 2007 guideline (HSCB) | | | | | | | | | | | | | | |
| 5 | Identify data needs in line with the national strategic plan requirements and UNGASS guidelines<br>1) Technical assistance to review available data needs, requirements and quality (SI TWG)<br>2) Identify relevant tools for data collection | | | | | | | | | | | | | | |
| 6 | Develop and disseminate plan for data collection, analysis and report writing, including timelines and the roles of HSCB, NCASC and Civil Society (HSCB/UNAIDS/SITWG) | | | | | | | | | | | | | | |
| 7 | Formation of working team for UNGASS report: a) Overall Guidance, b) Data, c) NCPI, d) NASA, e) Best Practice and f) Report writing (HSCB) | | | | | | | | | | | | | | |
| 8 | Collect and collate national program indicator data in coordination with partner organizations from government, civil society and international community (Working Team) | | | | | | | | | | | | | | |
| 9 | NCPI sharing and review workshop, for data collection<br>a) Regional civil society consultations<br>b) Central level civil society consultations (with both governemnt officials and central level civil society organistions) | | | | | | planning for consulati on/invitat ion | 11-12 (Butwal) | 28-29 (Ktm) | | | | | | |
| 10 | The National Funding matrix to be filled in for submission (NASA) | | | | | | | | | | | | | | |
| 11 | National data vetting workshop to present the draft indicator data, sources used all key stakeholders (HSCB and UNAIDS) | | | | | | | | | | | | | 7th March | |
| 12 | Review/update and Share the output on all chapters of UNGASS report (HSCB andn UNAIDS) | | | | | | | | | | | | | | |
| 13 | Analysis/validation of data and enter it into the UNGASS reproting tool (HSCB/working team) | | | | | | | | | | | | | | |
| 14 | First Draft of country progress Report ready | | | | | | | | | Zero Draft | 25 Jan (circualtion for comment) | | | | |
| 15 | Draft open for comments from civil society **on -line** | | | | | | | | | | | | | 8th March | |
| 16 | Circulate the Narative report to SI TWG members, JTA, Civil society Organisations and EDPs for final inputs - **Online format** (HSCB) | | | | | | | | | | | | | 9-16 March | |
| 17 | Final report submitted to the government for endorsement | | | | | | | | | | | | | | 25-Mar |
| 18 | Upload the Final report in the website (HSCB) | | | | | | | | | | | | | | 30-Mar |

## Annex 2: Process and steering committee for report preparation

### Consultation and preparation process for the Nepal Country Report on monitoring the progress towards the implementation of the Declaration of Commitment on HIV/AIDS (UNGASS).

The preparation of the Nepal UNGASS report 2010 was led by HIV AIDS and STI Control Board (HSCB). HSCB initiated the report preparation process in July 2009 by inviting stakeholders together to decide on executing bodies, data requirements and consultations.

Timeline of meetings and actions taken:

1. HSCB organized a preliminary consultation meeting with the stakeholders to discuss UNGASS 2010 report preparation(3rd July 2009).
    - Meeting gave mandate for HSCB to form an UNGASS 2010 core team. The core team consists of an overall guidance group and two subgroups: one to work with NCPI and another with programme, coverage and impact data and M&E.
    - Meeting decided that in addition to national consultations wider regional consultations would be organized with relevant governmental and civil society representatives.
    - Data needs assessment was assigned to Strategic Information Technical Group (SI-TWG) and to the previously mentioned Data and M&E group formed to work on UNGASS. The latter group would also gather the data on service coverage, behaviour and impact (3rd July 2009).
2. After a request from HSCB and UNAIDS Nepal's Ministry of Health gave HSCB authorization to lead the UNGASS 2010 report process (27th July 2009).
3. HSCB and UNAIDS drafted a roadmap for UNGASS 2010 preparation process (11 Aug 2009).
4. Decision was also made of the formation of three thematic committees of specific MARP groups (FSW, MSM and IDU), which would provide their inputs for the report preparation process (8th Sep 2009).
5. National AIDS Spending Assessment (NASA) 2007 was adapted to the matrix proposed by UNGASS 2010 (8 Sept 2010).
6. M&E officers from HSCB and NCASC took part in Regional M&E Meeting for Asia-Pacific training in Bangok that also discussed the UNGASS report preparation process (29 Sep - 2 Oct 2009).
7. Third consultation meeting reviewed thoroughly UNGASS indicators and discussed the possibilities of reporting them in relation to Nepal's epidemic. Data requirements and sources for different indicators were identified. Process and contents regarding regional consultations as well as their dates were finalised (16th Oct 2009).
8. Strategic Information Technical Working Group meeting was held to further discuss key issues for UNGASS report preparation and the roles of responsible working groups. (2nd Nov 2009).
9. After SI-TWG meeting, a special core working group for UNGASS 2010, consisting of six people, was formed. Timelines for individual tasks were framed (2nd Nov 2009).

10. Core working group met to plan the Regional NCPI Consultations for government and civil society representatives. Working group also discussed the updating of current National AIDS Spending Assessment and the timeline of UNGASS 2010 report draft version (4th Nov 2009).
11. HSCB and two thematic committees held separate meetings that discussed and agreed on definitions of FSW and MSM (6th Nov 2009).
12. Core working group met again to discuss the participation and agenda of upcoming Regional NCPI meetings. Meeting also decided the dates for National Consultation (30th Nov 2009).
13. The regional NCPI Consultation in Dhangadi (Far Western region) was postponed due to unstable security situation in the country (6th Dec 2009).
14. Regional consultation was held in Butwal (Western region). Government and Civil Society Representatives were introduced to UNGASS process and its' purpose on separate days. NCPI parts A and B were administered with the both groups (11-13th Dec 2009). Second consultation planned to be held in Dhangadi was cancelled for second time due to politically unstable situation.
15. Internal review meeting after Butwal consultations was held and discussed the experiences and lesson learnt while conducting NCPI for both regional government officials and CSO members. Meeting also made plans for the forthcoming national consultations (17th Dec 2009).
16. Internal meeting in HCSB reviewed the status of data processing, remaining data needs for specific indicators, NASA and collated case studies (23rd Dec 2009).
17. National NCPI Consultations with representatives of government officials and civil society (28-29th Dec 2009).
18. Zero Draft report shared within the team (18th Jan 2010)
19. Members of the UNGASS report writing team took part in regional UNGASS 2010 workshop organized by UNAIDS and Technical Support Facility South Asia (12-14th January 2010).
20. Representatives from HSCB and UNAIDS shared the UNGASS draft and progress to the Secretary of Ministry of Health and Population (8th Feb 2010).
21. Director of HSCB presented UNGASS 2010 reporting process and progress so far in the meeting of United Nations Joint Team of AIDS (16th Feb 2010).
22. Internal Progress Update Meeting with UNAIDS and HSCB reviewed UNGASS report draft, assessed needed inputs and gave a timeline for forthcoming data workshops and report submission (2nd March 2010).
23. UNGASS process was represented to a member of National Planning Commission by representatives from HSCB, civil society and UNAIDS (4th March 2010).
24. UNGASS report authors held an internal report editing meeting with technical support from UNAIDS (5-6th March 2010).
25. Data vetting workshop was held with partners providing indicator data for the report (7th March 2010).
26. UNGASS report was uploaded on-line to be commented by civil society and other partners (8th March 2010).
27. Core working group incorporated the comments received on the report (16th March 2010).
28. High level policy meeting for UNGASS 2010 reporting conducted with Secretary of MoHP, member of NPC and representatives of key partners and get final comments and feedback on the report (19th March 2010).
29. Final UNGASS 2010 report was submitted for endorsement to the Ministry of Health and Population (25th March 2010).

30. Final UNGASS 2010 report was uploaded to Geneva(30th March 2010).
31.Hard copy of the UNGASS 2010 report will be disseminated in April 2010.

The 2010 country report is also seen as an opportunity to provide a bi-annual national update on status of the HIV epidemic and the national response, particularly to discuss progress made, future challenges, and any corrective actions required in terms of policy and programmes. In addition, the report will be used to showcase available data, inform future programmes and advocate further strengthening of monitoring and evaluation in Nepal.

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**Annex 4: NCPI**

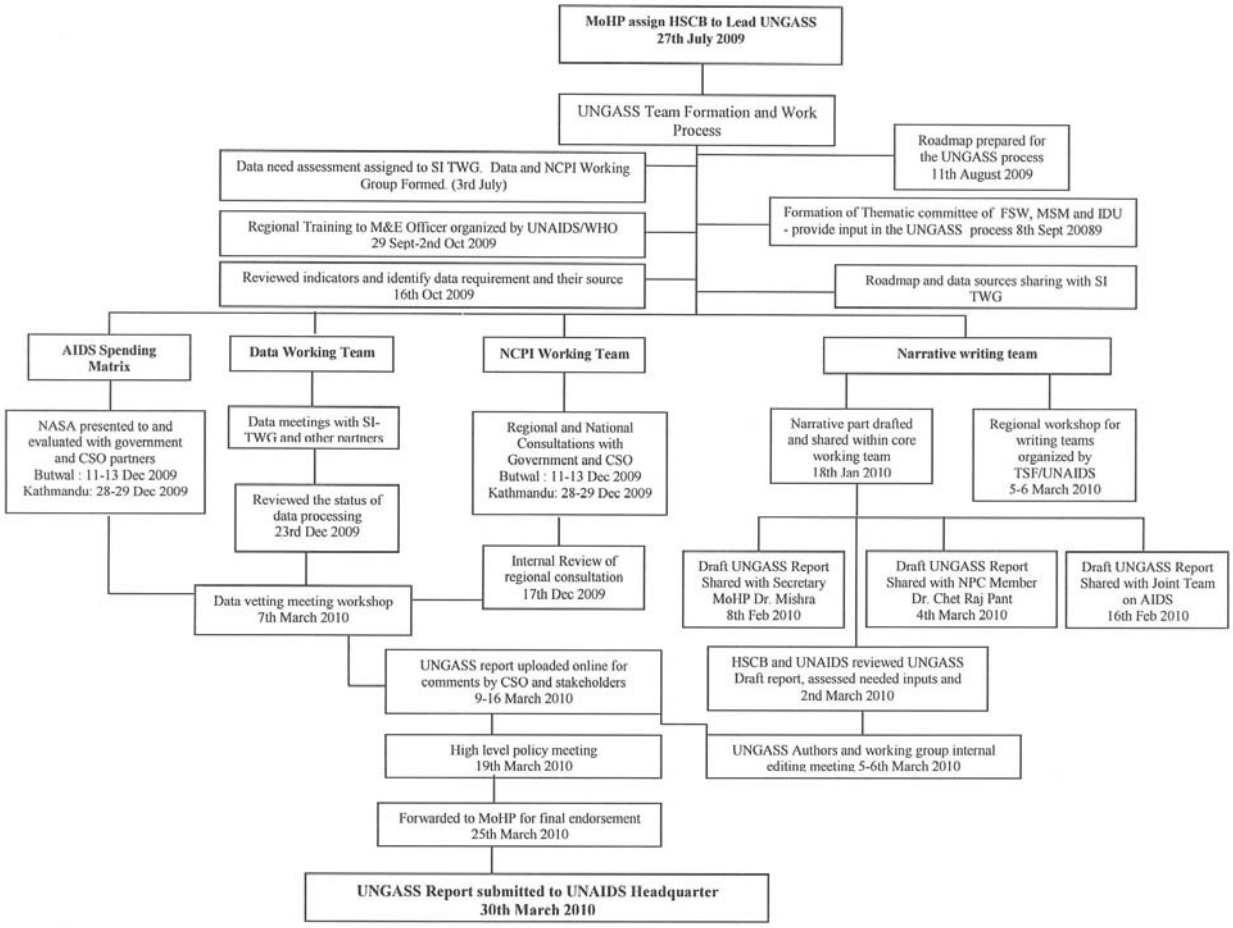
Uploaded separately on http://ungass2010.unaids.org

## Annex 5: AIDS Spending Matrix

(On this online version of the report, AIDS Spending matrix is separately uploaded, therefore not attached here)

## Annex 6: Proposed mapping zone and districts

### Proposed zones and district mapping

| Proposed Epidemic Zones | Number of districts | Name of Districts |
|---|---|---|
| Kathmandu Valley | 3 | Kathmandu<br>Lalitpur<br>Bhaktapur |
| Highway districts (Mahendra, Prithvi and Pokhara – Butwal highways) | 26 | Jhapa, Morang, Sunsari, Saptari, Siraha, Dhanusha, Mahottari, Sarlahi, Rautahat, Bara, Parsa, Chitwan, Dhading, Makawanpur, Syanja, Kaski, Palpa, Rupendehi, Kapilbastu, Dang, Banke, Bardiya, Kailali, Kanchanpur, Tanahu, Nawalparasi |
| Far–western hill (7 hill districts of the Far–western development region) | 7 | Bajura, Bajhang, Accham, Doti, Dadeldhura, Baitadi, Darchula |
| Eastern Hill | 13 | Dolkha,Taplejung, Panchthar, Ilam, Dhankuta, Tehrathum, Khotang, Sankhuwasabha, Bhojpur, Solukhumbu, Okhaldunga,<br>Udayapur, Ramechhap |
| Western & Mid-western Hill | 13 | Myagdi, Parbat, Baglung, Gulmi, Arghakhanchi, Puthan, Rolpa, Rukum, Salyan, Surkhet, Dailekh, Jajarkot, Kalikot |
| Remaining Hill | 13 | Lamjung, Gorkha, Sindhupalchowk, Sindhuli Kaverpalanchok, Nuwakot, Rasuwa, Mugu, Humla Dolpa, Jumla, Manang, Mustang, |

## Annex 7: Work Flow of the UNGASS Process