

# Country Progress Report on HIV/AIDS Response NEPAL

Submission Date: 31 March 2014



**Government of Nepal**  
**Ministry of Health and Population**  
**National Centre for AIDS and STD Control**

**March 2014**

# **Country Progress Report on HIV/AIDS Response, Nepal, 2014**

**Submitted on 31 March 2014**

**© National Centre for AIDS and STD Control (NCASC), 2014**

**Recommended Citation: NCASC (2014) Country Progress Report on HIV/AIDS Response, Nepal, 2014**

All rights reserved. The document may, however, reviewed, quoted, or translated in part or full provided the source (NCASC) is fully acknowledged. The document may not be sold or used for any kinds of commercial purposes without prior written approval from the National Centre for AIDS and STD Control (NCASC). NCASC does not warrant that the information contained in this publication is complete and correct, and shall not be liable for any damages incurred as a result of its use.



Ref: .....

Government of Nepal

# Ministry of Health & Population



Phone : 4.

262987  
262590  
262802  
262706  
262935  
262862

Ramshahpath, Kathmandu  
Nepal

Date : 31 March 2014

## FOREWORD

As part of Nepal's commitment to "2011 UN Political Declaration on HIV and AIDS: Intensifying our Efforts to Eliminate HIV and AIDS" (General Assembly resolution 65/277), which was adopted at the United Nations General Assembly High Level Meeting on AIDS in June 2011, we are pleased to put forward the Nepal Country Progress Report on AIDS Response, 2014. This report focuses on our efforts and achievements in the areas of prevention of HIV, treatment, care and support of infected people, human right issues, engagement of civil society organizations, enabling environment and tracks our progress with respect to the commitment. This report also ascertains challenges of the national response to the fore.

A review of the latest data indicates that the epidemic transmission of HIV has halted in Nepal. This achievement is a result of collaborative efforts of national government entities, external development partners, civil society organizations, vulnerable groups and people living with HIV.

Nepal, during 2013, has reinforced its national response to HIV with a number of potentially transformative initiatives to keep the response updated with the latest advancements in medicine and public health practice in prevention and control of HIV and sexually transmitted infections.

The need of the hour clearly calls for instantaneous scaling up of treatment coverage including pediatric ART. Similarly services related to prevention of mother-to-child transmission of HIV need to be expanded in an extensively wider scale but smartly ensuring value for money. There is also a pressing need to intensify and scale up its targeted prevention interventions that have been proven successful for containing the spread of HIV among key populations.

We would like to express our sincere thanks to all individuals, national government entities, external development partners, civil society organizations, vulnerable groups, including people living with HIV for their contribution and active role played in prevention and control of HIV, providing data and help in preparation of this report.

Finally, we would like to express that the Government of Nepal is fully committed to address the vulnerability, risks, threats, and impact of HIV in order to reach the targets of "Zero New HIV Infections, Zero Discrimination, and Zero AIDS-related Deaths".

Dr Praveen Mishra  
Secretary

Ministry of Health and Population

Dr Lakhan Lal Sah  
Director General

Department of Health Services  
Ministry of Health and Population

Dr Naresh Pratap KC  
Director

National Centre for AIDS and STD Control  
Ministry of Health and Population

# TABLE OF CONTENTS

FOREWORD.....	i
TABLE OF CONTENTS.....	ii
LIST OF FIGURES.....	iii
LIST OF ABBREVIATIONS.....	iv
<b>I. STATUS AT A GLANCE.....</b>	<b>1</b>
<b>A. The inclusiveness of the stakeholders in the report writing process.....</b>	<b>1</b>
<b>B. Status of the epidemic.....</b>	<b>1</b>
<b>C. The policy and programmatic response.....</b>	<b>1</b>
<b>D. Indicator data in an overview table.....</b>	<b>2</b>
<b>II. OVERVIEW OF THE AIDS EPIDEMIC.....</b>	<b>4</b>
<b>III. NATIONAL RESPONSE TO THE AIDS EPIDEMIC.....</b>	<b>9</b>
<b>A. Policy and structural response.....</b>	<b>9</b>
<b>B. Prevention, treatment, care and support.....</b>	<b>10</b>
<b>C. Support for Creating an Enabling Environment.....</b>	<b>16</b>
<b>D. National programme and achievements.....</b>	<b>18</b>
<b>IV. BEST PRACTICES.....</b>	<b>20</b>
<b>A. A Multi-prong Approach to Integration of Family Planning and HIV Services.....</b>	<b>20</b>
<b>B. Early Infant Diagnosis (EID) Service in Nepal.....</b>	<b>21</b>
<b>C. Moving towards HIV Drug Resistance Monitoring in Nepal: Monitoring Early Warning Indicators.....</b>	<b>21</b>
<b>V. MAJOR CHALLENGES AND REMEDIAL ACTIONS.....</b>	<b>23</b>
<b>VI. SUPPORT FROM THE COUNTRY'S DEVELOPMENT PARTNERS.....</b>	<b>26</b>
<b>VII. MONITORING AND EVALUATION ENVIRONMENT.....</b>	<b>29</b>
<b>A. Surveillance of HIV and STIs.....</b>	<b>29</b>
<b>B. Monitoring and Evaluation (M&amp;E).....</b>	<b>30</b>
<b>C. Research.....</b>	<b>31</b>
<b>D. Challenges and Remedial Actions.....</b>	<b>31</b>
REFERENCES.....	32
ANNEXES.....	34
<b>ANNEX 1.1: COUNTRY CONSULTATION/PREPARATION PROCESS FOR REPORT ON MONITORING THE PROGRESS TOWARDS THE IMPLEMENTATION OF THE DECLARATION OF COMMITMENT ON HIV AND AIDS.....</b>	<b>34</b>
<b>ANNEX 1.2: TERMS OF REFERENCES (TOR) OF TECHNICAL WORKING TEAM (TWT) AND ADVISORY GROUP (AG).....</b>	<b>35</b>
<b>ANNEX 2: NATIONAL COMMITMENTS AND POLICY INSTRUMENT (NCPI).....</b>	<b>37</b>

## LIST OF TABLES

Table 1: Status of Nepal’s Progress on HIV/AIDS Response, 2012-2014 .....	2
Table 2: Key Populations Reached with Targeted Prevention Interventions .....	10
Table 3: Key Populations Reached out with BCC Activities (16 July 2012-15 July 2013) .....	11
Table 4: Key Populations Reached with Targeted Prevention Interventions .....	12
Table 5: Key Populations Tested for HIV and Know their Test Results in the Last 12 Months .....	12
Table 6: Resources Allocation by Sources: 2011/12 - 2013/2014 .....	26
Table 7: The GFTAM Contribution to Nepal’s Response to HIV/AIDS: 2011/12-2013/14 .....	27
Table 8: Contribution of EDPs (Except the GFATM) to the National Response to HIV/AIDS: 2011/12-2013/14 .....	28

## LIST OF FIGURES

Figure 1: Declining Trend of HIV Prevalence among 15-49 Years, 1985-2020 .....	4
Figure 2: Estimated New HIV Infections Occurring Annually in Nepal: 1985-2020 .....	5
Figure 3: Estimated HIV Infections by Age and Sex in 2013 .....	5
Figure 4: Estimated HIV Infections among Key Populations in Nepal, 2013 .....	6
Figure 5: Changed Level of HIV Prevalence among Key Populations in Nepal .....	7
Figure 6: Treatment Cascade in Nepal .....	13
Figure 7: NCPI Rating 2003-2014 (Part A: Administered to Government Officials) .....	17
Figure 8: NCPI Rating 2003-2014 (Part A: Administered to Civil Society’s Representatives) .....	18

## LIST OF ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral (drugs)
AusAID	Australian Agency for International Development
BCC	Behaviour Change Communication
BSS	Behaviour Sentinel Surveillance
CABA	Children Affected By AIDS
CBO	Community-Based Organisation
CCC	Community Care Centre
CD4	Cluster of Differentiation 4
CHBC	Community and Home-Based Care
CTTC	Community Test and Treat Competence
CT	Chlamydia Trachomatis
DACC	District AIDS Coordination Committee
DBS	Dried Blood Spot
DDC	District Development Committee
DFID	Department for International Development (UK)
DOTS	Directly Observed Treatment, Short-Course
DNA	Deoxyribonucleic Acid
DQA	Data Quality Assessment
EDP	External Development Partner
EID	Early Infant Diagnosis
EQAS	External Quality Assurance
EWI	Early Warning Indicators
FHD	Family Health Division
FHI	Family Health International
FP	Family Planning
FSW	Female Sex Worker
GARP	Global AIDS Response Progress
GAVI	Global Alliance for Vaccination and Immunization
GBV	Gender-Based Violence
GFATM	The Global Fund to Fight AIDS, Tuberculosis and Malaria
GIZ	Germany's Agency for International Development
GoN	Government of Nepal
GV	Gender Violence
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HLM	United Nations High Level Meeting
HMIS	Health Management Information System
HSS	Health Systems Strengthening
HSS	HIV Sentinel Surveillance
HTC	HIV testing and counselling
IBBS	Integrated Biological and Behavioural Surveillance
IEC	Information, Education, Communication
KAP	Key Affected Population
LGBTI	Lesbian, Gay, Bisexual, Transgender and Intersex
LMD	Logistics Management Division

M&E	Monitoring and Evaluation
MoHP	Ministry of Health and Population
MSM	Men who have Sex with Men
MSW	Male Sex Workers
NASA	National AIDS Spending Assessment
NCASC	National Centre for AIDS and STD Control
NCPI	National Commitments and Policy Instrument
NDHS	National Demographic Health Survey
NG	Neisseria Gonorrhoea
NGO	Non-Governmental Organization
NHIP	Nepal HIV Investment Plan 2014-2016
NHSP	Nepal Health Sector Programme
NHSP-IP	Nepal Health Sector Programme Implementation Plan
NPHL	National Public Health Laboratory
NSP	National HIV Strategy Plan
OI	Opportunistic Infection
OST	Opioid Substitution Therapy
OVC	Orphan and Vulnerable Children
PCR	Polymerase Chain Reaction
PMTCT	Prevention of Mother to Child Transmission
PWID	People who Inject Drugs
PWID-M	Males Who Inject Drugs
SI	Strategic Information
SRH	Sexual and Reproductive Health
SSP	Saath-Saath Project
STI	Sexually Transmitted Infection
SW	Sex Worker
SWAp	Sector-Wide Approach
TB	Tuberculosis
TG	Transgendered person/people
TGSW	Transgendered Sex Worker
TTR	Test, Treat and Retain
UN	United Nations
UNAIDS	United Nations Joint Programme on AIDS
UNDP	United Nations Development Programme
UNODC	United Nations Office on Drugs and Crime
USAID	United States Agency for International Development
USD	United States Dollar
WHO	World Health Organization

## **I. STATUS AT A GLANCE**

### **A. The inclusiveness of the stakeholders in the report writing process**

The National Centre for AIDS and STD Control (NCASC) was entrusted with the responsibility of leading the preparation and submission of the Nepal Country AIDS Response Progress Report 2014. In January 2014, NCASC formed an Advisory Group (AG) and a Technical Working Team (TWT) along with terms of reference (ToR). The road map for the Country AIDS Response Progress (GARP) reporting process was developed in consensus with the AG and TWT. A series of consultations, key informant interviews and group discussions were conducted for the data collection process for the reporting of the core indicators and National Commitments and Policy Instruments (NCPI). A data validation workshop was held for all the stakeholders who participate in the national response to HIV/AIDS in Nepal. The draft report was shared with the stakeholders and a timeline was provided to them for submitting their comments. The relevant comments from the stakeholders were incorporated in the final report.

### **B. Status of the epidemic**

Nepal's HIV prevalence has not changed much over the last five years, it has remained within 0.3 - 0.2 percent. The estimated HIV prevalence among 15-49 years is 0.23 percent in 2013. With this level of HIV infection, there are approximately 40,720 people living with HIV in Nepal. Although HIV prevalence has not changed much, the country has achieved reduction in the number of new infections, from 8,039 new infections annually in 2000 to 1,408 in 2013. Apart from overall low HIV prevalence among adult population, the country's epidemic scenario looks much different among key populations where, in certain groups, HIV prevalence is much higher, notably among People who Inject Drugs (PWID), Men who have Sex with Men (MSM), Transgender People, Female Sex Workers (FSW) and Male Labour Migrants and their families. Besides HIV prevalence among key populations, their size remains a considerable challenge for achieving as well as maintaining optimal coverage.

### **C. The policy and programmatic response**

The national response to HIV is premised upon the National AIDS Policy 2011. Moreover, the National HIV/AIDS Strategy 2011-2016, embracing the principal of universal access, human right-based approach and multi-sectoral approach, guides the national response. In the reporting period, Nepal is implementing the programmatic strategies in prevention of HIV through targeted prevention interventions among key populations and pregnant mothers and providing antiretroviral treatment (ART) to medically eligible (CD4 cut off value of 350) people living with HIV and also providing care and support services such as community and home base care (CHBC). On top of policy and strategy Nepal has developed a three years investment plan (Nepal HIV Investment Plan 2014-2016) to further prioritize HIV interventions as well as improve HIV coordination. The Nepal HIV Investment Plan 2014-2016 (NHIP) calls for intensifying and scaling up its quality targeted prevention interventions that have been proven successful for containing the spread of HIV among key populations. A rapid scale up of the coverage of PMTCT has become an imperative for achieving the national target of reducing 90% of new infections among children.



## D. Indicator data in an overview table

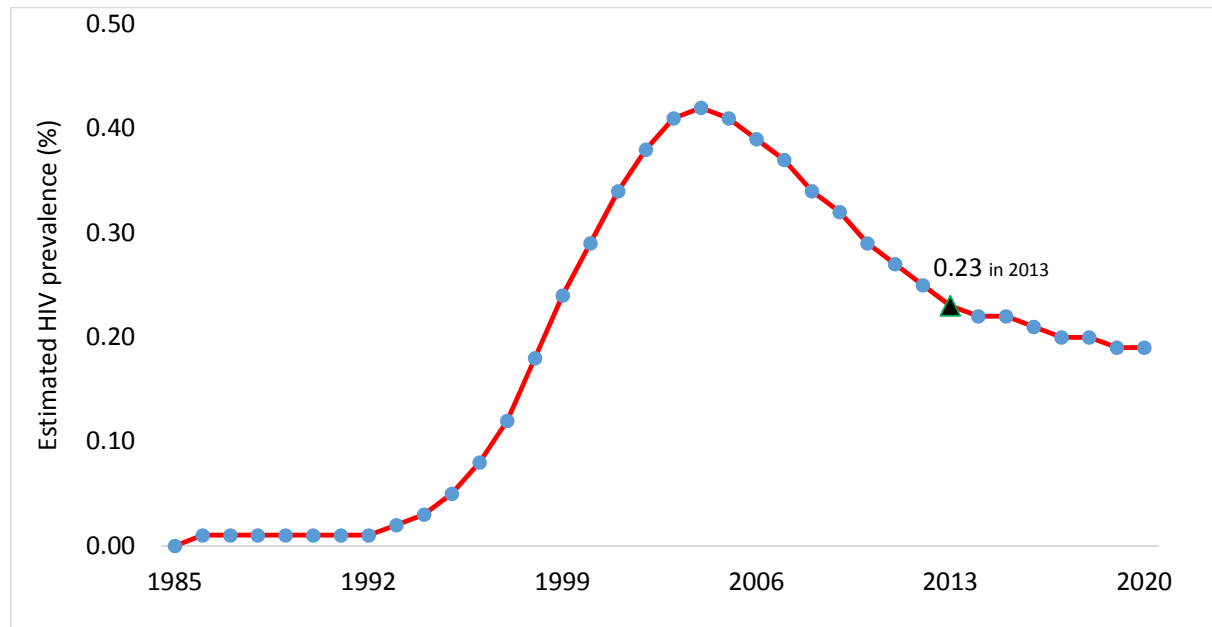
**Table 1: Status of Nepal's Progress on HIV/AIDS Response, 2012-2014**

Indicator #	Indicators Titles	2014	2012	Data Source (2013)	Remarks
<b>Target 1. Reduce sexual transmission of HIV by 50 per cent by 2015</b>					
<i>Indicators for the general population</i>					
1.1	Percentage of young women and men aged 15–24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	M=33.9%, F=25.8%	M=33.9%, F=25.8%	NDHS, 2011	Same data as reported in 2012
1.2	Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	M=3.1%, F=7.0%	M=3.1%, F=7.0%	NDHS, 2011	Same data as reported in 2012
1.3	Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months	M=3.8%	M=3.8%	NDHS, 2011	Same data as reported in 2012
1.4	Percentage of adults 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	M=26.5%	M=26.5%	NDHS, 2011	Same data as reported in 2012
1.5	Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results	M=7.5%, F=2.9%	M=7.5%, F=2.9%	NDHS, 2011	Same data as reported in 2012
1.6	Percentage of young people aged 15-24 who are living with HIV	Not applicable	Not applicable		
<i>Indicators for sex workers</i>					
1.7	Percentage of sex workers reached with HIV prevention programs	MSW=79.3% FSW=60%	MSW=93.3% FSW=60%	IBBS among MSM in KTM, 2009-2012 IBBS among FSW in KTM, 2011	Same data as reported as of 2012 in case of FSW
1.8	Percentage of sex workers reporting the use of a condom with their most recent client	MSW=90.4% FSW=82.6%	MSW=37.8% FSW=82.6%	IBBS among MSM in KTM, 2009-2012 IBBS among FSW in KTM, 2011	Same data as reported as of 2012 in case of FSW
1.9	Percentage of sex workers who have received an HIV test in the past 12 months and know their results	MSW=58.5% FSW=54.6%	MSW=65.2% FSW=54.6%	IBBS among MSM in KTM, 2009-2012 IBBS among FSW in KTM, 2011	Same data as reported as of 2012 in case of FSW
1.10	Percentage of sex workers who are living with HIV	MSW=8.7% FSW=1.7%	MSW=5.2% FSW=1.7%	IBBS among MSM in KTM, 2009-2012 IBBS among FSW in KTM, 2011	Same data as reported as of 2012 in case of FSW
<i>Indicators for men who have sex with men</i>					
1.11	Percentage of men who have sex with men reached with HIV prevention program	64.0%	77.3%	IBBS among MSM in KTM, 2009, 2012	
1.12	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	91.4%	75.3%	IBBS among MSM in KTM, 2009, 2012	
1.13	Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results	42.0%	42.0%	IBBS among MSM in KTM, 2009, 2012	
1.14	Percentage of men who have sex with men who are living with HIV	3.8%	3.8%	IBBS among MSM in KTM, 2009, 2012	
<b>Target 2. Reduce transmission of HIV among people who inject drugs by 50 per cent by 2015</b>					
2.1	Number of syringes distributed per person who injects drugs per year by needle and syringe program	30.5	71.3	Routine Programme Data, Jan-Dec 2013, NCASC	
2.2	Percentage of people who inject drugs who report the use of a condom at last sexual intercourse	46.5%	46.5%	IBBS among male IDUs in KTM 2011	Same data as reported in 2012
2.3	Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected	95.3%	95.3%	IBBS among male IDUs in KTM, 2011	Same data as reported in 2012
2.4	Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results	21.4%	21.4%	IBBS among male IDUs in KTM, 2011	Same data as reported in 2012
2.5	Percentage of people who inject drugs who are living with HIV	6.3%	6.3%	IBBS among male IDUs in KTM, 2011	Same data as reported in 2012
<b>Target 3. Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths</b>					
3.1	Percentage of HIV-positive pregnant women who receive antiretroviral to reduce the risk of mother-to-child transmission	139 (20.5%)	134 (12.2%)	Routine Programme Data –NCASC (Jan-Dec 2013) and EPP/Spectrum 2014	

Indicator #	Indicators Titles	2014	2012	Data Source (2013)	Remarks
3.1a	Percentage of women living with HIV receiving antiretroviral medicines for themselves or their infants during breastfeeding	136 (20%)	NA	Routine Programme Data, NCASC (Jan-Dec 2013) and EPP/Spectrum 2014	
3.2	Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	21 (3.1%)	22 (2.4%)	2013 data, FHI 360/USAID (5 sites) and EPP/Spectrum, 2014	
3.3	Estimated percentage of child HIV infections from HIV-positive women delivering in the past 12 months	35.6%	39.7%	EPP/Spectrum, 2014	
<b>Target 4. Have 15 million people living with HIV on antiretroviral treatment by 2015</b>					
4.1	Percentage of adults and children currently receiving antiretroviral therapy	21.8%	23.7%	Routine Programme Data –NCASC (Jan-Dec 2013) and EPP, 2014	Denominator in 2014 is estimated HIV infections
4.2	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	86.0%	82.5%	ART Cohort Analysis, 2013	
<b>Target 5. Reduce tuberculosis deaths in people living with HIV by 50 per cent by 2015</b>					
5.1	Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	551 (50.1%)	NA	Routine Programme Data–NCASC (Jan-Dec 2013)	
<b>Target 6. Reach a significant level of annual global expenditure (US\$22-24 billion) in low and middle-income countries</b>					
6.1	Domestic and international AIDS spending by categories and financing sources		20.45 mil	Resource inflow of HIV AIDS, 2010	No new data available for year 2014
<b>Target 7. Eliminating Gender Inequalities</b>					
7.1	Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months	14.4%	14.4%	NDHS, 2011	Same data as reported in 2012
<b>Target 8. Eliminating Stigma and discrimination</b>					
8.1	Discriminatory attitudes towards people living with HIV	M=24.9% F=30.7%		NDHS, 2011	
<b>Target 9. Eliminate travel restriction</b>					
	Travel restriction data is collected directly by the Human Rights and Law Division at UNAIDS HQ, no reporting needed				
<b>Target 10. Strengthening HIV integration</b>					
10.1	Current school attendance among orphans and non-orphans aged 10–14	NA	NA		
10.2	Proportion of the poorest households who received external economic support in the last 3 months	NA	NA		

## II. OVERVIEW OF THE AIDS EPIDEMIC

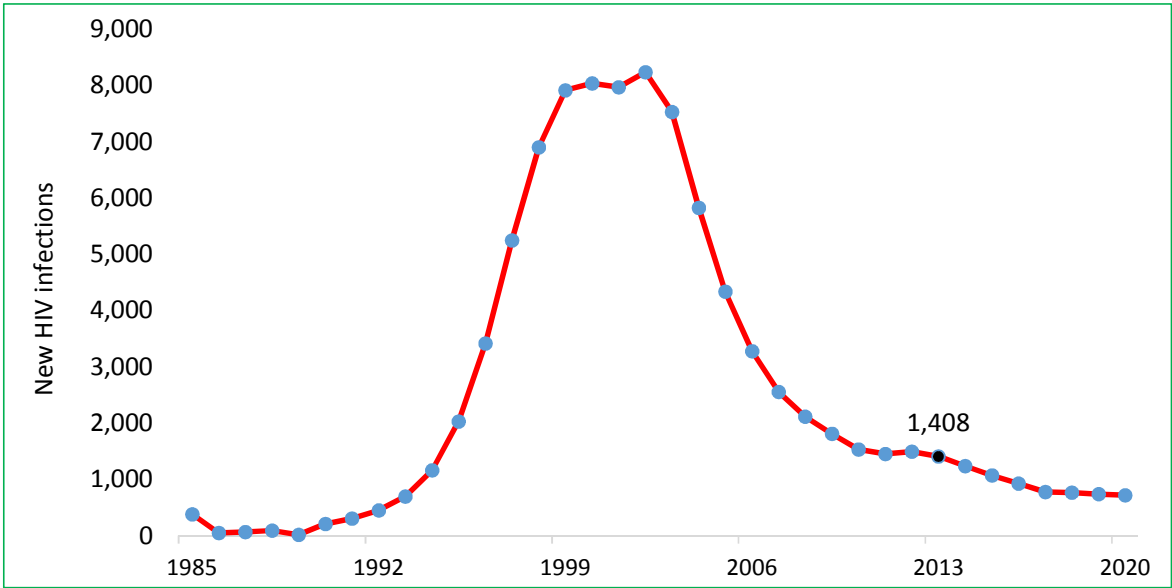
The epidemic of HIV in Nepal is dynamic and is concentrated among key populations at higher risk such as People who Inject Drug (PWID), Men who have Sex with Men (MSM) and Transgender People, Female Sex Workers (FSW) and Male Labour Migrants. Despite the higher prevalence among key populations, HIV prevalence is moderately declining after reaching the peak during 2002 – 2003 (Figure 1). In Nepal, the epidemic is largely driven by sexual transmission, which accounts for more than 4 of every 5 HIV infections.



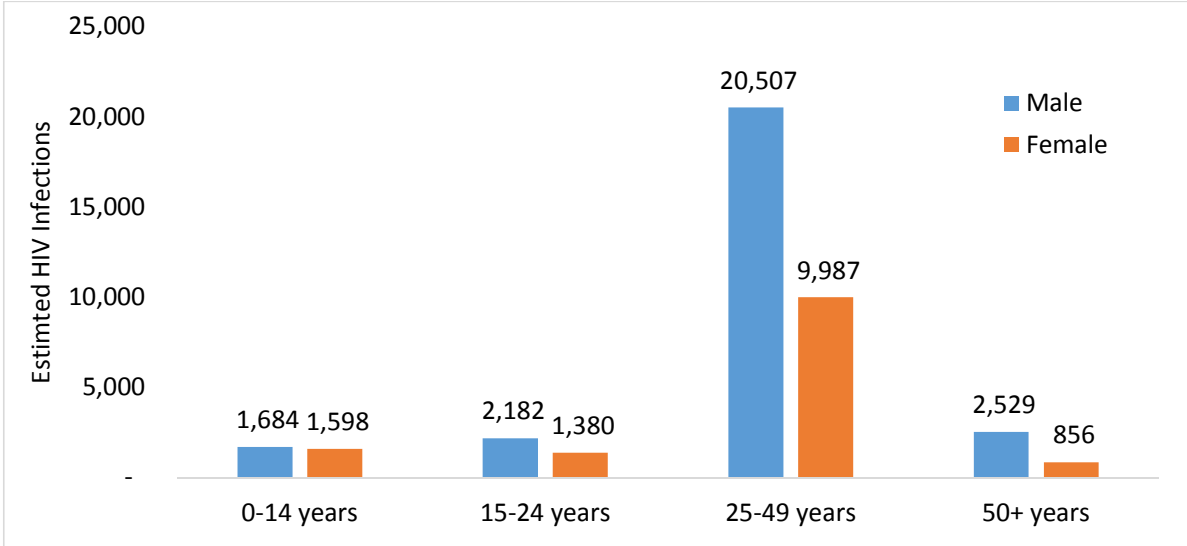
**Figure 1: Declining Trend of HIV Prevalence among 15-49 Years, 1985-2020**

This prevalence has decreased from 0.42% (highest level projected in 2004), and will maintain a plateau between 0.22% and 0.19% during 2014 through 2020 with the current level of efforts (Figure 1). Nevertheless, new infections have reduced significantly in the last one decade (7,500 in 2003 to 1,400 in 2013: about a reduction by 80%) (Figure 2).

There are about 3,281 (8% of total estimate) children up to the age of 14 years that are estimated to be living with HIV in Nepal in 2013, while the adults aged 15 years and above account for 92%. Due to the more matured epidemic, there are also 3,385 infections estimated among population aged 50 years and above (8.3%). By sex, around two-thirds of the infections occurred among males (66%) and the remaining more than one-third (34%) of infections are in women, out of which around 92.2% are in the reproductive age group of 15-49 years (Figure 3). The male to female sex ratio of total infection is 1.95 in the year 2013. This was higher of 3.45 (1990), 2.36 (2000), 2.15 (2006) and projected to be 1.86 by 2020.

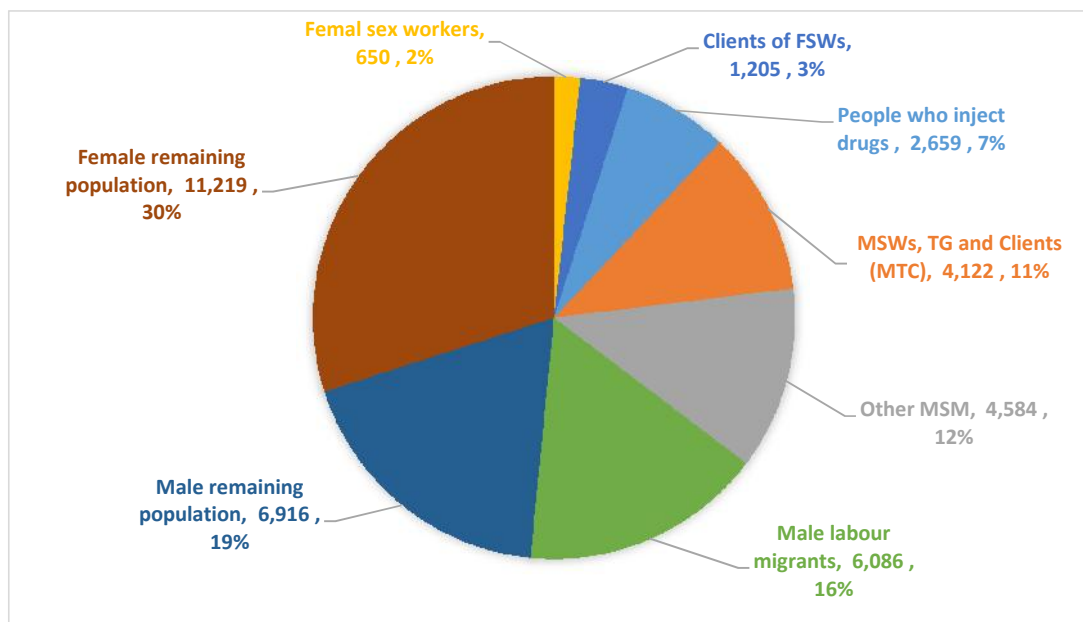


**Figure 2: Estimated New HIV Infections Occurring Annually in Nepal: 1985-2020**



**Figure 3: Estimated HIV Infections by Age and Sex in 2013**

The latest estimates also indicate that out of the total estimated people living with HIV, the population group of remaining females accounts for approximately 30.0% of the total infections, followed by remaining males, male labour migrants, other MSMs, MTCs, PWIDs, clients of FSWs, and FSWs with 18.5%, 16.3%, 12.2%, 11.0%, 7.1%, 3.2% and 1.7% respectively (Figure 4).



**Figure 4: Estimated HIV Infections among Key Populations in Nepal, 2013**

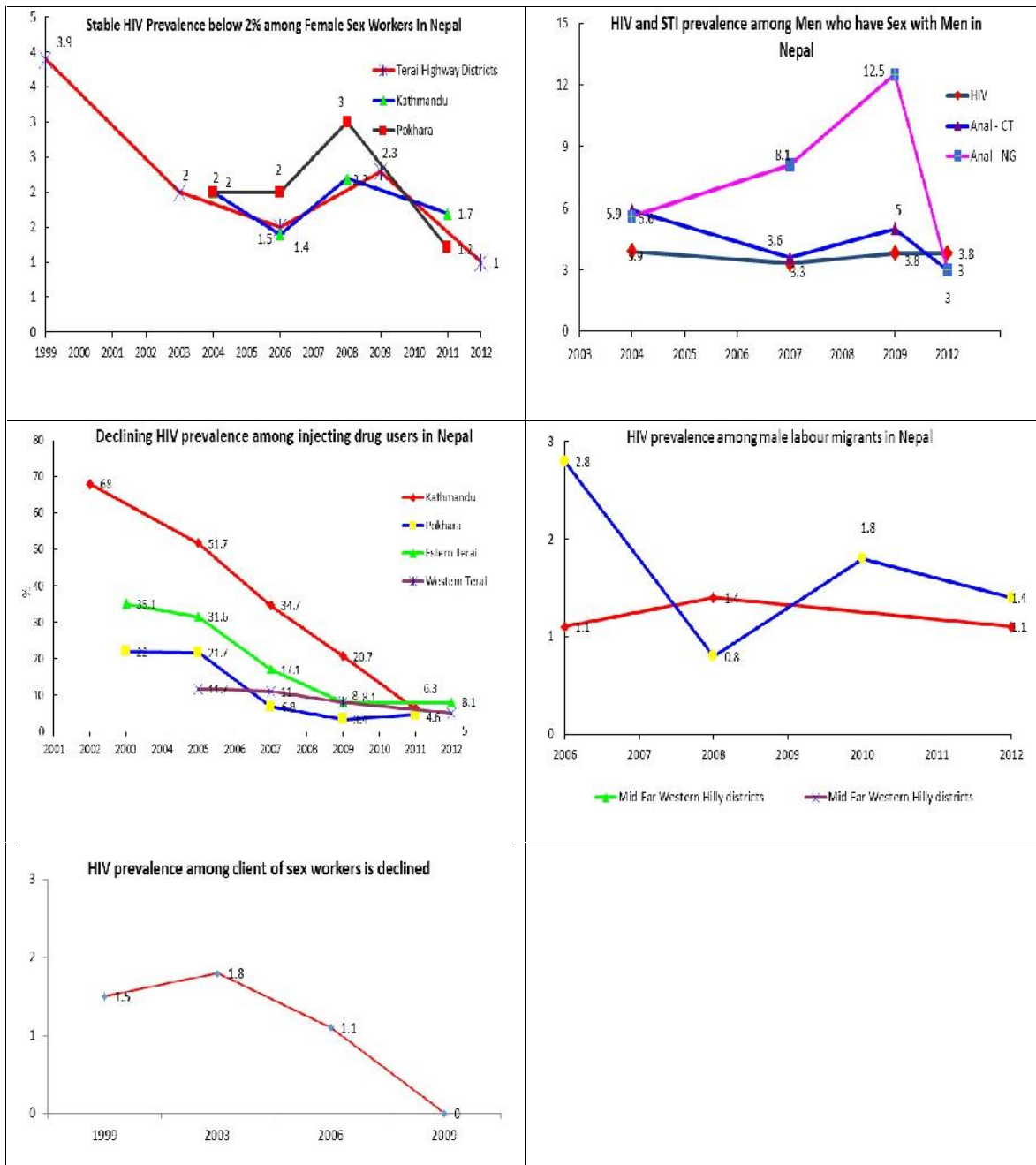
The estimated number of annual AIDS deaths of all ages is projected to decrease from the current 2013 estimate of 3,362 to 641 by 2016. This decline is most likely due to the increase of the number of people on antiretroviral treatment.

## HIV Situation among Key Populations

### Female Sex Workers (FSW) and their Clients

There were about 26,504 female sex workers estimated in 2010 in Nepal (HSCB/NCASC, 2011). The IBBS studies conducted since 2004 among FSWs in Kathmandu, Pokhara and other cities (22 Terai districts) suggests that the country has successfully kept the HIV prevalence below 2% Figure 5:. The disaggregated data among FSW however suggests a much higher HIV prevalence among street-based sex workers in Kathmandu (4.2% in 2011). The country has limited data to assess the HIV situation among the clients of FSW. The IBBS surveys among truckers (considered as proxy of clients of sex workers in Nepal) observed in 2003 and 2006 as 1% and 1.8% respectively while the similar survey among truckers conducted in 2009 found no HIV infection.

Despite the consistent trend of low prevalence of HIV among FSWs for the last decade or so, STI prevalence among FSWs has varied considerably over the last decade. While prevalence of Active Syphilis among FSWs of Terai districts has decreased from 9.0% in 2003 to 0.3% in 2012, prevalence of Gonorrhoea among the same population soared from 1.5% in 2009 to 4.5% in 2012.



**Figure 5: Changed Level of HIV Prevalence among Key Populations in Nepal**

**People Who Inject Drugs (PWID)**

The Central Bureau of Statics (CBS) estimated that there were around 52,000 people who inject drugs in Nepal in 2013 which is much higher than the previous size of 32,563 estimated in 2011 (CBS 2069, HSCB 2011). In 2011, HIV prevalence among PWID was recorded at 6.3% in Kathmandu and 4.6% in Pokhara (IBBS, 2011) representing a significant and consistent decline from 68% in 2002 in the Kathmandu valley and 22% in Pokhara in 2003 (IBBS, 2011; IBBS, 2003). Similar declines among PWID have also been reported in Eastern Highway districts as well as Western Highway districts. HIV prevalence among PWID in Eastern Highway districts dropped from 35% in 2002 to 8% in 2009 and remained around 8% since then (8% in 2012). Similarly, HIV prevalence in Western

Highway districts declined from 8% in 2009 to 5% in 2012. An estimated 4,453 of the PWID are female (NCASC, 2013). HIV prevalence among female who inject drugs was reported at 4% in a UNODC study (UNODC, 2011), and 15.% of them were also found to be infected with Hepatitis C. IBBS 2012 revealed that prevalence of Active Syphilis is below 2% among PWID in Eastern High districts as well as Western Highway Districts.

One specific concern of increased risks among female who inject in drugs is the sub population who are also involved in sex work. Data among female injecting drugs users who are also involved in sex work in Nepal is limited.

### **Men who have Sex with Men**

Men who have sex with men in Nepal are comprised of several sub-populations of male sex workers (population size estimated between 10,450-12,300), transgendered people and transgender sex workers (population ranging between 6,606-9,220) and clients of Transgender Sex worker (TGSW), Male Sex workers (MSW) (population estimated to be 46,000 - 56,000) and Men Who Have Sex with Men (MSM) at lower risk with the population size estimated at 142,145 (HSCB/NCASC, 2011). Overall HIV prevalence among MSM is 3.8% but is as high as 8.7% among Male Sex workers (MSW) (IBBS, 2012) in Kathmandu Valley.

### **Labour Migrant and mobile populations**

Male labour migrants (particularly going to India), account for about 16% of HIV infections among 15-49 years in Nepal (Figure 4) NCASC, 2013). Work-related migration is higher from the Western, Mid-Western and Far Western Hill regions than anywhere else in Nepal (UNAIDS, 2011, with 42% and 39% migrants of Far Western going to Delhi to Maharastra (UNAIDS, 2011) respectively. Similarly, 43% of migrants from Western and Mid-Western regions go to Maharastra for their work (UNAIDS, 2011). Mumbai of Maharastra and Delhi are categorized as high risk destinations due to the higher HIV prevalence among sex workers compared to other parts of India (UNAIDS, 2011). HIV prevalence among male labour migrants shows considerable variation by district (UNAIDS, 2011). Among labor migrants in the Mid and Far West Regions surveyed in the 2012 IBBS, overall HIV prevalence was 1.4% (IBBS, 2012), compared to 0.8% in 2008 and 2.8% in 2006.

### **III. NATIONAL RESPONSE TO THE AIDS EPIDEMIC**

#### **A. Policy and structural response**

The national response to HIV is built primarily upon the plinth of the National Policy on HIV and STI, 2011. Several other policies with their enactments precede the reporting cycle of this report; notably the National Policy on HIV in the Workplace (2007) and National Drug Control Policy (2006) has reinforced the National HIV response working in tandem with that National Strategy Plan 2011-2016. National AIDS Policy on HIV and STI, 2011 has explicitly outlined the coordinating roles for National AIDS Council. Though the policy has foreseen advisory and monitoring roles for HIV and STI Control Board, it no longer convenes. The NCASC has functioned as the coordinating department to support the implementation, monitoring and oversight of HIV/STI activities for the overall activities under the MoHP. At districts level, District AIDS Coordination Committees (DACC) are the coordinating mechanisms for generating local response to HIV.

Pursuant to the National Strategy Plan, this reporting cycle has seen a couple of milestone activities that helped ensure the national HIV response is abreast with the latest scientific advancements as well as fine tuned to the latest dynamics of HIV in the country. These milestones are: (a) Nepal HIV Investment Plan, 2014-2016 and (b) the Midterm Review of Implementation toward achieving objectives of National HIV/AIDS Strategy, 2011-2016.

#### **Nepal HIV Investment Plan 2014 -2016**

Built on the principles of UNAIDS' Investment Framework, National Strategy Plan 2011-2016 and comprehensive national review (2013) recommendations, the Nepal HIV Investment Plan, 2014-2016 serves as a compelling case for strategic investments in Nepal's response to HIV. With the inclusion of a three year operational plan and budget, NHIP will guide the implementation of National Strategy, 2011-2016 for the period of 2014-2016. This NHIP aims to ensure that the resources are concurrent with Nepal's HIV program objectives and goals, and contribute to the effectiveness and efficiency of the entire national HIV response towards reaching three Zeros: Zero new HIV infections, Zero Discrimination and Zero AIDS-related deaths.

With the guiding principles of shared government and community leadership in a true public-private partnership, evidence-informed policies, and outcome and impact-driven public health approaches, the NHIP 2014-2016 is structured around the rapid scale-up of HIV testing and Antiretroviral Treatment (ART). The plan introduces Nepal's 'test, treat and retain' paradigm and focuses on the Prevention of Mother to Child Transmission (PMTCT) of HIV, aiming to ensure that no child is born with HIV in Nepal and that mothers are kept alive and well. In alignment with UNAIDS' 'Treatment 2015' (UNAIDS, 2012) and the June 2013 WHO HIV treatment guidelines (with Update in March 2014) (WHO, 2013), this plan envisages Antiretroviral Treatment for all population groups that have been identified in Nepal as being key population, regardless of CD4 count, and for these persons to remain on treatment. Premised upon on a carefully crafted health economics model, this NHIP embraces innovation, such as the roll-out of the 'Community Test and Treat Competence (CTTC)' model as the driving force for community-led HIV testing and treatment.

The NHIP emphasizes that TG SW; FSW who inject drugs on a regular basis; street-based FSW; and MSW are the topmost priority for investing in basic programme activities and critical enablers to achieve HIV prevention within the most affected of these key populations in Nepal. NHIP, 2014-2016



disaggregates these harder-to-reach sub-groups, currently underserved, from the larger FSW and MSM populations to ensure that they are covered by HIV interventions. Other high priority groups of NHIP are migrant and mobile populations and their families, particularly in the Far West and Mid-West of the country; female sex workers and females who inject drugs whose partners are males who inject drugs, and gay men and other men who have sex with men (MSM).

## B. Prevention, treatment, care and support

### HIV Prevention

Improving coverage along with behavioral change remains the priority focus of HIV prevention among key populations in Nepal. The country has achieved relatively high programme coverage among FSW and MSW whereas improving coverage particularly among migrants (8.3%) remains a huge challenge given that the size of the migrants are quite large in numbers (estimated about half a million visiting high HIV burden districts of India).

Information, commodities and services in the form of a package are entailments of targeted interventions tailored differentially to the preventive needs of populations at higher risk of being infected; namely people who inject drugs, men who have sex with men, transgender people, female, male and transgender sex workers and male labour migrants (particularly those going to certain destinations in India). Besides, the targeted interventions also include prison inmates and uniformed forces.

The last three national strategy plans, have been linearly continuous in the implementation of targeted interventions. As a result, the declining trajectories of HIV prevalence and incidence among adult populations over the period of last ten years stands out as cogent evidence of effective and sustained targeted interventions. This has kept the country on track to achieve the goals set by the National HIV Strategy 2011-2016 of reducing new HIV infections by 50% and reducing HIV-related deaths by 25% by 2016, compared to the 2010 baseline.

**Table 2: Key Populations Reached with Targeted Prevention Interventions**

Key populations	2006	2007	2008	2009	2011	2012
FSW (KTM)	38.6%		40.8%		60%	
MSW (KTM)		55.6%		93.3%		79.3 %
MSM (KTM)		46.8%		77.3%		64.0%
Migrants (Far & Mid-West)	13.9%		6.96%			8.3%

Source: IBBS surveys: 2006-2012

A series of IBBSs conducted over the years revealed variations of service coverage among FSW. The coverage has been increasing in Kathmandu. The 2011 IBBS indicated that 60% of FSW in Kathmandu were reached by HIV prevention services in 2011, compared to 40% in 2008. However, IBBS conducted in 2012 among FSWs in 22 Highway districts revealed that exposure to HIV program like participation in awareness programs, visits to HTC and visits to STI clinics has decreased in 2012 in comparison to 2009. Services coverage of other populations at higher risks; notably MSM/TG with HIV prevention programs has also been well maintained, achieving 79.3% coverage for male sex workers and 64% for men who have sex with men in 2012. Program coverage among migrants is

remarkably low as a 2011 report on Migration and HIV-related Risk and Vulnerability among migrants from Nepal disclosed that only 14% of all migrants in the country were covered by HIV programs, with coverage of migrants in the West and Far West being particularly limited to 5.6% and 8.3% respectively. Service coverage among PWID in Kathmandu Valley, as per NCASC's programmatic data for 2012, is around 35.5%.

Besides coverage, safer sex practices have improved among key populations. Consistent condom use by female sex workers increased from 75% in 2008 to 83% in 2011 in Kathmandu, while condom use among MSM was reported at 86.3% in 2012. Safe injecting practices are at a similarly high level, with 95.3% of people who inject drugs in the Kathmandu valley reporting the use of sterile injecting equipment in 2011 compared to 85% in 2007.

Global Fund, USAID and Pool fund through Sector Wide Approach are providing a large part of financial support to the prevention programme with activities being implemented by NGOs and community based organizations (CBOs). These implementing NGOs and CBOs are reaching out to FSWs and their clients, Migrants and their spouses, MSM and TG population; and PWID with the package of Behavior Change Communication (BCC) initiatives. Apart from these populations, prison inmates of eight districts were also targeted with BBC initiatives. The package of behavior change communication initiatives for these populations includes provision of condoms, services like HIV testing and counseling as well as treatment of Sexually Transmitted Infections (STIs). Further in this context, PWID were reached out with harm reduction programs entailing needle/ syringe exchange program and Opioid Substitution Therapy (OST). Methadone Maintenance Treatment (MMT) Program and Buprenorphine Maintenance Treatment Program (BMT) are the entailments of Opioid substitution Therapy. The Table 3 illustrates BCC activities provided to key populations.

**Table 3: Key Populations Reached out with BCC Activities (16 July 2012-15 July 2013)**

Indicators	Female sex workers	Clients of FSW	Prison Inmates	Migrants and their spouses	MSM and TG	People who inject drugs
Reached through BCC	28,686	69,631	1,610	309,954	44, 496	11,832
Condoms distributed	2,813,118	1,502,802	NA	1,215,896	2, 012,381	535,824
Tested and counseled for HIV	7,720	10,553	1,247	60,929	9,810	4,561
STIs diagnosed and treated	7,769	729	251	40,701	8,348	1,111
Needle/Syringe exchanged/ Provided	NA	NA	NA	NA	NA	2,033,101
On Methadone	NA	NA	NA	NA	NA	421
On Buprenorphine	NA	NA	NA	NA	NA	550

Source: NCASC, 2013: Programme Monitoring Data

#### **HIV Testing and Counselling Coverage**

Programmatic data from NCASC shows that a total of 139,566 people were tested and counseled in 2013, of them 99% received their test results. The total number of people tested and counseled annually for each year has been increasing from last five years.

**Table 4: Key Populations Reached with Targeted Prevention Interventions**

Indicators	2008	2009	2010	2011	2012	2013
Pre-test counseled	65,167	71,377	115,013	101,063	126,511	146,706
Tested for HIV	53,309	62,672	106,325	95,501	120,450	139,566
HIV positive	2,387	2,110	2,015	2,060	2,433	2,426
Post-test counseled	51,845	61,170	104,666	94,190	118,570	137,928

Source: NCASC, 2014. Routine HIV Testing and Counseling Data: 2008-2013.

Table 5 illustrates the HIV testing and counseling coverage captured by IBBS conducted over the years and shows low HIV testing and counseling coverage among key populations. The problem of low coverage is most prominent for the returning labor migrants among all key populations. This is true, despite the fact that there are more than 239 HIV Testing Centers operating in different parts of the country and the total number of clients who received HIV testing and counseling in a year has been continuously increasing over the years. Key populations tested for HIV and who knows their test results in the last 12 months.

**Table 5: Key Populations Tested for HIV and Know their Test Results in the Last 12 Months**

Key populations	2006	2007	2008	2009	2011	2012
FSW (Kathmandu)	36.8%		32.4%		54.6%	
FSW (Pokhara)			31.0%		58.8%	
FSW (22 Terai Highway districts)				61.2%		44.3 %
MSW (Kathmandu)		51.8%		65.2%		58.5%
IDUs (Male, Kathmandu)		21%		21.5%	21.0%	
IDUs (Male, Pokhara)				39.9%	31.%	
IDUs (Male, Far-Western Terai)				23.3%		33%
IDUs (Male, Eastern Terai)				33.3%		43.0%
MSM (Kathmandu)		30.0%		42.0%		42.0%
Truckers (Terai Highway districts)	11.1%			13.8%		
Male labour migrants (West, Mid & Far West)	3.2%					
Male labour migrants (West)			3.3%			0.5 %
Male labour migrants (Far-West)			6.7%			0.27%

Source: NCASC: IBBS surveys: 2006-2012

### Prevention of Mother to Child Transmission (PMTCT)

Pursuant to its commitment of reducing 90% of new infections among children by 2016 compared to the baseline value of 2010, Nepal has scaled up PMTCT services in recent years. These services are now offered at 65 sites in 33 districts across the country, compared to 41 sites in 2012 and just 22 sites in 2010 (HLM Review, 2013, NCASC 2013). As a result of this scale up of PMTCT sites, the number of women attending ANC who were tested and received results increased to 142,043 in 2013 from 128,936 in 2012 and 84,284 in 2010. Despite this relative increase in uptake, the coverage for PMTCT remains low. During the entire period of 2013 only 136 pregnant women received ARV prophylaxis - up from 126 in 2012 accounting for 20% PMTCT coverage. Out of the babies born to these 136 pregnant women, 134 infants received ARV prophylaxis. In a similar context, a DNA testing facility has been set up at National Public Health Laboratory in Kathmandu for the purpose of Early Infant Diagnosis (EID) along with the adoption of guideline for EID. Despite this, only 3.1% of babies born to pregnant women with HIV have received a virological test in 2013. There is also provision of collecting blood samples from 5 service sites for EID. This has been complemented by the development of a training package on preparation of Dried Blood Sample (DBS).

### Treatment Care and Support

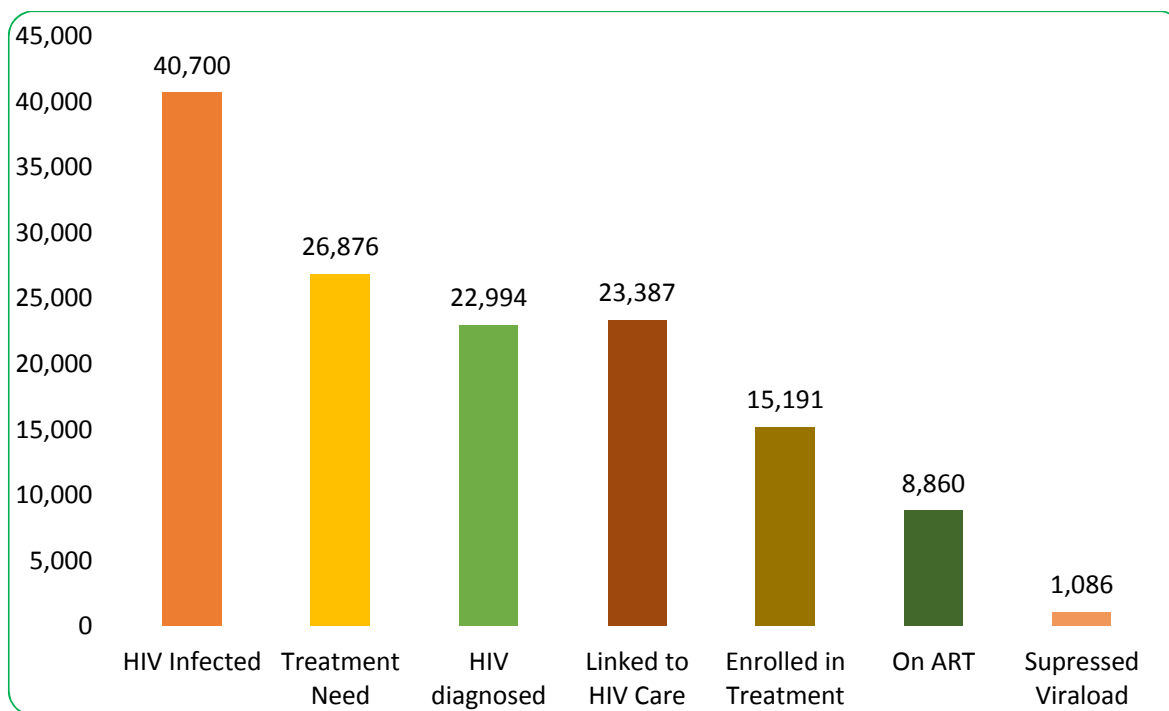


Figure 6: Treatment Cascade in Nepal

With the addition of more than 1,000 people each year for the last five years to the ART program, the total cumulative number of PLHIV currently on ART by the end of December 2013 has increased to 8,866. Out of this total of 8,866 who are on ART, 4,327 are adult male and 3,871 are adult female. There are 30 transgender people and 638 children on ART. Latest data also showed by the end of December 2013, a total of 23,387 people living with HIV have been ever linked to HIV care and a total of 11,704 people have ever been on ART. Out of this total of those who are ever on ART, 1,613

had died, whereas another 1,159 were lost in follow up, 41 were missing and 25 stopped their treatment. As per the results of the viral load tests conducted by National Public Health Laboratory, from 2009 to 2013, a total of 1,529 viral load tests were conducted and 1,086 tests reported viral load below 1000 copies/mm<sup>3</sup> (Figure 6).

Out of the total of 8,866 who are currently on ART, 5,374 adults and 627 children are on first line regimens, while another 2,740 adults and 102 children are on substituted first line regimens. Similarly 115 adult and 8 children are on second line regimens.

Even with the consistent increments of PLHIV in ART enrollment for the last half a decade or so, around 21.8% of eligible adult and children living with HIV are receiving ART which highlights that an alarming gap between the estimated population and a total of 22,994 reported cases that needs to be bridged. The treatment cascade depicted in the Figure 8 explicitly shows the considerable leakage in each step of the cascade that denies the national response from drawing benefits of “treatment as prevention”. Despite all these, Nepal has been able to enroll and provide ART to all those reported cases of PLHIV who are eligible and require ART.

Currently there are 18 CD count machines across 18 different ART sites operating in tandem with one viral load testing machine and one DNA PCR testing machine placed at the National Public Health Laboratory in Kathmandu. Realizing further needs of viral testing machines in different regions of the country, Nepal has envisaged the adding four more viral load testing machines by the end of 2014.

Strong bidirectional referral linkages between Community Care Centers (CCC), Community Home-Based Care (CHBC) program and ART sites to facilitate the quality of ART services, especially in ensuring adherence and follow up of PLHIV on ART and HIV-positive mothers and infected and exposed babies, have played important roles in enhancing ART coverage as well as in supporting retention and adherence to ART.

### **TB-HIV co-infection**

The sentinel site survey conducted in 2011/2012 showed 2.4% TB patients are living with HIV and 11.5% people living with HIV are co-infected with TB (NTC, 2013). The National Tuberculosis Centre is currently implementing TB/HIV activities in 30 TB high burden districts. While almost all known PLHIV are screened for TB in HIV testing facilities, not all TB patients are currently tested for HIV. The national policy aims to address this situation in its revised version for 2013 calls for HIV Testing of all TB patients (WHO, 2013). Isoniazid prevention therapy (IPT) is being implemented in 5 sites in 3 districts (Kathmandu, Kaski and Kailali). Over 3,000 have been screened for IPT since the project was rolled out in December 2012 (HLM Review, 2013). A total of 665 people living with HIV have been enrolled in IPT (WHO, 2013).

### **Elimination of Gender Inequalities**

One Stop Crisis Centres for victims for Gender Based Violence (GBV) established under the aegis of the National Plan of Action against GBV in selected districts are drawing encouraging responses. The Nepal Demographic and Health Survey (2011) for the first time has included specific questions to measure GBV and data suggests that intimate partner violence in Nepal is 14.4%. The Government has launched a number of programmes that contribute to the empowerment and reduction of vulnerability among marginalized people, including education scholarships for girls, school enrolment programmes and a social security allowance for single women. These programs, along with the direct involvement of NGOs representing populations affected by HIV have contributed

substantially to minimizing gender inequalities and have influenced high level policy and law making. Many civil society groups are actively documenting and advocating against human rights violations, gender inequality and gender-based violence (HLM Review, 2013).

Despite improvements in the legal and policy landscape, gender and social inequalities persist. In 2012 a IBBS survey conducted in 22 Terai Highway District found that more than one-fourth of FSW had been subjected to forced or non-consensual sex and more than one-tenth FSW had been physically assaulted in Terai Highway Districts (IBBS, 2012). Similarly one in seven MSM had been forced to have non-consensual sex and one in five were discriminated against because of their work in Kathmandu (IBBS, 2012).

### **Elimination of Stigma and Discrimination**

Building upon the strategic action of 'reduction of stigma and discrimination' of National HIV/AIDS Strategy 2011-2016; the network of people living with HIV, women living with HIV, Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI), PWID, and FSW are engaged in the response to HIV in an effort to empower these populations to access HIV prevention and treatment services in a conducive environment free of stigma and discrimination. In this context, Information Education and Communication (IEC) materials, responding to Stigma Index conducted in 2011, have also been adjusted in the light of the stigma and discrimination realities in the country (HLM Review, 2013). These apart, enactments of the 2006 Gender Equality Act, and the 2007 Human Trafficking and Transportation (Control) Act have yielded reinforcing impacts in the ushering in of an inclusive environment to guide the national response to HIV. As a result, social acceptance of sexual and gender minorities is gradually improving. Similarly, social acceptance of people living with HIV, PWID and Female who inject drugs is improving. When asked about stigma and discrimination related questions, 60% FSW of 22 Terai districts was found to be willing to take care of HIV positive relatives (IBBS, 2012). Whereas in the majority of the FSW of Kathmandu Valley were willing to take care of any of their HIV positive male relative (92.4%) or a female relative (93.9%) at their home if necessary.

### **Integration of AIDS Response to Health and Development Efforts**

With the continuous emphasis on multi-sectoral involvement in the last three national strategic plans, some tangible outcomes have been achieved, showing a number of measures that have been put in for integrating an AIDS response to health as well as other development efforts.

National guidelines and standard operating procedures produced by the Family Health Division and the NCASC adhere to integrated approaches to sexual and reproductive health (SRH) and HIV services. In this regard, a coordination mechanism has been established to integrate reproductive health services with HIV programs. Efforts are underway to have basic TB and HIV curriculum teach basic HIV- and TB-related information. The National Planning Commission has developed sector-specific guidelines for key ministries for addressing HIV from their sectors.

The NCASC is in the process of transferring its procurement and supply chain management functions to the Logistics Management Division (LMD) under the Ministry of Health and Population. A capacity building plan for the transition is being implemented at present. A planned, phased transition of NCASC's procurement function to LMD is underway with the support from USAID's Health for Life project. The integration of HIV recording and reporting into the national Health Management Information System (HMIS) is currently taking place with the inclusion of number of HIV indicators related to HTC, STI, PMTCT, ART, TB-HIV, OST and needle syringe exchange programme.

The National Public Health Laboratory (NPHL) is leading capacity building activities for public and NGO-run HIV testing laboratories and the management of viral load and CD4 testing, including participation in the external quality assurance scheme (EQAS).

The HIV programme is included in Joint Annual Reviews of the health sector which sets out harmonized procedures for performance reviews, financial management and coordinating planning, monitoring and review exercises.

Apart from the health sector, there are also notable improvements on the integration of HIV into other development efforts. HIV has been incorporated in the approach paper for the Thirteen National Periodic Plan. The National Planning Commission has developed sector-specific guidelines for key ministries for addressing HIV from their sectors. Ministry of Education has been incorporating the HIV into school level curriculum since 2002. Ministry of Labour and Employment has included a session on HIV in the pre-departure training for formal labor migrants travelling abroad. Ministry of Home Affairs is currently reviewing that National Drug Control Policy, which provides overarching oversight also to drug use as it pertains to HIV. In the same way, Ministry of Women, Children and Social Welfare has incorporated HIV related contents in its various training manuals. In addition to that, it has also included HIV related treatment and care in the guidelines for National Minimum Standard of Care and Protection for Women affected by Human Trafficking. A number of District Development Committees have been allocating resources for the issue of HIV including for maintenance of human resources of DACC for many years. Many Village Development Committees particularly of Far West and Mid-West have also contributed their resources for the wellness of families affected by HIV.

### **C. Support for Creating an Enabling Environment**

#### **Administration of National Commitment and Policy Instruments (NCPI)**

During the preparation of this National AIDS Response Progress Report, two separate consultative workshops: one with government representatives and other with representatives of civil societies; were conducted for the administration of NCPI. Apart from consultative workshops, group discussions and key informants interview were also conducted especially with government representatives.

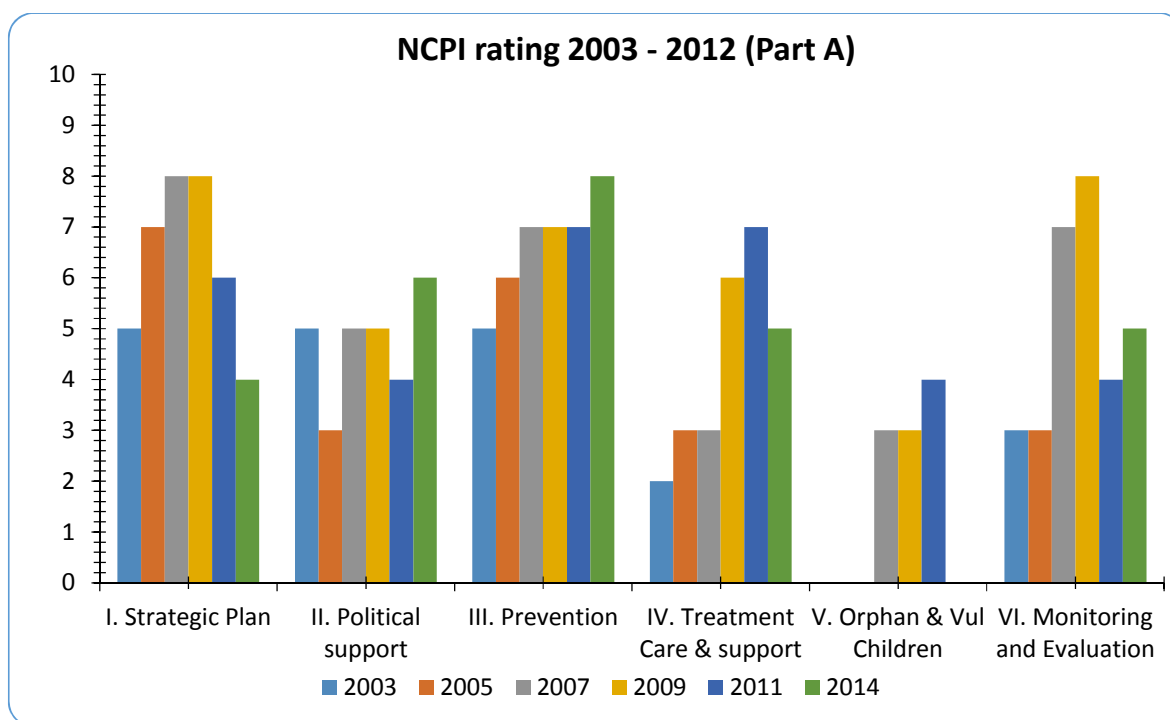
The National HIV/AIDS Strategy 2011-2016 is the fourth in line. Based on the strategy, Nepal also prepared NHIP 2014-2016 with the inclusion of three years implementation plan and budget in it. National response to HIV has been garnering political support with the involvement of the highest-level political leaders in different forums and events. In fact, the national response to HIV has been consistently receiving political support over the years despite changes in the government. There are a number of structural provisions such as National AIDS Council and Country Coordinating Mechanism (CCM) that ensure meaningful participation of civil societies in coordinating and providing oversight to the national response. This aside, civil societies have played pivotal roles in implementation of targeted interventions. All these make civil societies participation in the response well established. Similarly the issue of human rights has become one of important factors in combating HIV. Civil societies, media, activists are passionately vigilant in monitoring human right situation in the country. Prevention programs have been proven successful in slowing down the transmission of epidemic in Nepal. The treatment, care and support program the provision of ARV along from 44 sites. The participants from government agencies and civil societies were found to

have cognizance of all these facts during the rating exercise for National Commitment and Policy Instrument.

An analysis of the trend of National Commitment and Policy Instrument (NCP) shows that findings over the course of five reports from 2003 to 2014 yielded a mixed result.

**Overall rating Part A (A Part of NCPI Administered to Government Officials)**

Overall rating of Part A shows three areas namely: Political Support, Prevention and Monitoring and Evaluation have seen improvement in 2013 when compared to 2011. In contrast, the same comparison also shows that there is a decline in Strategic Planning, and Treatment Care and Support. Moreover, the area of Orphan and Vulnerable Children (OVC) has done miserably as it has failed to score a single point in 2013. Despite the lively implementation of the National HIV Strategy Plan 2011- 2016, the mid-term review of 2013 that tracked the progress in implementation toward achieving the objective of NSP 2011- 2016, and National HIV Investment Plan that was built upon NSP 2011- 2016, NCPI rating of Strategic Planning, surprisingly, has been in a declining trend since 2009. Proven targeted prevention interventions that have successfully brought down prevalence rates and new infections in the recent years is a reason behind a marked improved scoring for prevention in 2013. This reporting period did not see any notable development for OVC, in particular for CABA. This may be one reason for the bad rating for OVC in 2013.



**Figure 7: NCPI Rating 2003-2014 (Part A: Administered to Government Officials)**

**Overall Rating Part B (A Part of NCPI Administered to Civil Society’s Representatives)**

The rating for two areas: (1) Prevention, and (2) Enforcement of law and policies remained the same for 2013 and 2011 in Part B with maintaining a steady plateau. Policy, law and regulation is an area that has shown improvement in 2013 when compared to 2011. Rating for civil society participation in Part B is in a declining trend since 2009. Treatment care and support is at a decline in 2013 when compared to 2011. The NCPI rating for civil society participation in the national response is always



low in 2013 after maintaining a plateau for the three last reports i.e. 2007, 2009 and 2011. Worryingly, the ratings for treatment care and support in both Part A and Part B have decreased in 2013 when compared with 2011.

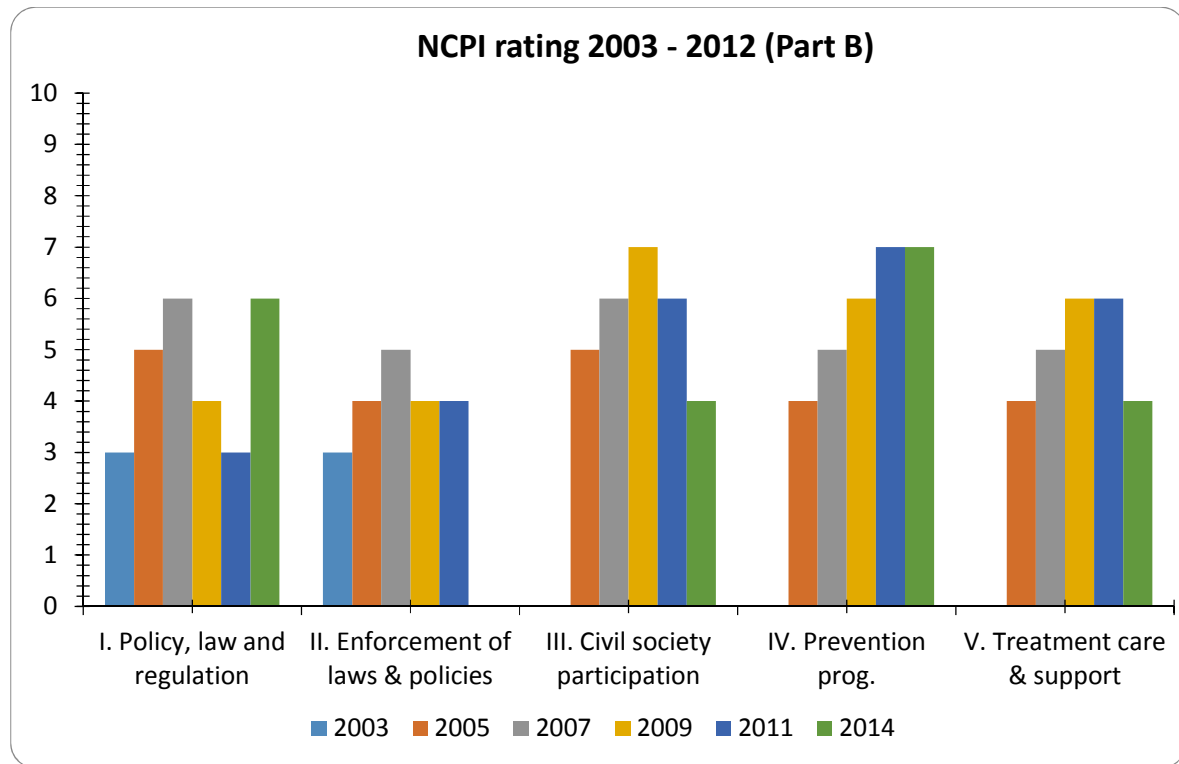


Figure 8: NCPI Rating 2003-2014 (Part A: Administered to Civil Society’s Representatives)

#### D. National programme and achievements

##### The Midterm Review of Implementation towards Achieving of Objectives of National Strategy

An independent comprehensive mid-term review conducted in the middle of 2013, with the intent of tracking the progress in implementation toward achieving the objective of NSP 2011- 2016 revealed that Nepal is on track to achieve two of overarching three NSP’s goals set out to be achieved by 2016 against their baseline values of 2010. These two are (1) reducing new HIV infections by 50%, and (2) reducing AIDS-related deaths by 25%. The midterm review opined that the goal of reducing new infections among children by 90% is more challenging to reach.

The midterm review 2013 found that programme interventions are well aligned with the national strategy and that targeting, implementation approaches, and resource allocations are focused and effective in responding to Nepal’s epidemic. Further, programs are often implemented by the communities themselves and as a result, the accessibility and acceptability of services has increased.

Keeping these findings apart, the review came up with a list of useful recommendations aimed at keeping the national response abreast with the latest medical and other scientific advances. Notable recommendations are:

- Adopting recommendations of World Health Organization (WHO) ARV treatment consolidated guidelines 2013 and initiating ART at CD4 level of 500 and below;
- Moving to 'Test, Treat and Retain Strategy' in a more cost-effective approach;
- Immediately moving towards Option B+ for vertical elimination of HIV transmission;
- Providing HIV testing and counseling all Directly Observed Treatment Short Course (DOTS) center and microscopy centres;
- Establishing a regular and transparent mechanism that collects, analyses and disseminates financial flow in the country as pertains to HIV; and
- Building national response to HIV on the basis of investment cases.

Nepal also conducted a midterm review of High Level Meeting (HLM) Targets as a part of the midterm comprehensive review of Implementation toward achieving the objectives of National Strategy. Apart from feeding into the comprehensive national review, the midterm review of HLM targets highlighted Nepal's progress toward the 10 High Level Meeting (HLM) Targets set United Nations General Assembly Political Declaration on HIV.

#### **Other Notable Milestones**

Some other progress has been observed with respect to the national commitment and the strengthening of the national response during this reporting period. The major achievements during this period are as follows:

- The operational guidelines for the District AIDS Coordination Committee (DACC) have been updated and enforced for implementation with the intent of generating a strong effective and coordinated local response to HIV.
- Similarly the preparation of consolidated national treatment guideline is underway under the aegis of NCASC encapsulating the country's decisions to adopt the recommendations of consolidated WHO HIV Treatment Guidelines (2013).
- All the preparations for the implementation for CABA targeted cash transfer program have been finished ensuring the program will be started in 2014.

## IV. BEST PRACTICES

### A. A Multi-prong Approach to Integration of Family Planning and HIV Services

United States Agency for International Development (USAID)-funded Saath-Saath Project (SSP) (October 2011-September 2016), in partnership with Government of Nepal, provides integrated Family Planning (FP) and HIV prevention to care, support and treatment services for key population - female sex workers (FSWs) and their clients, migrants and their spouses and people living with HIV (PLHIV) through its outreach activities and expanded integrated health services in 33 districts of Nepal.

Under SSP, a key approach has been the integration of FP services into existing HIV services for key population. To streamline and coordinate the overall FP/HIV integration in Nepal, SSP supported the formation of the FP and HIV Integration Technical Advisory Group which brings together the expertise of government and civil society actors. The current integration has focused on strengthening FP/HIV integration through strengthening of both existing NGO and government outreach and service delivery sites. SSP has successfully rolled out the integration of FP and HIV services in outreach activities and expanded integrated health services (EIHS) run by SSP supported implementing agencies. Currently the project is providing integrated HIV and FP counseling, services and referral through 53 EIHS sites in 26 districts. Similarly, SSP rolled out community-based FP information and referrals by mobilizing Female Community Health Volunteers (FCHV) from its four migrant project districts of Nepal. In addition, SSP supported to develop FP/HIV/STI integrated counseling toolkit for use by service providers to effectively provide FP information, counseling and services. SSP has been providing on-site orientation on FP/HIV integration including FP/HIV/STI integrated counseling toolkit to service providers at government health facilities in collaboration with Family Health Division (FHD) and National Center for AIDS and STD Control (NCASC). Such orientations are assisting health facilities to develop action plans to strengthening FP/HIV integration at the facility.

Additionally, SSP initiated operation of satellite clinics from government health facilities in four districts of Nepal since January 2013 in collaboration with District Public Health Offices and NCASC. This initiative derives further impetus as SSP envisions piloting a demonstrable model of HIV/FP integration. Furthermore these sites can easily be replicated and sustained as the initiative would be owned by the government.

SSP also developed FP/HIV integrated Strategic Behavioral Communication (SBC) materials in coordination with the National Health Education Information and Communication Center (NHEICC) to support this integration approach. Likewise to promote FP methods and tackle local myths on FP, the project organizes a community discussion forum called “*Saath-Saath ko Chautari*” in all project districts. These *Chautari* share on FP method use experiences by a peer champion (a representative from key population currently using dual protection method) and discuss over existing FP method-related misconceptions. The number beneficiaries using FP method are in increasing trend after the event. Thus the efforts of SSP has given meaningful drive to a national integration effort for FP and HIV services that can greatly increase access and utilization of both HIV and FP services and pave way for a future of integrated health services from single service site.

Between August 2012 and January 2014, the project’s outreach activities reached 196,678 individuals from key populations (FSWs and their clients, migrants and their spouses) and PLHIV with FP and HIV messages. A total of 33,091 individuals were screened for FP services and 41% (13,683) among them received FP counseling services at SSP EIHS sites. A total of 1,317 people received non-

condom FP methods (536 oral contraceptive pills, 557 Depo (injectable), 186 implants and 38 IUCD). In the same time period, 7.4 million condoms were also distributed through outreach and EHS sites.

### **B. Early Infant Diagnosis (EID) Service in Nepal**

Early Infant Diagnosis (EID) uses DNA Polymerase Chain Reaction (PCR) testing for early detection of HIV in children 1.5 to 18 months of age. The EID service was first initiated in Nepal in 2009 at selected HIV clinics under United States Agency for International Development (USAID)-funded ASHA Project for early detection of HIV among HIV-exposed babies.

Currently, the USAID-funded Saath-Saath Project (SSP) is providing EID service from two government and three NGO sites in the country: Achham District Hospital, Achham; Seti Zonal Hospital, Kailai; Nepal National Social Welfare Association (NNSWA), Kanchanpur; Nepal STD and AIDS Research Center (NSARC), Banke and STD AIDS Counseling and Training Service (SACTS), Kathmandu. Trained laboratory technicians with practical training are supporting the programme through collecting blood samples from babies using Dried Blood Spot (DBS) paper. The collected samples are currently sent out to Bangkok, Thailand in absence of such testing in Nepal. However efforts are made to ensure the test results are provided within two weeks. Based on the test results, second confirmatory PCR test is also conducted. Also all babies diagnosed with HIV are enrolled onto ART and linked to HIV related care support and treatment services including community and home based care to ensure drug adherence and wellbeing of the baby. Information on EID services are provided through ongoing SSP outreach activities and from its clinical sites.

From January 2009 to January 2014, a total of 289 PCR samples were collected; out of which 35 were found to be HIV DNA PCR positive. Among the total positives, 25 babies have been enrolled on and continued ART while three have been lost to follow-up. There has been no death reported among those enrolled on ART. In 2013 only, total 76 babies were enrolled for EID from the sites in the EID implemented districts, which is 10 % of the total expected national births of HIV exposed children for the year.

This initiative with the limited area of coverage is able to save the lives of the HIV positive babies through the timely initiation of ART. Based on the experience of SSP, National Center for AIDS and STD Control (NCASC) has developed National Guidelines for Early Infant Diagnosis. National Public Health Laboratory (NPHL) has initiated the process of EID in Nepal with in country DNA PCR testing. The experience of SSP has formed a base for National EID program in the country.

### **C. Moving towards HIV Drug Resistance Monitoring in Nepal: Monitoring Early Warning Indicators**

Nepal has initiated its Anti-Retroviral Therapy (ART) programme in 2004 enrolling nearly 100 patients, receiving treatment from 2 centers. Over the years the programme has evolved and currently more than 8,500 people are on ART, receiving the treatment from 44 centers. Emergence and transmission of HIV drug resistance (HIVDR) is an unavoidable consequence of ART, even when appropriate drugs are prescribed and adherence is maximally supported. Early warning indicators (EWI) of HIVDR are a key component of the public health strategy to minimize and assess HIVDR in countries scaling up antiretroviral therapy. EWIs are quality of care indicators which specifically assess factors at individual antiretroviral therapy clinics associated with emergence of HIVDR. Where widely implemented, EWIs provide the necessary programmatic context to interpret results of surveys of transmitted and acquired HIVDR.

After a decade of implementing ART programme in Nepal, MOHP, National Center for AIDS and STD Control (NCASC) has embarked on monitoring HIVDR with the technical support from WHO. Pilot survey of EWI monitoring was conducted in 3 sites during November – December 2013. These sites were selected based on the patient population size and accessibility. ART clinic attendees at these sites had different HIV exposure categories and sex distribution, economic status and barriers to access services such as cost or distance travelled to obtain care. Majority of the patients attending these sites have already completed more than 24 months of receiving ART from these sites, which is also an advantage whereas HIVDR is concern. Sites selected are

- ART Clinic at Sukraraj Infectious & Tropical Disease Hospital, Teku (STDH) - one of the first sites where ART was initiated in 2004.
- ART Clinic at Tribhuvan University Teaching Hospital, Maharajgunj (TUTH) - this clinic situated in a specialized tertiary care hospital with an affiliation to the 1st medical academy in Nepal.
- ART Clinic at Bir Hospital, Kathmandu (BH) - government tertiary care health facility.

It was decided to monitor EWIs 1-4 – on-time pill pick up, retention in care, pharmacy stock out and dispensing practices. EWI-5 – Virological Suppression could not be monitored as there is no standard way of conducting viral load testing and recording of it yet at ART centers, data was collected for the period 16th July 2011 to 15th July 2012. Data abstractors were trained based on the guide prepared for data abstractors, and ART counselors were trained as data abstractors.

- EWI 1: On time pill pick up- Results of the pilot survey show that during the data collection period all the 3 ART clinics did not obtain desired results for on-time pill pick up for both adults and paediatric patients. The 3 sites selected are unique in their nature and expected to perform better – they are situated in Kathmandu, in the capital where all the resources are available comparing with the clinics situated at district level, two of the clinics are considered as teaching hospital clinics affiliated to academic institutions. Therefore the National Programme with the support of the clinicians, PLHIV networks and other NGOs should take immediate measures to improve the on-time pill pick up.

Surprisingly on-time pill pick up for paediatric patients was inferior to adults in all the 3 pilot sites. The consequences of this are definitely not favourable as infants and children have an exceptionally high risk of poor outcomes from HIV infection unless the treatment was not started early and continued appropriately. It is very important to further investigate it and carry out corrective measures.

- EWI 2: Outcome of this indicator for 2 sites out 3 was satisfactory. All the clinics should take further measures to improve retention in care of both the categories of patients – adults as well as paediatric cases.
- EWI 3: Pharmacy stock-out - all the 3 pilot sites did not report pharmacy stock-out for any ARVs both adult and paediatric.
- EWI 4: Dispensing practices - All the pilot sites had never dispensed mono or dual therapy during the data collection period.
- Results of EWI 3 & 4 are commendable and programs should strive to maintain them.

Way forward: During the first half of 2014 it is planned to scale up the monitoring of EWI to another 7 ART sites representing all the regions in Nepal. One of the 7 sites will be the only ART site currently in Nepal managed by a civil society. By 2015 National HIV programme should aim to scale up EWI monitoring to all ART sites in Nepal.

## **V. MAJOR CHALLENGES AND REMEDIAL ACTIONS**

### **Improving Architecture for Coordination, Governance and Management**

National Review 2013, noted that a lack of clarity in the national governance and coordination framework for HIV/AIDS in Nepal has led to the NCASC being overburdened, which has adversely impacted its capacity for coordination, oversight and accountability. With both the National AIDS Council and the HIV and STD Control Board (HSCB) currently inactive, the NCASC's current responsibilities go beyond its core mandate of coordination, quality control, policy guidance and leadership in the health sector response to HIV, undermining its ability to perform these roles effectively.

In the absence of the system for regularly collecting and reviewing the financial flows, assessing information on the financing on the response to HIV is difficult in Nepal. This is further aggravated by the relatively long interval between the two National AIDS Spending Assessments (NASA); the last of which was conducted in 2007, the next being underway presently.

Nepal Red Cross Society has been receiving financial support through NCASC from GFATM for ensuring blood safety. Though this financial support has helped ensure safe blood for transfusion, the project based financial support suffers occasional pitfalls such as interrupted and delayed disbursements from NCASC that results in delayed procurement of screening kits. This calls for funding for the vital issue of ensuring safe blood to not be contingent upon a project based source but should rather be on an ongoing budgeted government resource for sustained support.

### **Prevention**

A key challenge for the country will be not only to maintain the current high level of coverage of interventions among the key populations; for illustration, FSW with 85.5% coverage in Kathmandu and MSW with 79.3%. Apart from that, the low programmatic coverage among migrants population highlights the need for an immediate scale up of coverage. Compounding to all these, low HIV testing and counseling coverage among the most of key populations is one of major ailing problems for the effective national response to HIV.

National response, as it relates to prevention, is fraught with the problem of duplication of services; notably; HTC and STI treatment services in selected districts in major cities. This has weakened the response to HIV.

The national response to HIV as it pertains to prevention among migrants and spouses is overwhelmingly confined to the sources of migration largely undermining the risk of migrants at destinations – many of which are epicenters of transmission. Also ignored among migrants are TG/MSM who sell sex in India as targeted interventions for migrants do not cover these groups of population.

The low number of female drug users who are accessing services in Nepal and their marginalization is a cause for concern.

Taking cognizance of the considerable variations of the quality and range of services offered for PWID through civil societies the National Midterm Review highlighted the need to develop a Standard Operating Procedures for a low-threshold Needle and Syringe Programme.

Methadone Maintenance Treatment (MMT) Program i.e., Opioid Substitution Therapy (OST) is fraught with the problem of a large proportion of drop-outs along with low retention rates of its clients in all six service sites of the country. The low retention rates of the client in the program can potentially impede in further expansion of the methadone program across different parts of the country.

Coverage for elimination of Vertical Transmissions is remarkably low; reaching only 20% of the total pregnant women needing PMTCT service in 2013. Along with the sub optimal PMTCT coverage, pediatric ART coverage is also low.

Although, the integration of STI management into a HIV response in the package of targeted interventions for population at higher risks has reduced the spread of HIV as well as enhanced access to STI treatment, it has also inadvertently resulted in downfall of response to remaining STIs. This has a detrimental impact on other national commitments, notably elimination of congenital syphilis.

### **Treatment, Care and Support**

Inadequate coverage of HIV counseling and testing has meant that ART coverage is still meeting only a fraction of the estimated need. Moreover, the relatively slow pace of detection of HIV imposes challenges in minimizing the gap between the estimated and identified cases, despite an increase in HTC sites.

Although HTC coverage for key populations has increased, primarily through NGOs and community organizations, there are still important gaps in the provision of health system-based testing facilities for migrant workers, PWID, MSM and FSW (National Review, 2013). This is in contrast to WHO consolidated guidelines 2013, which recommend that key population's community based HTC should be provided alongside provider initiated HTC in health settings.

With the current low ART coverage, Nepal is not leveraging the benefits of 'treatment as prevention' especially for population at higher risk.

There has been a robust expansion of ART services up to 44 sites within a decade. Laboratory facilities that complement ART services have not been scaled up in parallel with the expansion of ART sites. Important ART monitoring tests (CD4 testing, liver function tests (LFT) and renal function tests (Creatinine) are carried out only at teaching hospitals and zonal hospitals, putting them out of the reach of many patients from remote districts due to cost, time and distance.

The country so far there is only one viral load machine that is placed at National Public Health Laboratory, Kathmandu. The National Review noted that the limited availability of viral load testing machine - a primary requisite for the diagnosis of treatment failure - adds to the challenge of identifying treatment failure among patients on ARV. There is a plan to procure additional viral load testing machines through external funding covering all five regions.

With TB prevalence of 11.5% among people living with HIV, the national response to HIV is meeting the mounting problem of TB-HIV co-infections. Addressing diagnostic challenges has become one of major issues in the management of TB-HIV co-infections. In this context, ensuring the availability of counseling and testing services for HIV at the same peripheral level facilities that provides TB services also has become critically important for diagnosing HIV among TB patients.

Co-infections of viral hepatitis are becoming a compounding problem for the effective response to HIV. Reportedly high mortalities and morbidities associated with HIV and viral hepatitis co-infections

in the face of lacking diagnostic infrastructures and treatment options have become a looming problem in the management of co-infections, particularly among people who inject drugs.

### **Health System Strengthening**

Unfilled posts and frequent turnover have limited the capacity for scaling up and providing quality HIV services at both national and sub-national levels, with services reportedly unavailable in many public health facilities due to the absence of trained staff (National Review, 2013). However, the Ministry of Health and Population is currently undergoing a comprehensive reform process that encompasses the development of a new health policy, an organizational restructuring and a revision of the human resource policy. The integration of the HIV programme and human resource planning and deployment for HIV-related services will be addressed through this reform process.

### **Addressing Inequalities**

Despite improvements in the legal and policy landscape, gender and social inequalities still persist and are increasing the vulnerability of certain groups to HIV and obstructing their access to services. HLM Review conducted by NCASC in 2013 reported incidences of discrimination by health care providers are regularly reported even where equitable services are available. Sex workers continue to report raids and detention for 'public order offences' (UNDP et al, 2013). They are also at risk subjected to non-consensual sex from employers and clients.



## VI. SUPPORT FROM THE COUNTRY'S DEVELOPMENT PARTNERS

The HIV programme in Nepal depends heavily on external development partners for the resources it requires for combating HIV. The financial resource tracking of investments made to the national response to HIV clearly showed that almost 90% of resources for the national response come from external sources while domestic resources account for 10% every year for the last three years. Admittedly, the domestic resource mentioned here does not take into account contributions from other ministries, such as the Ministry of Education and Sports, the Ministry of Labour, Ministry of Local Development and others local resources generated through District AIDS Coordination Committees (DACC).

**Table 6: Resources Allocation by Sources: 2011/12 - 2013/2014**

Particulars	2011/ 2012	2012/ 2013	2013/2014
Total external resource	21,035,345	20,434,649	22,063,289
Domestic resource	2,261,976	2,249,417	2,500,772
Total resources	23,297,321	22,684,066	24,564,061
Proportion of the government resource to the total resource	9.7%	9.9%	10.1%

Source: NCASC, 2013. NHIP, 2014-2016

The Global Fund, bilateral agencies, namely USAID and GIZ, UN agencies, pool fund partners of NHSP-II (the World Bank, DfID of UK, AusAID, KfW) sector wide approach (SWAp) on HIV/AIDS and INGOs are the external sources that are contributing to the national HIV response. In spite of involvement of a number of external development partners, the national response to HIV has successfully managed to ensure that spending is, for the most part, aligned to the national strategy, owing to good cooperation between government and external development partners.

### **The Global Fund to Fight AIDS, TB and Malaria (GFATM)**

The latest portfolio update from Global Fund showed that Nepal has so far signed USD 60,331,527, dollar with GFATM for the national response to HIV out of which around USD 50,283,885 have been disbursed ([portfolio.theglobalfund.org](http://portfolio.theglobalfund.org)). The Table 7 shows GFATM contribution to the national response through different grants for the period of the 2011/2012 -2013/2014. The support from GFATM revolves around strengthening the capacities of the government and key organizations, including civil organizations, and mobilizing a sectoral response that enhances and contributes to the achievement of Nepal Health Sector Programme (NHSP) II implementation for increased access to prevention and care services for key population at higher risk, migrants and women belonging to the reproductive age group in priority districts. Apart from that, preparation of a new proposal for the submission to GFATM on the basis on new funding mechanism is underway.

**Table 7: The GFATM Contribution to Nepal's Response to HIV/AIDS: 2011/12-2013/14**

GFATM Contribution (in US\$)	2011/ 2012	2012/ 2013	2013/2014
GFATM NEP-H-NCASC	3,073,875	4,279,048	6,058,776
GFATM NEP-H-SCF	4,227,093	4,602,930	5,789,036
GFATM NEP-708-G11-H	1,777,916	1,796,574	656,545
GFATM NEP-708-GO9-H	4,147,552		
GFATM (PSI)	66,875	143,022	
<b>Total contribution from GFATM</b>	<b>13,293,311</b>	<b>10,821,574</b>	<b>12,504,357</b>

Source: Global Fund R10 Phase II Renewal Request

### Bilateral Agencies

USAID's efforts to mitigate the effects of HIV in Nepal started in 1993 through the implementation of the first ever HIV-related project in the country, AIDSCAP I. Since then USAID has invested more than US \$80 million and implemented six consecutive, tailored and evidence-based HIV projects in the country. Building on more than two decades of this successful partnership with the Government of Nepal to support the national HIV response, USAID is currently implementing its five year HIV and FP intervention, 'Saath-Saath Project (SSP)', from October 2011. The project aims to reduce the transmission and impact of HIV/AIDS and improving reproductive health among selected key populations at higher risk. The project works in partnership with the Government of Nepal at both the national and local levels to provide HIV prevention to care, support and treatment services along with FP services to key populations (FSWs and their clients, migrant workers and their spouses and PLHIV) in 33 districts across Nepal. SSP is managed by FHI 360 Nepal with Association of Medical Doctors of Asia as a core partner and more than 40 local NGO partners and national networks implementing the project activities in the districts.

The German Development Cooperation (GIZ) has been providing supporting for National Opioid Substitution Therapy (OST) program particularly for Methadone Maintenance Program in Nepal along with GFATM and Government of Nepal.

### Pool Funders

The Government of Nepal has, since the fiscal year 2011/12, maintained a dual stream of resources to the national HIV response: (a) through its regular funding to NCASC and (b) through the Pool Fund. The Pool Fund, comprising a basket of funds from both government as well as external resources including the World Bank, KfW, AusAID, and DFID, supplements the entire health sector budget in the sector wide approach. This comes as a part of NHSP II, in which the Pooled funding partners i.e. KfW, AusAID, and DFID, have committed USD 19 million for a period of five years for the activities that range from supporting the implementation of targeted intervention programs to strengthening the national surveillance system.

### UN Systems

The UN system has been supporting the HIV response in Nepal in diverse areas notably; preparation of national strategy; size estimation of key affected populations; preparation of guidelines and directives; and expansion of PMTCT services over the period of decades. The main activities it

supports for this reporting period are: preparation of NHIP, Midterm Review, guidelines of HIV drug resistance early warning indicators, composite guidelines on treatment (as it relates to HIV) and elimination of vertical transmission, support to OST program (Buprenorphine) and expansion of service coverage for elimination of vertical transmission. UNAIDS, the secretariat of the joint UN Programme on HIV, works with all stakeholders to coordinate and provide technical support on strategic issues including resource mobilization, review of national response, engagement of civil society and generating strategic information.

### Other Agencies

The Lottery Fund of UK provides financial contribution to Care International for the implementation of Emphasis Project, a cross border intervention for labor migrants. Similarly, Family Planning Association Nepal (FPAN) with its core funding also contributes to the national response to HIV. Save the Children, apart from the resources received from GFATM, contributes to combating HIV in Nepal with its own resources.

**Table 8: Contribution of EDPs (Except the GFATM) to the National Response to HIV/AIDS: 2011/12-2013/14**

External resources (except GFATM) (in US\$)	2011/ 2012	2012/ 2013	2013/2014
Care International	610,663	597,545	369,609
FPAN	236,878	207,448	444,951
GIZ	266,000	798,000	931,000
Pool Fund (EDP portion only)	392,668	470,676	597,386
Save the Children	50,000	180,439	55,000
UNAIDS Secretariat	300,000	95,000	95,000
UNICEF	556,783	569,795	383,000
UNODC	1,053,609	487,515	337,200
USAID	3,923,250	5,946,893	5,970,755
WHO	352,183	259,764	375,031
<b>Total contribution from other external resources</b>	<b>7,742,034</b>	<b>9,613,075</b>	<b>9,558,932</b>

Source: Global Fund R10 Phase II Renewal Request

## VII. MONITORING AND EVALUATION ENVIRONMENT

The National Centre for AIDS and STD Control (NCASC), with its mandate to function as the coordinating department to support the implementation, monitoring and oversight of activities under the MoHP, monitors the relevant activities from the central to peripheral implementing levels and reports relevant national and international committed indicators. The overall monitoring of the national response, which extends beyond the health sector is lacking.

NCASC has set up a vibrant Monitoring and Evaluation (M&E) system that has tracked the HIV epidemic to informed national response to HIV over the years. Along with the Strategic Information (SI) Unit at the NCASC, a system of data collection, management and analysis that covers district, regional and central levels have been put in place. NCASC is leading the planning, monitoring, reviewing and updating of the overall HIV related M&E systems, tools and activities, coordinates various stakeholders and conduct capacity building activities to strengthen strategic information system. With all these systemic set up put in place, progress has been made on the strategic information-related activities envisaged in the National HIV/AIDS Strategy, 2011-2016. Some notable progress that has been made in this reporting cycle are as follows:

### A. Surveillance of HIV and STIs

Nepal has been monitoring HIV/STI epidemic by routinely collecting data from the following sources:

#### Case Reporting of HIV and STI

Routine case reporting of STI and HIV is continued from HIV testing and counseling and PMTCT sites as well as other routine programmatic data. Nepal has been keeping a close watch on the HIV situation among different key populations within the country. This routine reporting of HIV and STI from sites is on monthly basis and analyzed monthly, quarterly and annually.

#### Integrated Biological and Behavioral Surveillance

Nepal has been conducting HIV/STI surveillance particularly among key populations, namely: PWID, FSW, and clients, MSM/TG, and male labor migrants for more than a decade mainly tracking changes in HIV and STI prevalence along with behavioral components such as condom use. In 2012, NCASC conducted Integrated Biological and Behavioral Surveillance (IBBS) surveys among MSM/TG (in Kathmandu Valley), Male Labor Migrants (in Western to Mid and Far Western Regions), FSWs (in 22 Terai Highway districts), and PWID (in Eastern and Western Terai Highway districts). Similarly, NCASC has also completed all preparatory works for another rounds for IBBS due to take place in early 2014 among key populations in different epidemic zones.

#### Monitoring of HIV Drug Resistance

This apart, preparations for setting up a system for monitoring of HIV drug resistance with including monitoring early warning indicators is underway. In this regards guidelines on monitoring for HIV Drug Resistance Early Warning Indicators has been prepared in November 2013.

#### Estimation and Projection HIV Infections

With the refinement of available surveillance data and update, NCASC conducted epidemic analysis and modeling to estimate and project HIV infections annually and share the results with its national and global stakeholders. Based on these annual estimations and projections, Nepal has been contributing to regional and global estimates of epidemic updates through UNAIDS/WHO calendar.

NCASC has regularly produced strategic information factsheets with epidemic update and programmatic achievement annually.

In the same reporting period, over 100 health workers, M&E personnel, district and regional manager, program focal persons from public, private and academic institutions were trained on national systems, key activities, its functions and roles for on HIV and STI surveillance.

## **B. Monitoring and Evaluation (M&E)**

Monitoring is very routine work to check the progress against the planned activities, so the NCASC does on its regular programme through monthly (all programmatic) and bimonthly (DACC and logistics) reports, regular field visits to sites for supportive monitoring, and comprehensive annual review of programs by districts.

A mid-term review of national HIV/AIDS strategy plan 2011-2016 was conducted in the middle of 2013, with the intent of tracking the progress in implementation toward achieving the objectives. The review came up with a number of recommendations to keep national response abreast with latest medical advancements.

Alongside this midterm review, Nepal also conducted the midterm review of High Level Meeting (HLM) Targets that highlighted Nepal's progress toward the 10 High Level Meeting (HLM) Targets set United Nations General Assembly Political Declaration on HIV.

National Centre of AIDS and STD Control (NCASC) has updated National Guidelines on Monitoring and Evaluation of HIV Response in November 2013. The recent update Guidelines on is aligned with the key monitoring and evaluation policies and to the requirements of the government of Nepal.

In the course of mainstreaming HIV recording and reporting into greater Health Information System, the NCASC has made effort to integrate routine recording and reporting of key programs namely HTC, PMTCT, STI, ART, TB-HIV, OST through Health Management Information System (HMIS), and so the related preparation and training have conducted to health workers.

Aiming at the effective monitoring of TB-HIV co-infections, a TB-HIV register has been prepared. TB cases are also being recorded in the register of ART patients as well as the register of patients with opportunity infections (Status Report on TB-HIV in SEARO 2013). Similarly an EID register has been started to maintain the record of pediatric ART cases.

### Data Quality Assessment

Annual Data Quality Assessment (DQA) was conducted annually as a regular M&E activity in the districts. In 2012, DQA was conducted in 19 districts, and it has been planned in 50 districts in 2013. DQA is conducted at the service site level by trained DACC coordinators, HIV focal persons, and regional HIV/AIDS Officers and reports to NCASC.

### Training on Monitoring and Evaluation

Over 150 workers consisting of DACC coordinators, HIV-focal persons, Regional HIV/AIDS Officers, Regional HIV-focal persons and key representatives of non-governmental organizations were trained in the reporting period on National M&E of HIV Response. It focused on M&E systems, frameworks, tools, indicators, recording and reporting tools, data analysis and use, and data quality assessment. Also about more than 150 health workers were trained on specific areas of strategic information such as data analysis and use, data quality assessment and improvements, geographical information

systems (GIS), and monitoring of targeted prevention interventions among key population at higher risk in the reporting period.

#### Financial Monitoring

Nepal has been conducting National AIDS Spending Assessment (NASA) at a regular interval of time. NASA 2014 is in underway under the aegis of NCASC.

### **C. Research**

National HIV response includes research as a tool for generating evidence for improving programmatic performances as well as providing inputs for policy process.

A national HIV research agenda, July 2014- July 2016 has developed and has enlisted 102 research priority areas. The national HIV research agenda has focused on fulfilling the knowledge gap to improve coverage, quality and effectiveness of its interventions. Thus, the priorities are clearly operational, implementation and health system research.

Key research conducted in this reporting period includes a rapid assessment for situation assessment of children affected with AIDS in 9 districts of the country conducted by Save the Children in 2012. Similarly, Saath-Saath Project has conducted baseline study among labor migrants and their spouses in 4 districts during this reporting period.

### **D. Challenges and Remedial Actions**

The midterm review conducted in 2013 highlighted a lack of functional set up to collect information on HIV from other ministries such as Ministry of Labor and Employment, Ministry of Education etc. Strategic Information from these ministries has been neither collected nor fed to the national response.

Absence of Strategic Information Technical Group, which used to provide technical guidance in collection, analysis, reporting and advocacy for use about strategic information has not been in the place in the last one year.

There are significant gaps in data on key populations, including the lack of disaggregated data on the various MSM sub-populations, males and females who inject drugs, and FSW who use drugs.

Strategic information for most of the impact and behavioral data largely relies on IBBS surveys among key populations; however, the survey tools, timing and coverage need to be reviewed in light of cost effectiveness and updated.

The midterm review also calls for immediate action to identify the high-risk migration streams and their spatial locations and volume.

The need for a monitoring tool for drug resistance surveillance was raised from different sections including ART sites. NCASC, with the support from WHO, has prepared a guideline for monitoring HIV drug resistance surveillance in 2013.

The review 2013 made a recommendation of adopting Unique Identification Code for ensuring quality of collected data.

Data quality and timeliness of reporting are the most persisting problem for Monitoring and Evaluation. The capacities of field-level functionaries in M&E need to be developed; this will improve the quality of data collection, thereby enabling better understanding through more rigorous analysis.

## REFERENCES

- AC Neilson/ NCASC (2011a). Integrated Biological and Behavioral Survey among Female Sex Workers, Pokhara Valley, Round-IV 2011, Kathmandu Nepal
- AC Neilson/ NCASC (2011b). Integrated Biological and Behavioral Survey among Female Sex Workers, Kathmandu Valley, Round-IV 2011, Kathmandu Nepal
- AC Neilson/SACT/FHI (2009). Integrated Bio- Behavioral Survey among Female Sex Workers covering 22 Districts of Nepal, Round- III 2009, Kathmandu Nepal
- Central Bureau of Statistics/Ministry of Home Affairs (2013). Survey on Current Hard Drug Users in Nepal 2009, Kathmandu Nepal
- FHI/CREPHA (2005). New ERA/FHI, (2007). Integrated Bio-behavioral Survey (IBBS) among MSM Population in the Kathmandu Valley, Kathmandu Nepal.
- HSCB/NCASC (2011). Mapping & Size Estimation: Most at risk Populations: Volume I, II and III
- MOHP/New ERA/ICF International Inc. (2012). Nepal Demographic and Health Survey 2011. Kathmandu, Nepal: Ministry of Health and Population, New ERA, and ICF International, Calverton, Maryland
- NCASC (2011). National HIV/AIDS Strategy Plan 2011-2016, Kathmandu Nepal
- NCASC (2012a). Integrated Bio-behavioral Survey (IBBS) among Men who have Sex with Men in and Transgender Population in the Kathmandu Valley. Round-IV, Kathmandu Nepal
- NCASC (2012b). Integrated Biological and Behavioral Survey among Female Sex Workers covering 22 Districts of Nepal, Round-V 2012, Kathmandu Nepal
- NCASC (2012c). Integrated Biological and Behavioral Survey among People Who Inject drugs (PWIDs) Eastern Terai Highway Districts of Nepal, Round V, Kathmandu Nepal
- NCASC (2012d). National Guidelines on HIV and STI Surveillance in Nepal, Kathmandu, Nepal, July 2012
- NCASC (2013a). 2013 Mid-Term Review of the 10 Targets and Elimination Commitments: Nepal Country Report, Kathmandu Nepal
- NCASC (2013b). National Country Progress Report 2012, Kathmandu Nepal
- NCASC (2013c). National Estimates of HIV Infections, 2012, Kathmandu Nepal
- NCASC (2013d). National Guidelines on Monitoring and Evaluation of HIV Response in Nepal (updated in November 2013)
- NCASC (2013e). National HIV Research Agenda in Nepal, Kathmandu, Nepal, 2013
- NCASC (2013f). Review of The National Response to HIV in Nepal: May - June 2013, Kathmandu, Nepal
- NCASC (2013g). The Nepal HIV Investment Plan 2014-2016, Kathmandu Nepal
- NCASC (2014). National Estimates of HIV Infections, 2013, Kathmandu, Nepal
- NCASC/Save the Children (2011) Integrated Biological and Behavioral Surveillance Survey among Male Labour Migrants in Mid and Far Western Regions Round-3, 2010

Nepal Central Bureau of Statistics (2012). National Census Report 2011, Kathmandu, Nepal

New ERA/FHI/SACTS (2007). Integrated Bio-behavioral Survey (IBBS) among Male Injecting Drug Users (IDUs) in the Western and the Far-Western Terai

New ERA/FHI (2006). Integrated Biological and Behavioral Survey among Female Sex Workers covering 22 Districts of Nepal, Round- II 2006, Kathmandu Nepal

New ERA/FHI (2007). Integrated Bio-behavioral Survey (IBBS) among Men who have Sex with Men in the Kathmandu Valley, Kathmandu Nepal

New ERA/FHI (2009a). Integrated Bio-behavioral Survey (IBBS) among Men who have Sex with Men in the Kathmandu Valley” Kathmandu Nepal

New ERA/FHI (2009b). Integrated Biological and Behavioral Survey among male Eastern Terai Highway Districts of Nepal, Round IV, Kathmandu Nepal

New ERA/FHI/SACTS (2000). STD and HIV Prevalence among Female Sex Workers and Truckers Highway routes in Terai, Nepal

New ERA/FHI/SACTS (2004). STD and HIV Prevalence among Female Sex Workers and Truckers Highway routes covering 22 districts in Nepal, Kathmandu Nepal

New ERA/FHI/SACTS (2005). Integrated Bio-Behavioral Survey (IBBS) among Male Injecting Drug Users (IDUs) in Western to Far Western Terai, Kathmandu Nepal

New ERA/FHI/SACTS (2006). Integrated Biological and Behavioral Surveillance among Male Labor Migrants in 11 districts of Western Mid and Far Western Region of Nepal; Kathmandu, Nepal

New ERA/FHI/SACTS (2007a). Integrated Bio-Behavioral Survey among IDUs in Pokhara Valley and Eastern Nepal, Kathmandu Nepal

New ERA/FHI/SACTS (2007b). Integrated Bio-Behavioral Survey among IDUs in Kathmandu Valley, Kathmandu Nepal

New ERA/FHI/SACTS (2008a). Integrated Biological and Behavioral Surveillance Survey among Wives of Migrant Laborers in Four Districts of Far-Western Regions of Nepal Round-I, Kathmandu, Nepal

New ERA/FHI/SACTS (2008b). Integrated Biological and Behavioral Surveillance among Male Labor Migrants in 11 districts of Western Mid and Far Western Region of Nepal; Kathmandu, Nepal

UNAIDS (2011). Migration and HIV Related Risk and Vulnerability among Migrants from Nepal, Kathmandu Nepal

UNDP (2013). Sex work and violence in Kathmandu, Nepal: Understanding factors for safety and protection (Draft report 2013)

UNODC/Ministry of Home Affairs (2011). Profile, Drug Use Pattern, Risk Behavior & Selected Bio-Markers of Women Drug Users from Seven Sites in Nepal, Kathmandu Nepal

WHO (2013). Consolidated Guidelines on the use of Antiviral drugs for treating and preventing HIV. Geneva

WHO Regional Office for South East Asia (2013). TB/HIV in the South- East Region: A status Report, New Delhi India



## ANNEXES

### ANNEX 1.1: COUNTRY CONSULTATION/PREPARATION PROCESS FOR REPORT ON MONITORING THE PROGRESS TOWARDS THE IMPLEMENTATION OF THE DECLARATION OF COMMITMENT ON HIV AND AIDS

Date	Activities
2 February 2014	Formation of Advisory Group (AG) and Technical Working Team (TWT) with clear TOR
10 February 2014	First meeting of TWT held
18 February 2014	TWT meeting held for National Estimation
20 February 2014	TWT meeting held for National Estimation
21 February 2014	Advisory Committee meeting held and the roadmap and status of reporting shared
6 March 2014	National Consultation on National Commitments and Policy Instruments held with Government Agencies
7 March 2014	National Consultation on National Commitments and Policy Instruments held with CSOs including multilateral and bilateral organizations held
20 March 2014	TWT meeting held for National Estimation
23 March 2014	Draft narrative report shared with stakeholders for comments and feedbacks
27 March 2014	TWT addressed valid comments and suggestions received from stakeholders
28 March 2014	Data validation workshop held
31 March 2014	Final endorsement of the Nepal Country Progress Report on HIV/AIDS Response, 2014 by Ministry of Health and Population (MoHP)
31 March 2014	Progress Report submitted to UNAIDS Headquarters

## **ANNEX 1.2: TERMS OF REFERENCES (TOR) OF TECHNICAL WORKING TEAM (TWT) AND ADVISORY GROUP (AG)**

### **A brief Terms of Reference (TOR) for Technical Working Team (TWT):**

- Identify the data needs (including sources and collection tools) as required by the indicators to be reported;
- Develop a road map for the completion of country progress report preparation in time;
- Collect and collate data;
- Analyze data, obtain final result values (findings) and complete the data forms;
- Prepare draft results of Nepal Country AIDS Response Progress Reporting 2014;
- Conduct data validation workshop with relevant stakeholders;
- Share the draft report to Advisory Group and other experts for their technical inputs;
- Conduct final dissemination workshop of Nepal Country Progress Report 2014; and
- Submit the final narrative report and indicator data to Director of NCASC

### **Members of Technical Working Team (TWT):**

- |     |  |   |  |
|-----|--|---|--|
| (1) | Mr. Shambhu Kaphle, Sr Public Health Officer, NCASC    | - | Focal Person for GARP Reporting 2014 (Nepal) |
| (2) | Mr. Bir Bahadur Rawal, Statistical Officer, NCASC      | - | Team Member                                  |
| (3) | Mr. Deepak Kumar Karki, Surveillance Officer, NCASC    | - | Team Member                                  |
| (4) | Mr. Mahboob Aminur Rahman, SI Advisor, UCO, Nepal      | - | Team Member                                  |
| (5) | Dr. Supriya Warusavithana, Medical Officer, WHO, Nepal | - | Team Member                                  |
| (6) | Mr. Birendra Pradhan, UNICEF, Country Office, Nepal    | - | Team Member                                  |
| (7) | Mr. Mahesh Shrestha, FHI 360, Nepal                    | - | Team Member                                  |
| (8) | Mr. Komal Badal UNAIDS SI Associate, UCO, Nepal        | - | Team Member                                  |

### **Data support from Strategic information Unit of NCASC:**

- Mr. Biwesh Ojha, Surveillance Associate
- Mr. Upendra Shrestha, Data/MIS Associate
- Mr. Dinesh Bista, M&E Associate
- Mr. Rakesh Panthi, M&E Assistant
- Mr. Suman Shrestha, M&E Assistant

### **A brief Terms of Reference (TOR) for Advisory Group (AG):**

- Provide technical advice to TWT to carry out timely preparation of Nepal Country Progress Report 2014 successfully;
- Specifically, provide technical advice to TWT in terms of identifying the data need, source of data and data collection tools required for indicators as well as to document the limitations of the data available; and
- Provide timely constructive feedback to TWT to finalize the Country Progress Report 2014.

**Member of Advisory Group (AG):**

- (1) Dr. LakhaniLal Shah, Director General, Department of Health Services (DoHS)
- (2) Dr. Padam Bahadur Chand, PPICD, Ministry of Health and Population (MoHP)
- (3) Dr. Dipendra Bahadur Singh, Chief, Monitoring and Evaluation, MoHP
- (4) Dr. Naresh Pratap KC, Director, National Centre for AIDS and STD Control (NCASC)
- (5) Dr. Rajendra Prasad Pant, Director, National Tuberculosis Centre (NTC)
- (6) Dr. Kiran Regmi, Director, Family Health Division (FHD), DoHS
- (7) Dr. Sinendra Raj Upreti, Director, Child Health Division (CHD), DoHS
- (8) Dr. Geeta Shakya, Director, National Public Health Laboratory (NPHL), DoHS
- (9) Dr. Hemant Chandra Ojha, Senior Medical Officer, NCASC
- (10) Senior Officer (Statistician/Demographer), HMIS, Management Division, DoHS
- (11) Senior Officer (Statistician/Demographer), Center Bureau of Statistics (CBS)
- (12) Representative, Institute of Medicine, Tribhuvan University
- (13) Dr. Ruben F. del Prado, UNAIDS Country Coordinator for Nepal and Bhutan
- (14) Ms. Nafisa Binte Shafique, Chief, HIV Unit, UNICEF/Nepal
- (15) Mr. Daniel Sinclair, USAID/Nepal
- (16) Ms. Tara Chetty, Chief of Party, Save the Children/Nepal
- (17) Mr. Satish Raj Pandey, Country Director, FHI 360/Nepal
- (18) President, NAP+N
- (19) President, NFWLHA
- (20) President, FSGMN
- (21) President, Recovering Nepal
- (22) President, Jagriti Mahila Maha Sangh
- (23) President, NANGAN
- (24) President, Prison Foundation
- (25) Representative, Nepal Red Cross Society (NRCS)
- (26) Mr. Manoj Bhatta, Programme Coordinator, NCASC

## **ANNEX 2: NATIONAL COMMITMENTS AND POLICY INSTRUMENT (NCPI)**