

Country Progress Report

NEPAL

To Contribute to Global AIDS Monitoring Report 2016

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ACRONYMS

AEM	AIDS Epidemic Model
AHF	AIDS Healthcare Foundation
AIDS	Acquired Immunodeficiency Syndrome
ANC	Ante-natal care
ARV	Anti-Retro Viral
ART	Antiretroviral therapy
CBO	Community Based Organization
CBS	Central Bureau of Statistics
CBT	Community-based testing
CD4	Cluster of Differentiation 4
CIBA	Children infected with AIDS
CSO	Civil Society Organization
DBS	Dried Blood Sample
DFID	Department for International Development
EID	Early Infant Diagnosis
eVT	Elimination of Vertical Transmission (of HIV)
FCHV	Female Community Health Volunteer
FSW	Female Sex Worker
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HTS	HIV Testing Service
IBBS	Integrated Biological and Behavioral Surveillance
IRRTTR	Identify, Reach, Recommend, Test, Treat and Retain
KP	Key Population
MCH	Maternal and Child Health
MLM	Male Labour Migrant
MOH	Ministry of Health
MOHA	Ministry of Home Affairs
MSM	Men who have sex with men
MSW	Male sex worker
NCASC	National Centre for AIDS and STD Control
NGO	Non-governmental organization
NHSP	National HIV Strategic Plan
NTP	National Tuberculosis Programme
OST	Opioid Substitution Therapy
PE	Peer Educator
PLHIV	People Living with HIV
PrEP	Pre-exposure prophylaxis
PSM	Procurement and supply chain management
PWID	People who inject drugs
RDT	Rapid Diagnostic Test
SRH	Sexual and Reproductive Health
SW	Sex worker
STI	Sexually transmitted infection
TB	Tuberculosis
TG	Transgender
TGSW	Transgender sex workers
UN	United Nations
UNAIDS	Joint United Nations Programme on AIDS
USD	United States Dollar
WHO	World Health Organization
YKAP	Young Key Affected Population

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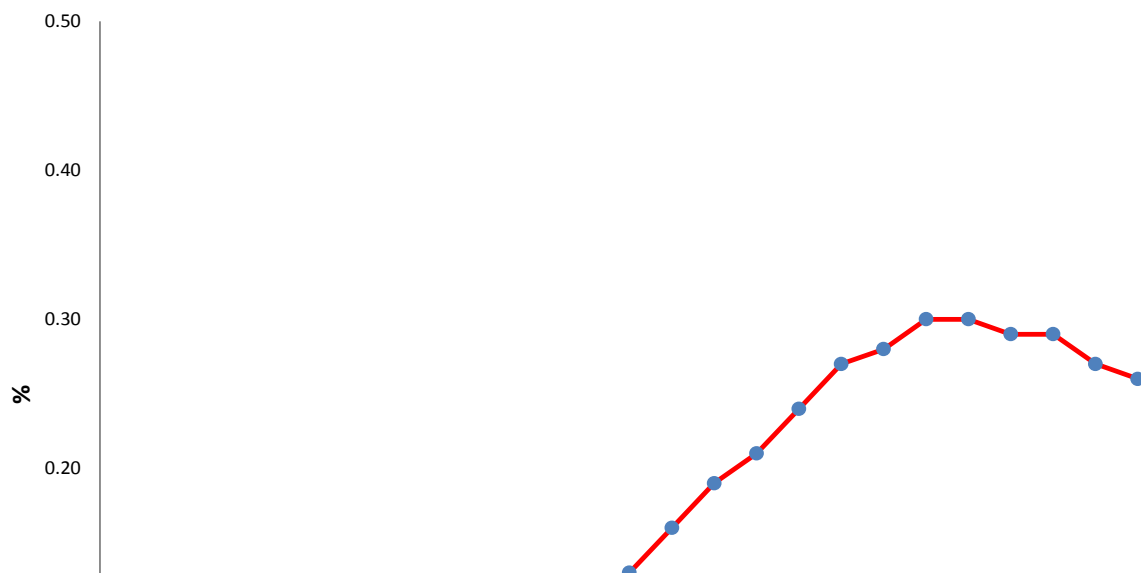
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OVERVIEW

Overall, the AIDS epidemic in Nepal is largely driven by sexual transmission that accounts for more than 90 percent of the total new HIV infections. The epidemic in Nepal remains concentrated among the Key Populations (KP) notably; People who Inject Drugs (PWID), Men who have Sex with Men (MSM), Transgender people (TG), Male Sex Workers (MSW), Female Sex Workers (FSW) and Male Labor Migrants (MLM) as well as their spouses. The HIV prevalence among adults (15-49 years) is 0.17 percent in 2016 and there are an estimated total of 33, 855 people living with HIV (Figure 1). Out of that, 62 percent are males and 38 percent are females. Furthermore, out of total people living with HIV around 4 percent are aged 0-14 years (National HIV Estimates, 2016, NCASC).

The estimated HIV prevalence among adult aged 15-49 years has dropped from a peak (0.35%) in 2005, and is likely to remain around 0.13 percent in 2020. HIV prevalence among young people (15-24 years) is 0.03 percent in 2016.

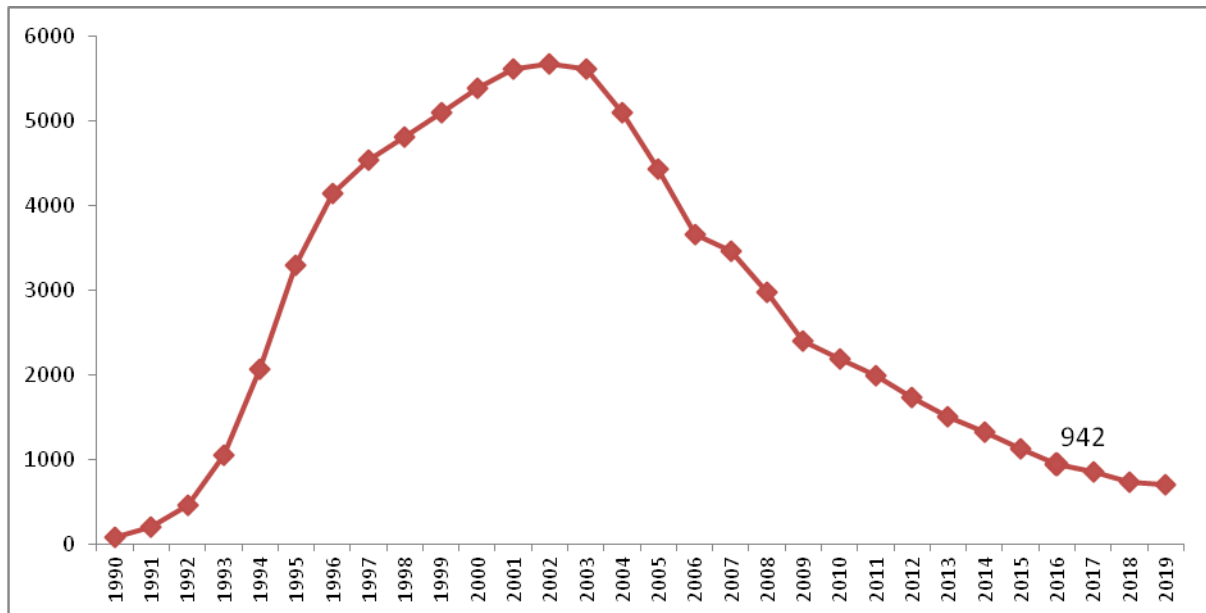
Figure 1: HIV prevalence among adults (15-49 years)



Source: National HIV estimates, 2016

The trend of new infection is decreasing over time and it is started to decline after 2003-2004. The epidemic that peaked in 2003 with almost more than 5,000 new cases in a calendar year has reached to 942 new HIV infections in 2016 (Figure 2).

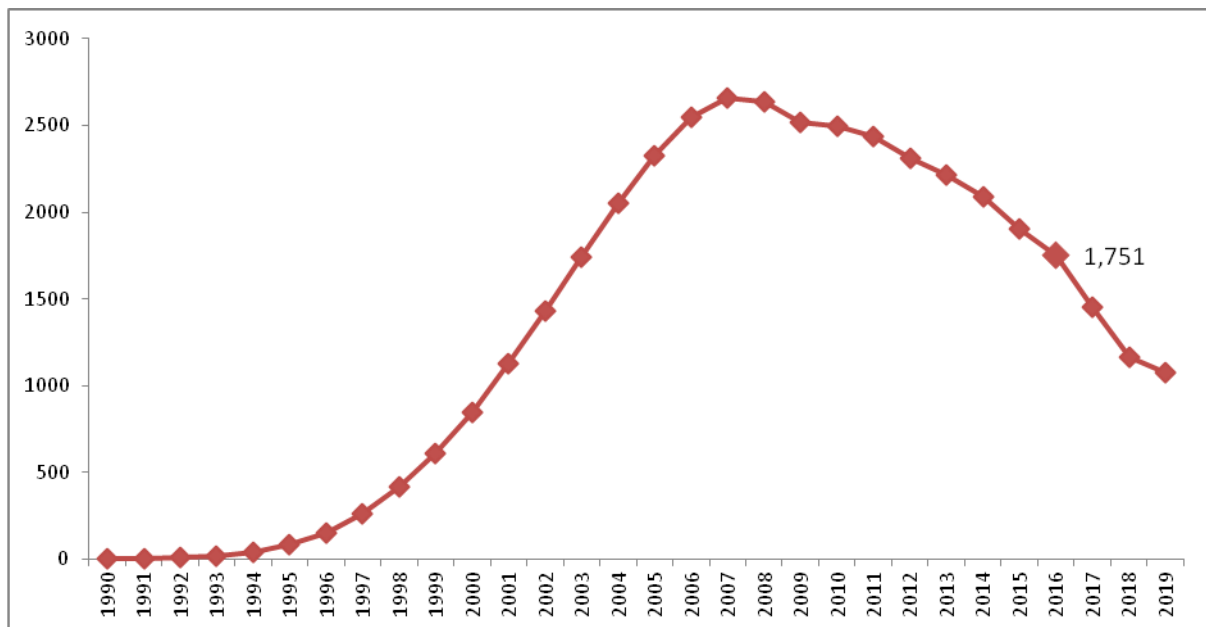
Figure 2: Trends of new HIV infections (1990-2020)



Source: National HIV estimates, 2016

The 2016 national HIV estimates showed that 1751 deaths were caused by AIDS, compared to 1,907 deaths in 2015 (Figure 3). The overall trend of AIDS related deaths is declining over the time. The AIDS mortality rate is 6.17 per 100,000 cases in 2016 and decreasing from 7.98 per 100,000 cases in 2015.

Figure 3: Trends of Annual Deaths (1990-2020)



Source: National HIV Estimates 2016

Nepal has set the following targets and indicators for fast-tracking the AIDS response by 2021.

- Identify, recommend and test 90 percent of key populations;
- Treat 90 percent of those diagnosed as HIV positive;
- Retain 90 percent of those on ART;
- Eliminate vertical transmission of HIV and keep mothers alive and well
- Eliminate congenital syphilis
- Reduce 75 percent of new HIV infections

The country has fully adopted 2015 WHO Consolidated guidelines on HIV testing services. Moreover, the country has also adhered to the recommendations from the 2016 WHO Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. The national consolidated guidelines for treating and preventing HIV in Nepal includes following component: a) adult antiretroviral therapy b) elimination of Vertical Transmission (eVT) c) pediatric antiretroviral therapy and d) Operational/service delivery. The country has started implementing "Test and Treat Strategy" from February 2017.

Overall challenges on the response

As country has recently started Test and Treat Strategy all over the country, there is need of orientation to health workers including ART counselors. NCASC has not conducted such orientation till date. This is an urgent priority to aware health workers and key partners (Key population led community organization) about the strategy otherwise it can create uncertainty of implementation of "Test and Treat strategy" at service site. For fast-tracking the response to achieve 90-90-90 by 2021, the public sector health services and NGOs working with and for KP and their partners need to find solutions that increase demand for services: a) Identify and reach KP for HIV prevention b) Increase HIV testing among KP and c) Retain in HIV care.

This Country Progress Report serves as a guide to gauge the overall performances of the national response, in particular, for the achievement of 10 international commitments.

COMMITMENT 1

Ensure that 30 million people living with HIV have access to treatment through meeting the 90–90–90 targets by 2020

Around 55 percent (55.4% of total male living with HIV and 54.8% female living with HIV) of people living with HIV know their status in Nepal. As of December 31st 2016, there are a total of 13,069 people on Antiretroviral Therapy (ART) in the country. Out of the total PLHIV on ART (13069); 6,780 are males, 6,289 are females and 982 are children (less than 15 years). The ART treatment coverage is 39.8 percent in 2016.

The retention of people on ART after 12 months is 86.6 percent in 2016. The retention in ART is defined as the percentage of PLHIV who are alive and on ART for at least 12 months. Out of 7,042 tested for viral load within the reporting period, a total of 6,209 people on ART (88%) were found to have their viral loads suppressed (≤ 1000 copies/mL). But when we compared it with total estimated number of PLHIV (32855 in 2016) then only 19% of PLHIV have suppressed viral loads in Nepal.

Thirty eight percent of 1783 PLHIV who initiated ART in between July 16, 2015 and 15 July 2016 presented late for HIV care (initial CD4 cell count less than 200 cells/mm³). 62.4 percent of them (1783) had initial CD4 cell count less than 350 cells/mm³. All ART centers (65) reported zero stock out of antiretroviral medicines in 2016.

Challenges

The low ART coverage implies that we are missing to link in care a large proportion of undiagnosed PLHIVs or those who diagnosed but not initiated ART. Thus identifying undiagnosed PLHIV or timely linking diagnosed PLHIV to care will act as barrier to achieve 90-90-90 by 2021.

The known barriers to test, treat and retain in care are a) lack of accessibility of services; b) Stigma and discrimination towards PLHIV and KP c) migration and mobility d) drug dependence e) unmanaged co-infections and f) mental health issues among KP.

Way-forward

The following activities may help to address the existing challenges:

- a) Improve HIV testing among KP through innovative approach such as community led testing. The community led testing should incorporate accompanied positive identified clients to a health facility for confirmatory testing and to avoid loss of such clients.
- b) The large duration between case identification and linking to HIV care need to be reduced. Also, immediately link to HIV care those PLHIV who are identified positive but not on ART. The recent implementation of test and treat strategy may help to address this issue in coming days.
- c) The information of individual client on ART should be kept and routinely updated in electronic database system since such information is more helpful to analyze the barriers and facilitators of retention in HIV care rather than aggregated level routine programme report (disaggregated by age, risk groups and gender).
- d) The viral load testing facility should be available in each region. There are three viral load testing sites (of which two are in capital city).

COMMITMENT 2.

Eliminate new HIV infections among children by 2020 while ensuring that 1.6 million children have access to HIV treatment by 2018

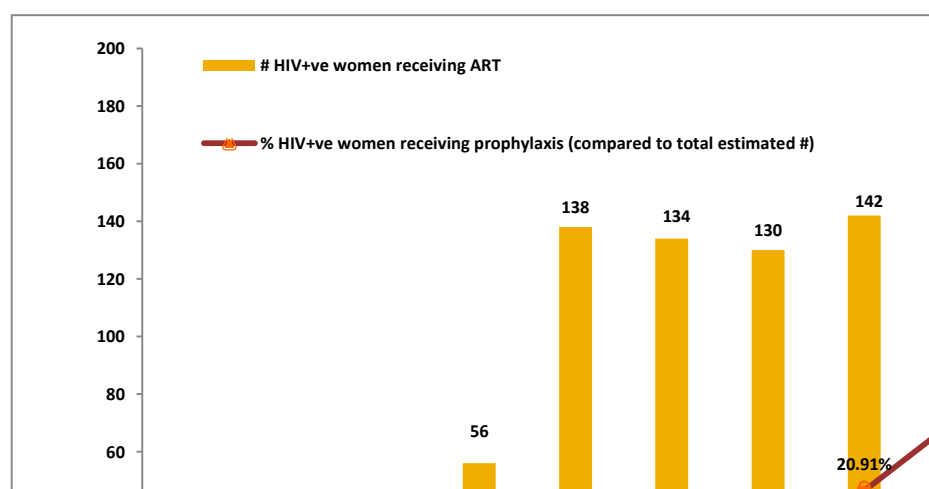
Early Infant Diagnosis (EID)

Nepal has been delivering Early Infant Diagnosis (EID) services since September 2014. Currently, Dried Blood Samples (DBS) are collected from 28 sites across the country. Only 29.17 percent of total estimated 288 infants born to HIV-positive mothers received an HIV test within 2 months of birth (Routine Programme Report, NCASC 2016).

Elimination of Vertical Transmission

Nepal has scaled up elimination of Vertical Transmission (eVT) services in recent years. The eVT services are expanded to at least birthing center in 55 districts out of 75 districts till the end of 2016. The service has been planned to scale up beyond the birthing centers across the country.

Figure 4: Coverage of eVT Programme in Nepal (2006-2016)



(Source: Routine Programme Data, NCASC, 2016)

During 2016, 181 pregnant women received antiretroviral therapy compared to 145 pregnant women in 2015. The eVT coverage is 62.8 percent in 2016 compared to 35 percent in 2015. Out of 181 pregnant women who were on ART in 2016, 141 (78%) newly initiated ART during the current pregnancy and remaining 40 (22%) were already on ART before the current pregnancy.

According to the report from Health Management Information System (HMIS, as of July 2016), only 0.0006 percent of women attending antenatal care services were tested positive and treated for syphilis. Similarly, 0.00029 percent congenital syphilis cases were reported among total live births (HMIS, as of July 2016).

Challenges

The number of expected pregnancies for Nepal is 724,839 (Annual Report 2014/2015, DoHS). Out of this number, only 306,872 pregnant women (42.3%) were tested for HIV in 2016 (Routine Programme Report, NCASC, 2016). Thus, testing all pregnant women for HIV as well as syphilis and to ensure the reporting of the tests in the national system is the biggest challenge. The programme did not capture those pregnant women who do not access antenatal services/delivery from health institutions. Low EID coverage is another obstacle in the national response particularly for improving mortality and morbidity among children living HIV.

Way-forward

The scaling up of the eVT service (that needs to be scaled up to 90 percent by the end of 2021 from the present coverage of 62 percent) through intensified case finding among pregnant women who do not access antenatal services and visit health institutions for deliveries is crucial. For this, the private sector contribution to eVT has to be enhanced, including through in-reach by women in the communities, such as Female Community Health Volunteers, in particular, reaching those pregnant mothers who do not access antenatal services and visit health institutions for deliveries. Moreover, pregnant women, who are members of the key populations, need to be unfailingly tested and, if HIV positive, should be enrolled in the ART to keep them alive and well.

COMMITMENT 3.

Ensure access to combination prevention options, including pre-exposure prophylaxis, voluntary medical male circumcision, harm reduction and condoms, to at least 90 percent of people by 2020, especially young women and adolescent girls in high-prevalence countries and key populations— gay men and other men who have sex with men, transgender people, sex workers and their clients, people who inject drugs and prisoners

Incidence

The incident rate of HIV is 0.03 per 1000 population. (Source: National HIV Infections Estimates, 2016, NCASC).

Prevention of HIV among key populations

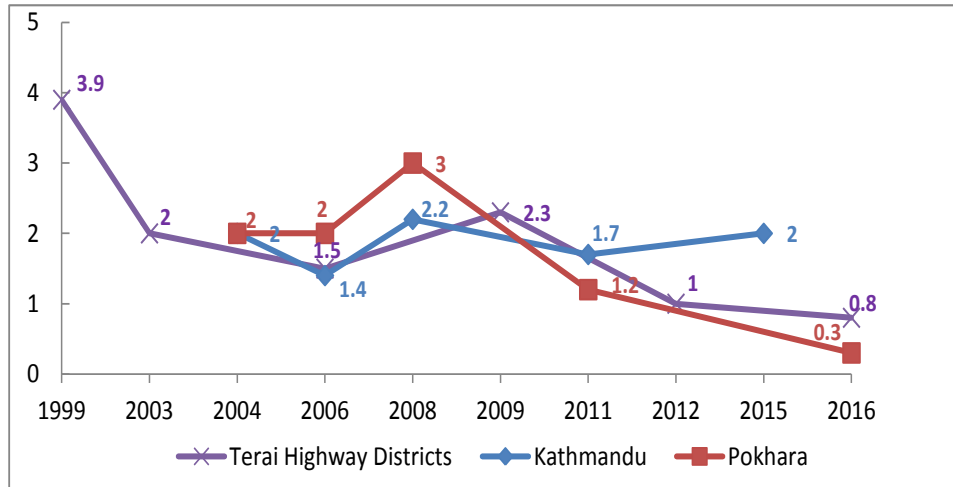
Targeted interventions are in place for more than one and half decades in Nepal. These interventions entail comprehensive packages tailored specifically for KPs - varying to the needs of each groups and include, Behavior Change Communication (BCC) activities, condom promotion and distribution, HIV Testing and Counseling (HTC), and referrals to a range of other critical services including ART, HIV care and support, family planning/sexual and reproductive health, sexually transmitted infections (STI) and TB. For PWID it also includes harm reduction programme such as needle exchange programme (NSP) and opioid substitution therapy (OST).

Female Sex Workers (FSW) and their Clients

The 2016 population size estimation conducted by NCASC estimated that there are about 49,013 female sex workers in Nepal (Mapping and Population Size Estimation, NCASC, 2016). The IBBS studies conducted since 2004 among FSW in Kathmandu, Pokhara and other cities (22 Terai districts) repeatedly noted that the country has kept the HIV prevalence under or around 2 percent. The 2016 IBBS studies conducted showed that HIV prevalence among FSW has decreased from 1.0 percent in 2012 to 0.8 percent in 2016 in 22 Terai districts (IBBS, NCASC, 2016). Similarly, HIV prevalence among FSW of Pokhara Valley has dropped to 0.3 percent in 2016 from 1.2 percent in 2011 (IBBS, NCASC 2016). Overall HIV prevalence among FSW in Kathmandu valley is stable i.e. 1.7 percent in 2011 to 2 percent in 2015 (IBBS, NCASC, 2015). However, the HIV prevalence widely differs among FSW working in different settings i.e., 4.0 percent among street-based sex workers in 2015 Vs 0.7 percent in establishment based sex workers (IBBS-Kathmandu Valley, 2015, NCASC).

Two IBBS surveys conducted in two different parts of the country in 2016 has shown two different trends of prevalence of Active syphilis among FSW. The prevalence of active syphilis among FSW in 22 Highway Districts increased sharply from 0.3 percent in 2012 to 10.3 percent in 2016 (IBBS, NCASC 2016). In contrast, the prevalence of active syphilis among FSW in Pokhara Valley decreased from 3.2 percent in 2012 to less than 1 percent in 2016. Likewise, 3.6 percent prevalence of active syphilis was observed among FSW of Kathmandu Valley (IBBS, NCASC 2015).

Figure 5: HIV Prevalence among Female Sex workers in Nepal



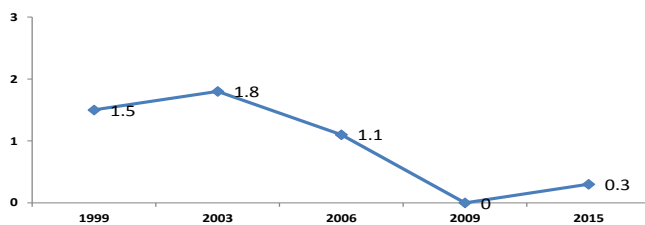
(Source: IBBS, NCASC, 1999-2016)

In Pokhara valley, 81.9 percent FSW reported to have used a condom with the last client. Around 42 percent of FSW in Pokhara Valley ever had HIV test, while in 22 Terai highway districts, 88 percent of FSW ever had HIV test (IBBS, NCASC, 2016). Percent of Female sex workers who knew their HIV status was 83.1 in Kathmandu Valley (IBBS, NCASC 2015).

Clients of Sex workers in Nepal

Prevalence of HIV among truckers- considered as proxy of clients of FSW - was found to be at 0.3 percent in 2016. The trend of prevalence of active syphilis among truckers remained stagnant around 0.3 percent since 2009. The prevalence of consistent condom use with FSW in past 12 months was 65 percent among truckers (IBBS, NCASC, 2015).

Figure 6: Trends of prevalence in clients of FSW

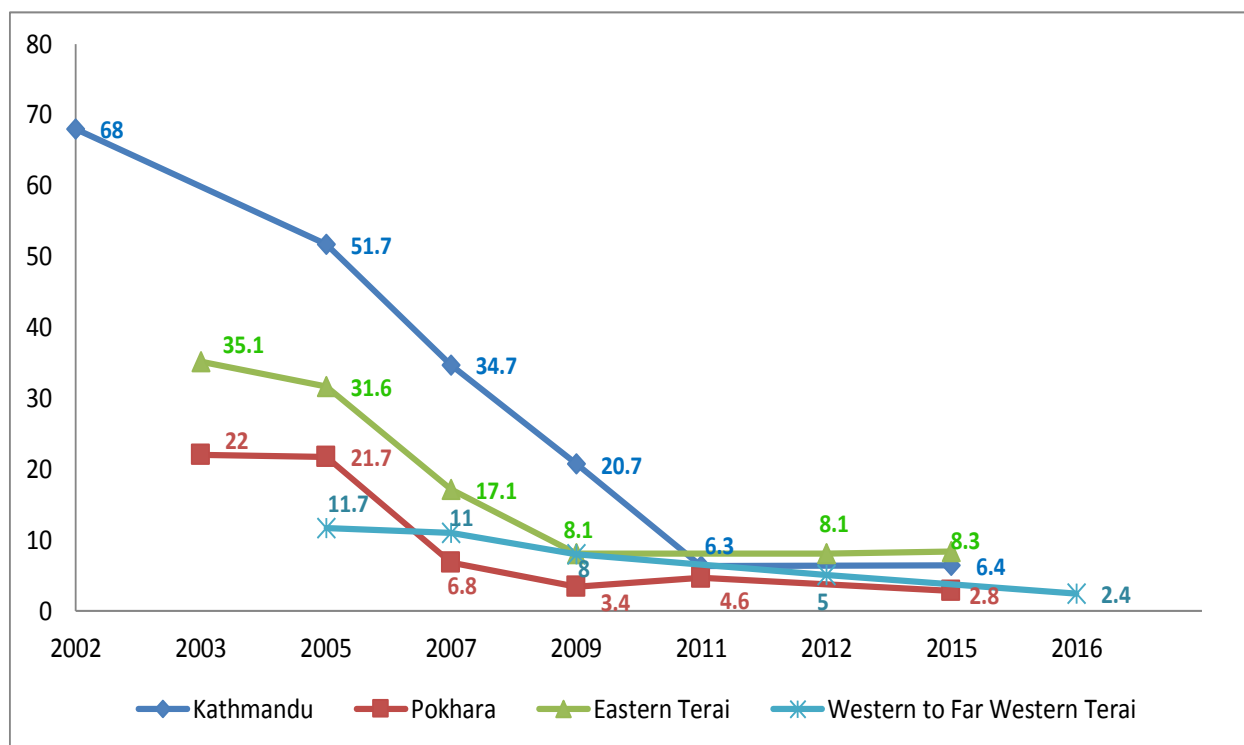


(Source: IBBS, NCASC, 1999- 2015)

People Who Inject Drugs (PWID)

The 2016 population size estimation conducted by NCASC estimated that there are around 30,868 people who inject drugs (PWID) (comprising of 27,567 males and 3,301 females) in Nepal (Mapping and Population Size Estimation, NCASC 2016). The HIV prevalence was 2.3 percent among People Who Inject Drugs (PWID) in 7 Terai highway districts of Western to Far Western region in 2016 (IBBS NCASC 2016). HIV prevalence of 8.3 percent was noted in the Eastern Terai in 2015 (IBBS NCASC, 2015), whereas it was 8.1 percent in 2012. HIV prevalence among PWID in Kathmandu has remained stagnant as it was 6.3 percent in 2011 and 6.4 percent in 2015. In contrast, HIV prevalence among PWID in Pokhara Valley has decreased from 4.6 percent 2011 to 2.8 percent in 2015.

Figure 7: HIV Prevalence among PWID in Nepal



(Source: IBBS, NCASC 2000-2016)

Number of needles and syringes distributed per person among PWID who injects drugs per year has remained low over the years in Nepal. Around 61 needles and syringes were distributed per person per year in 2016. Percentage of PWID reporting the use of sterile injecting equipment the last time they injected has been consistently over 85 percent for the last couple of years. In the year 2015, 96 percent and 97 percent of PWID reported the use of sterile injecting equipment the last time they injected, respectively, in Kathmandu Valley and Pokhara Valley (IBBS, NCASC, 2015). Similarly, 86 percent of PWID of Western Terai reported the use of sterile injecting equipment the last time they injected (IBBS, NCASC 2016).

Percentage of PWID- male who knows their HIV status in Kathmandu valley is 48.7 (IBBS, NCASC 2015). Over the years, the OST coverage among PWID is unacceptably low as only 957 PWID-Male were on Opioid Substitution Therapy (OST) in 2016.

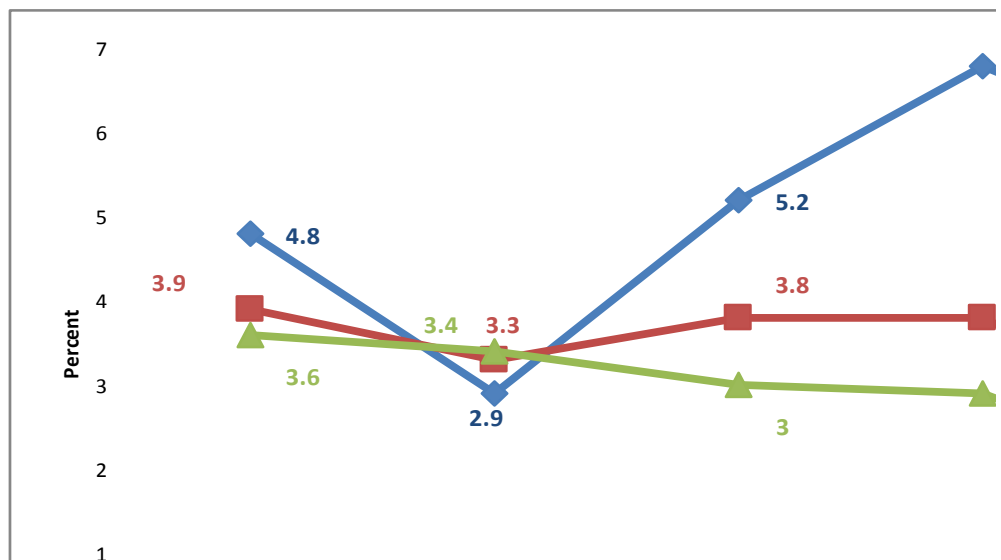
HIV prevalence among PWID-female was 8.8 percent in 2016. Around 68 percent of those females, reported to have ever had an HIV test. Percentage of PWID -female knew their HIV status was 67.6 in Kathmandu Valley. Likewise, 81 percent PWID Female of Kathmandu Valley reported using sterile injecting equipment the last time they injected (IBBS, NCASC 2016). The number of PWID-Female enrolled in OST was 16 in the period of 2016.

Men who have Sex with Men (MSM), Male Sex Workers (MSW) and Transgender (TG)

The 2016 Mapping and Size Estimation estimated that there are 60,333 Men Who Have Sex Men (MSM), 18,287 Male Sex Workers (MSW) and 21,460 Transgender in Nepal. The overall prevalence of HIV among MSM in Kathmandu Valley was recorded 2.4 percent in 2015, decreased by a small proportion in comparison to 3.8 percent that of 2012 (IBBS, NCASC 2015). HIV prevalence in Kathmandu Valley was higher among MSW group (5.6%) than among Non-MSW groups (1.8%).

Similarly 93.1 percent of MSW, 86.0 percent of MSM, and 83.1 percent of TG of Kathmandu Valley reported the use of condoms at the last time they had anal sex with male partners (IBBS, NCASC 2015).

Figure 8: Trends of HIV prevalence among MSW/MSM/Non MSW in Kathmandu Valley (2004-2015)



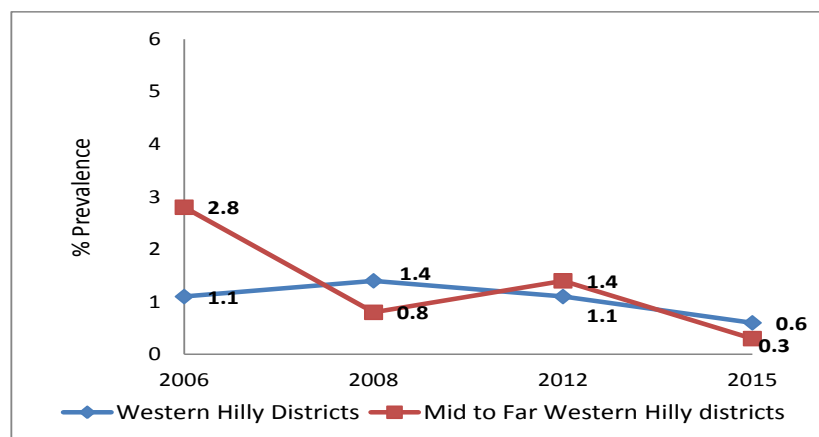
(Source IBBS, NCASC, 2004-2015)

Male Labor Migrants (MLM) going to India

Overall prevalence of HIV infection among Male Labor Migrant (MLM) is showing a decreasing trend as HIV prevalence among MLM of Western region dropped from 1.1 percent in 2006 to 0.3 percent in 2015. Similarly, HIV prevalence among MLM of Mid to Far Western region is also decreasing from 1.4 percent in 2012 to 0.6 percent in 2015 (IBBS, NCASC 2015). Nearly one-tenth (9.5 percent) of MLM of Western

region reported to have received an HIV test in the past 12 months. Only 2.8 percent of MLM of both regions were reached by the HIV prevention Programme (IBBS, NCASC 2015).

Figure 9: Trends of HIV prevalence among MLM



Source: (IBBS, NCASC 2006-2015)

Viral Hepatitis among Key Populations

The prevalence of viral hepatitis C (HCV) was 8 percent among PWID of 7 Terai highway districts of Western, Mid-Western and Far-Western regions of Nepal and viral hepatitis B (HBV) was 1.7 percent among them (IBBS, NCASC 2016). Over a fifth of the PWID (22 percent) were found to be infected with HCV in Kathmandu Valley in 2015 whereas none was found infected with HBV (IBBS, NCASC 2015). Moreover, HCV prevalence of 13.1 percent and HBV prevalence of 1.8 percent have been found among PWID-Male of Pokhara Valley (IBBS, NCASC 2015).

The HCV prevalence was 22 percent among PWID-Female in Kathmandu valley in 2016. Likewise the prevalence of HBV was 1.9 percent (IBBS, NCASC, 2016). The co-infection between HIV and HCV was 5.6 percent, and the co-infection of HBV and HCV was 1.2 percent among PWID – Female. Nearly half of PWID-Male in the Eastern Terai of Nepal (47%) (IBBS, NCASC, 2015) were found HCV positive while only 0.8 percent were found HBV positive.

Challenges

Testing levels among key population is still low, as only one-tenth (9.5%) of MLM of Western region reported to have received and HIV test in the past 12 months (IBBS, NCASC 2015).

In addition to the low testing levels, the coverage of needle and syringe exchange programme is only 54 percent, whereas OST coverage is below 2 percent (National HIV Strategic Plan 2016-2021). The needles and syringes provided per PWID per year are far below the recommendation of 200 needles and syringes per person per year. Only 61 needles and syringes were distributed per PWID per year. Key challenges with the current OST programme are: a) limited coverage of services; b) unavailability of HCV prevention and treatment services and c) poor retention rate among enrolled OST clients

Way -forward

With the enforcement of Test, Treat and Retain approach, Nepal now needs to emphasize on decentralizing HIV screening to communities, and expanding the use of rapid diagnostic tests (RDT) through the speedy roll out of Community-based/led testing (CBT) through 'test for triage' to increase HIV testing. Expanding HIV testing services (HTS) through trained lay providers working in the community will increase access to these services and their acceptability to people from key population.

The needle and syringe distribution programme and the OST programme need to be scaled up to a significant number of districts across the country, as the both number of PWID receiving new needles and syringes and OST are unacceptably low. These important harm reduction programmes need a standardized approach, as well as review and adoption of more cost effective approaches. The expansion, in particular, of OST need to address both the supply and demand side issues, and must be reviewed to make it more 'client centered' in order to improve demand. The current service delivery model for OST (Client should visit daily to the OST sites) need to be reviewed in consultation with clients and services and designed to take a differentiated approach towards unstable and stable clients.

Existing Standard operating procedures (SOP) for the implementation of HIV programme in the prison setting should be reviewed to ensure that the HIV related services are delivered incessantly during detention.

COMMITMENT 4.

Eliminate gender inequalities and end all forms of violence and discrimination against women and girls, people living with HIV and key populations by 2020

Nepal has become the first Asian country to identify the existence of ‘gender and sexual minorities’ in its constitution. Article 18 (2) of the constitution under Right to Equality states that no discrimination shall be made in the application of general laws on grounds of origin, religion, race, caste, tribe, sex, physical condition, condition of health, marital status, pregnancy, economic condition, language or region, ideology or on similar other grounds. The Article further guarantees that women specifically have the right to safe motherhood and reproductive health and to freedom from any kind of violence.

Prevalence of Stigma and Discrimination

The reduction of stigma and discrimination has been one of key elements of Nepal's National HIV/AIDS Strategy 2016-2021. In this context, Positive Protection Toolkit (PPT), to empower women affected by HIV so that they could protect themselves and their community members from the discrimination and violation in health care settings, was developed and translated into Nepali with the support of UNAIDS, UNDP and Asia Pacific Network of Positive People. In addition to that, 275 women leaders from key populations: women living with HIV, women who use drug, female sex workers, and transgender were trained about their legal and health rights, and; the complaint mechanisms in case of rights violations while accessing health services. Under the guidance and monitoring support of Right to Health Women's Group (RTHWG) at the national level, several ‘Right to Health’ action-groups are now actively engaged in documenting rights’ violation as well as in joint advocacy at the district level.

Gender Assessment of National Responses to HIV and TB was conducted in early 2016 and recommendations were incorporated in National HIV Strategic Plan 2016-2021.

Prevalence of recent Intimate Partner Violence

Violence in all three forms (psychological, physical and sexual) has been repeatedly observed among key populations over the years. According to IBBS conducted among FSW in the Pokhara Valley in 2016, around 15 percent of FSW had experienced verbal abuse (psychological violence), and 6 percent of them had experience of physical violence. Moreover, 6.1 percent of FSW in Pokhara Valley had experience of sexual violence (IBBS NCASC 2016). Similarly FSW in Kathmandu Valley noted that 26 percent of FSWs had ever experienced at least one emotional violence by their clients (IBBS, NCASC 2015). Around 16 percent FSW in Kathmandu Valley experienced sexual violence by their clients. Almost 9 percent of FSW had ever experienced of at least one of the physical violence (IBBS NCASC 2015).

One out of ten (12.3%) of the MSM experienced physical violence in Kathmandu Valley because of their sexual orientation, and about 11.5 percent MSM were forced to have sex in the past 12 months. The proportion of sexual violence was observed even higher for MSW (20.7%) as well as TG (17.2%) in Kathmandu Valley (IBBS NCASC 2015). One in ten (9.3%) of the MSM reported discrimination at job or everyday life. Such discrimination was reported higher by the MSW (42.3%) and TG (26.5%) (IBBS NCASC 2015).

Intimate Partner Violence (IPV) which often is considered as a potential barrier to women's access to health services was included in the Demographic Health Survey (DHS) 2011. The DHS 2011 has recorded that 14 percent of ever-married women reported experiencing physical and/or sexual violence from their spouse within 12 months prior to the survey, while 11 percent having experienced violence sometimes and 3 percent has experienced it often.

Recently, the numbers of agencies (both government along and civil societies) are incorporating the issue of gender based violence in their programme. Networks of KP, networks of people living with HIV; and other agencies are engaged in a national effort to empower these populations against any form of violence and ensuring their access to HIV prevention and treatment services in an environment free from prejudice. Their efforts in this context are complemented by the 2006 Gender Equality Act, and the 2007 Human Trafficking and Transportation (Control) Act. As a result, social acceptance of these groups is gradually improving. Information Education Communication (IEC) materials for HIV response also include anti-gender violence, anti-stigma and anti-prejudice message.

Challenges

Incidences of prejudice in health care setting are still being reported in news, though in a decreasing trend. There are a number of instances in which PWID have been arrested or harassed for using drugs. Similarly sex workers have been arrested or harassed in relation to selling sex and charged with creating public nuisance. These activities still remain as barriers in the national response to HIV.

Way -forward

Service providers, particularly health care workers and law enforcement personnel, must be oriented, trained and held accountable for service delivery with strong advocacy for zero tolerance against discrimination. Nepal needs to put in place accountability mechanisms so that health workers and law enforcement officials who commit human rights violations are held accountable.

The country needs to empower the communities to access quality health services and also to report discrimination cases to the national programme and the National Human Rights Commission. Apart from that, Right to Health Women's Group (RTHWG-networks of women living HIV, Transgender-women, sex workers and female drug users) should be strongly supported on its advocacy efforts for incorporating KP women's issues into prevention of gender based violence programmes.

COMMITMENT 5.

Ensure that 90 Percent of young people have the skills, knowledge and capacity to protect themselves from HIV and have access to sexual and reproductive health services by 2020, in order to reduce the number of new HIV infections among adolescent girls and young women to below 100 000 per year .

Nepal has education policies that guide the delivery of life skills-based HIV and sexuality education especially in secondary schools. Apart from that, life skills-based HIV and sexuality education are included in teachers' training.

Around, 28 percent of women and men belonging to the age group (15-24) correctly identified both ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission (DHS, 2011). Similarly 56.20 percent of women of reproductive age (15-49 years old) have their demand for family planning satisfied with modern methods (DHS, 2011).

Young Key Affected Population (YKAP) Group consisting of the young people from PWID, FSW, MSM and TG were actively engaged while developing National HIV Strategic Plan 2016-2021. YKAP led one of the thematic discussions with the key stakeholders to identify the gaps and the needs related to the strategic information to be addressed by the NHSP.

Challenges

Participation of young people (15-24 years old) is not adequate in developing of policies, guidelines and strategies relating to their health. HIV related services are still not delivered to young key affected population in a youth friendly manner.

Way –forward

Participation of young people (15-24 years old) should be enhanced in developing policies, guidelines and strategies relating to their health and in implementation of interventions targeting among them.

COMMITMENT 6:

Ensure that 75 Percent of people living with, at risk of and affected by HIV benefit from HIV-sensitive social protection by 2020

National social protection frameworks of Nepal entails cash beneficiaries including elderly people, single women, people of deprived community and remote areas and the school children of deprived community. In this context of HIV, Nepal has recognized social protection as a critical enabler of the HIV response in its current and previous National HIV Strategic Plans.

With the aim of improving maternal and new born health, Nepal has been successfully running a cash transfer incentive for pregnant women through the Safer Motherhood Programme since 2005. Taking a similar initiative especially for the elimination of vertical transmission, Nepal is preparing for a scheme that provides the payment of NRs. 5000 (USD 50) to HIV positive women on the completion of four ANC checkups, institutional delivery and EID of baby born to them. This cash incentive scheme is expected to play a number of important roles, as it: a) improves the HIV testing rate among pregnant women supporting in the elimination of vertical transmission in the country, b) helps HIV positive pregnant women in ART enrollment, c) helps link HIV exposed babies to infant prophylaxis; and d) helps link HIV exposed babies to EID services.

Aligning with the National HIV Strategic Plan, Nepal has been implementing a social protection programme for Children Infected by AIDS (CIBA). More than 1,000 CIBA aged between 0-18 years, across 60 districts, are getting a monthly amount of Nepali currency Rs 1,000, (roughly US 10\$) on their individual bank accounts. Apart from this, civil societies are also advocating for incorporating this social protection programme into the broader social protection framework of the Government of Nepal with the aim of ensuring the financial sustainability of social protection programme for CIBA. Moreover, Nepal has been providing nutritional supports to PLHIV especially to female and children living with HIV.

Challenges

In the face of dwindling resources from external development for the response to HIV, ensuring financial sustainability of HIV-sensitive social protection programmes remains as a challenge.

Way –forward

HIV sensitive social protection programmes need to be incorporated into the border social protection framework of the Government of Nepal.

COMMITMENT 7:

Ensure that at least 30 percent of all service delivery is community-led by 2020

Legal environment in Nepal place no restriction for the registration and operation of civil society and community-based organizations that operate HIV service delivery. The laws, policies or regulations of country enable access to funding for CSOs/CBOs from domestic as well as international funding. As a result, communities especially belonging to key populations have an overwhelming proportion of participation in a wide range of activities of the national HIV response. Networks of key populations participate in the preparation of strategies and policies related to HIV. Moreover, community level services, in particular, those meant to prevent new HIV infections, have been largely developed and implemented by and for key populations with the support from NGOs and international NGOs. Current revision in the national consolidated guidelines has cleared the way for community based testing by lay trainers.

Keeping the paradigm of IRRTTR at center, Nepal in its latest NHSP (2016-2021) has clearly emphasized for a much bigger and pivotal role for communities for the national response than in the past. Among key initiatives, that the NHSP has envisaged critical roles for communities, are: public-private partnerships between government and civil society, and 'task sharing' between health workers and trained lay persons. This has paved a way for applying the 'test for triage' approach for the community led testing in the expansion of HTS among key population by key populations.

PLHIV communities with their networks spanning across a large part of the country are involved in supporting treatment and care as well as overall wellbeing of more than 13000 PLHIV in the country. Community Based Home Care programmes implemented by and for PLHIV across 40 districts has played a key role especially in the retention and adherence support. The credit of maintaining the retention rate of more than 85 percent on ART after 12 months of initiation should also be attributed largely to them. There are a couple of ART sites in the country that are successfully managed by communities (such as outside public health-facilities: SPARSHA and Maiti Nepal).

Challenges

Inadequate capacity of communities especially for their new roles envisaged in the NHSP such as 'task sharing' and 'test for triage' can be one of hurdles for fast-tracking the response to achieve 90-90-90 by 2021.

Way-forward

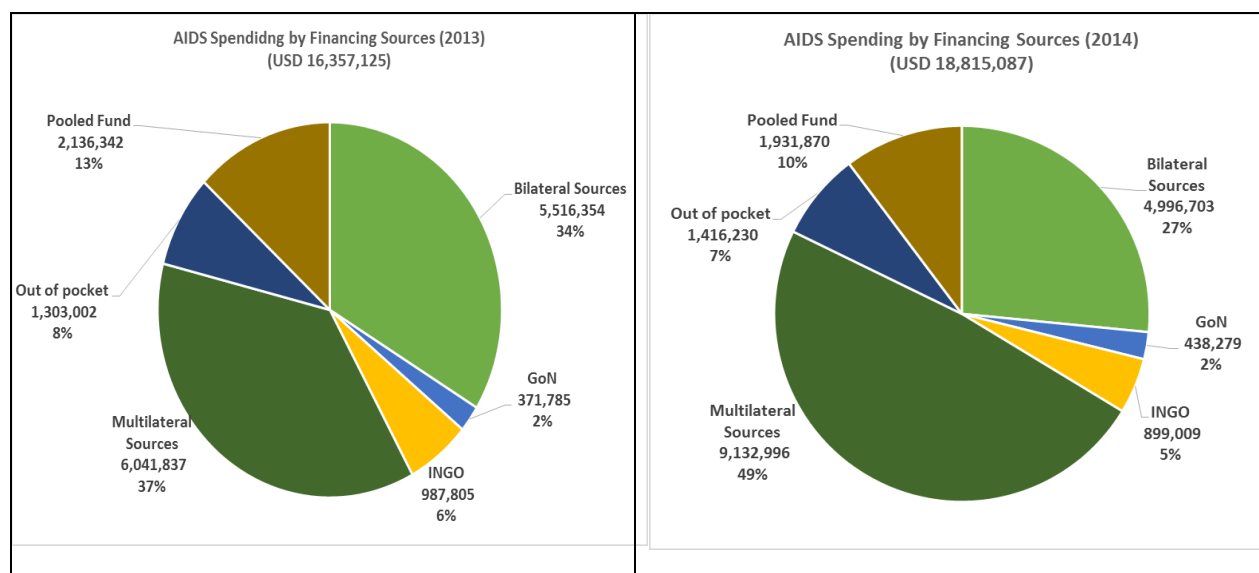
Capacity enhancement of communities and implementing partners – including KP communities/networks, government, donors, private sector, INGOs and NGOs should be done especially for 'task- sharing' and 'in-reach,' in the alignment of IRRTTR. Likewise, facilitating the smooth implementation of community led testing (CLT) to achieve the 90-90- 90 targets by 2020 by applying the Community Life Competence (CLC) process and approach should be a top priority.

COMMITMENT 8.

Ensure that HIV investments increase to US\$ 26 billion by 2020, including a quarter for HIV prevention and 6 percent for social enablers

The last National AIDS Spending Assessment (NASA) was conducted in 2015 for the period of 2013 and 2014. Overall US\$ 16,357,125 and US\$ 18,815,087 were spent for the year 2013 and 2014 and the largest source for HIV financing in Nepal were from external development partners such as multilateral and bilateral sources. The second largest source of HIV money is from Pooled Fund and Out of pocket expenses. Among external development partners GFATM, USAID, and GIZ have been the main contributors. UN agencies, pooled fund partners (the World Bank, DfiD, AusAID, Kfw) are also external sources that are contributing to the national HIV response. Other partners include Family Planning Association Nepal (FPAN) and AIDS Healthcare Foundation (AHF) Nepal are also contributing to the national response to HIV.

Figure 10: AIDS spending by sources



(Source: NASA, NCASC, 2015)

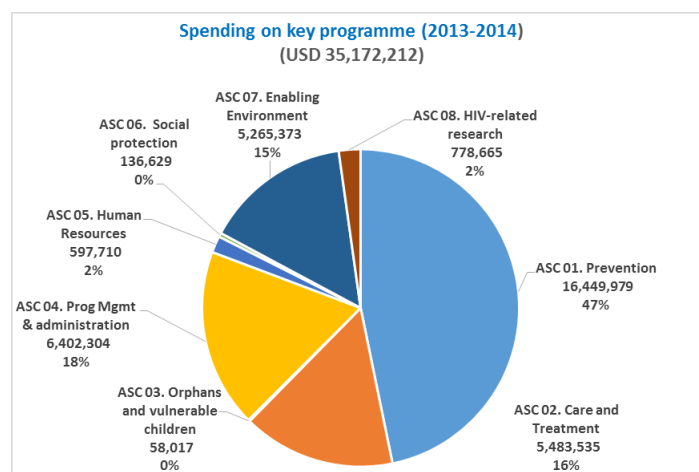
The Government of Nepal incurs spending on HIV prevention, care and treatment programmes in Nepal through the National Centre for AIDS and STD Control (NCASC) within the Ministry of Health (MoH). NCASC receives an earmarked budget that covers almost all government spending on HIV and STI. This includes human resource costs, training, skills development and awareness training, programme expenses, monitoring at central, regional and district levels, travel and procurement of medicines.

The Government of Nepal has, maintained a dual stream of resources to the national HIV response: a) through its regular funding to NCASC and b) through the ‘Pooled Fund.’ The Pooled Fund comprises a basket of funds from both government and external resources, including the World Bank, KfW, AusAID and DFID. The proportion of external resources to total resources in the Pooled Fund has varied from year to year, and generally has fluctuated around an annual average of 80 percent from government and 20 percent from donors.

In addition to the contribution through pooled fund, the Government of Nepal direct financing to the national response stands at 2 percent for the year 2013 and 2014. International sources occupied 78 percent in addition to the percentage contributed through pooled fund. Out of pocket expenses comprised of 8 percent to total spending in country during the two years period. The financing from INGOs sources comprises 5-6 percent over the period of two years.

Over the two years period (2013-2014), HIV prevention related activities shared a bulk (47%) of the total AIDS spending, whereas care and treatment and enabling environment spending comprised of 16 percent. Support to orphans and vulnerable children (OVC) or children affected by AIDS (CABA) received negligible share in total spending (0.15%). Similarly, spending for programme management and administration was recorded at eighteen percent of total AIDS spending in the country. The lowest spending were recorded for orphan and vulnerable children (0.15%), human resource (deploying additional human resources in point of care centers i.e. hospitals), social protection (0.36%) and HIV related research (2.08%).

Figure 11: Spending on Key Programme



(Source: NASA, NCASC, 2015)

Challenges

As discussed above, Nepal's HIV programme is heavily dependent on foreign aid. Development aid especially for HIV is reducing over time from donor countries and from the international financing mechanisms, such as the Global Fund, as priorities are shifting to support countries with the highest HIV burden. The 2016 United Nations High Level Meeting on ending the AIDS epidemic by 2030 Political Declaration that was also endorsed by Nepal, as Member State of the UN General Assembly, recommends that countries substantially increase their domestic contribution to a comprehensive HIV prevention, treatment and care response.

Way-forward

A further increase in domestic investment in HIV is required to ensure the sustainability of the HIV response in Nepal. Apart from this, HIV-related services that relied on this pooled funding need to be assessed and reshaped to fit the new prevention-treatment paradigm and public-private partnerships, through task-sharing. Formal engagements with recipients and sub-recipients of the pool fund needs to be

streamlined in light of more effectiveness and efficiency. Moreover multi-year contracts needs be issued, where feasible, to avoid implementation gaps.

Government of Nepal has been contributing to Targeted Interventions in particularly for key populations. Apart from this, the Government is contemplating for financing particularly for ART from its own sources. This initiative will leverage sustainable financing especially for ART as well as increase the share of domestic contribution to the national response.

COMMITMENT 9.

Empower people living with, at risk of and affected by HIV to know their rights and to access justice and legal services to prevent and challenge violations of human rights

The Constitution of Nepal (2015) guarantees that every person regardless of their situation or condition have, including but not limited to, the following fundamental rights: Right to live with dignity, Rights to freedom, Right to equality, Rights relating to justice, Right of victim of crime, Right against torture, Right against preventive detention, Right against untouchability and discrimination. Article 18 (2) under Right to Equality also states that no discrimination shall be made in the application of general laws on grounds of origin, religion, race, caste, tribe, sex, physical condition, condition of health, marital status, pregnancy, economic condition, language or region, ideology or on similar other grounds. The Constitution also contains a specific right to healthcare, including information on one's health condition, access to emergency health care and equal access to healthcare. Women specifically have the right to safe motherhood and reproductive health and to freedom from any kind of violence

The present NHSP has recognized that human rights, gender, justice, equity and inclusion are pivotal for an effective HIV response. Apart from that, Nepal has put in place accountability mechanisms in relation to discrimination and violations of human rights in healthcare settings. National Human Rights Commission takes care of complaints of cases of HIV-related discrimination as well as other forms of discrimination. Similarly existing legal system also takes care of any plea related to discrimination lodged at it. Envisaging special attention to human rights and gender issues, the present NHSP has underpinned the monitoring for zero tolerance. Further in this context, NHSP has also realized the need to conduct a review of existing laws and regulations in the lights of HIV as it relates to human rights.

There are training and/or capacity improving programmes for people living with HIV and key populations to educate them and raise their awareness concerning their rights (in the context of HIV). Similarly there are training programmes of a limited scale for police and law enforcement personnel, the judiciary, elected representatives and health care workers on human rights and non-discrimination legal frameworks as applicable to HIV. Likewise, there are training programmes of a limited scale for police and law enforcement personnel, the judiciary, elected representatives, and; health care workers on preventing violence against women and gender-based violence.

Challenges

Training and/or capacity improving programmes on: a) human rights and non-discrimination legal frameworks as applicable to HIV and b) on preventing violence against women and gender-based violence are of a very limited scale and mostly limited to the national level and need to be expanded to the local level. Inadequate funding is the major hurdle in the expansion of these capacity improving activities to the local level.

Though human rights, gender, justice, equity and inclusion are considered as key elements, these elements have not been recognized as the major areas of investment in the national response. Thus inadequate funding has been a key concern for empowering people living with HIV, at risk of and affected by HIV to know their rights and to access justice and legal services.

Way-forward

Human rights, gender justice, equity and inclusion should be clearly recognized as critical enablers as well as important areas of the investment for the success of national HIV response. Recognizing that law enforcement agencies and other uniformed services have an important role in protecting the disadvantaged key populations, they should be well trained in order to provide supportive and protection services to key populations. To address the funding barrier, in addition to regular funding for HIV, the global fund is allocating additional 1.3 million USD as catalytic investment to address human rights related barriers to access health services among key populations.

COMMITMENT 10.

Commit to taking AIDS out of isolation through people-centered systems to improve universal health coverage, including treatment for tuberculosis, cervical cancer and hepatitis B and C

Co-managing TB and HIV treatment

HIV prevalence among TB patients is 2.4 percent, and TB prevalence among people living with HIV is 11.2 percent (Status Report on TB-HIV in SEARO 2013). The National Tuberculosis Programme (NTP) is implementing TB/HIV activities in all districts. Currently Isoniazid prevention therapy (IPT) services are being provided through all ART Centers.

A total of 73 (58 males and 15 females) of HIV-positive new and relapse TB patients started on TB treatment in 2016 who were already on antiretroviral therapy or newly started antiretroviral therapy during TB treatment. The proportion of people living with HIV newly enrolled in HIV care with active TB disease is 27.3 percent (313 out of 1,147).

Management of STI

Percentage of men reporting urethral discharge in the past 12 months is 8.6 percent, whereas the rate of laboratory-diagnosed gonorrhoea among men is 0.1 percent (NCASC Routine Programme Report 2016).

Management of Viral Hepatitis

By incorporating HCV and HBV in IBBS survey, from 2015 Nepal has started to monitor prevalence of these viral diseases among PWID male and female. Country is planning to treat 450 PWID through its study to validate treatment protocol of HCV.

Challenges

High rate of HIV/Hepatitis C co-infections, ranging from 13.1 percent to 47.5 percent, has been diagnosed among PWID in recent IBBS studies. Comprehensive surveillance systems for Hepatitis B and Hepatitis C are yet to be developed in the country. The treatment service is not freely available among the PWID.

Way-forward

Nepal needs to fulfill information gaps and also put in surveillance mechanisms for tracking the dynamics of Hepatitis B as well as Hepatitis C. Apart from this, the country needs to address the burden of HBV and HCV among PWID with the planned and sustained response.