UNGASS COUNTRY PROGRESS REPORT

[Nepal]

Reporting period: January 2006–December 2007

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Table of Contents

List of Tables

List of Figures

Foreword

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FOREWORD

I am pleased to present Nepal's third country report to the United Nations General Assembly Special Session on HIV and AIDS (UNGASS) 2008. This report details major achievements, current status of the HIV epidemic in the country, the national response and critical challenges facing the country. Nepal successfully submitted two UNGASS reports in 2003 and 2005.

Recent data and information clearly indicate a number of positive trends in the response to the epidemic, despite the decade long political instability surrounding our efforts. Over the period, the government of Nepal has been active in formulating national policies and harmonising donor inputs for an effective response. Recent policies like the National Policy on Drug Control (2006) and National Workplace Policy (2007), for example are major steps in the response. In addition, the Three-year Interim Plan (2008 – 2010) places HIV and AIDS as a priority– giving a clear indication for line ministries to formulate sector-specific HIV and AIDS programmes.

The government has also activated existing structures such as the National AIDS Coordination Committee and setting up a semi autonomous entity: "HIV/AIDS and STD Control Development Board". This entity is mandated by the government to formulate HIV and AIDS related policies and programmes while increasing multi-sectoral engagement through the mobilisation and collaboration with national and international development partners and stakeholders.

Generally, NGO participation in the national response against HIV and AIDS has increased significantly in all national processes. Over 200 NCOs now actively provide services to various vulnerable groups and communities. Vulnerable groups and communities of people living with HIV are now more organised, active and better positioned for effective and collective action.

As a result of national commitment and support from External Development Partners (EDP), HIV prevalence among some groups (e.g. IDUs, FSW) has started to decline and/or stabilise. The challenge will be to maintain the downward trend by intensifying the response and expanding programme reach to mobile populations and other vulnerable groups with a view to Universal Access. More people in need are now on Anti retroviral therapy (ART) in the government and non governmental sector but still large numbers remain to be reached. These challenges call for the wider participation of all stakeholders, multisectoral engagement and sustained commitment from EDPs in terms of technical and financial assistance.

The collaborative work that has begun in the country with government, civil society organisations, PLHIV, vulnerable groups and EDPs is a clear indication of the collective commitment in the fight against the HIV epidemic.

It has been encouraging to note the enthusiasm and contributions from government ministries, NGOs, PLHIV, vulnerable population and EDPs in the preparation of this report. The government of Nepal would like to extend its appreciation to our technical and programme partners alike for the energy and expertise contributed to strengthen the content of this report.

We would also like to express our profound gratitude to UNAIDS for the technical and financial support that made the preparation of the report a broad-based and inclusive process. Finally, a word of thanks and appreciation for the active role played and vigorous responsibilities taken by individuals in the prevention of HIV and control of AIDS in the affected families and communities across the country of Nepal.

The Government of Nepal remains committed to the principles of the United Nations General Assembly Special Session on HIV and AIDS (UNGASS) and is committed to every effort required to respond to the growing challenges.

On behalf of the government of Nepal, I look forward to a sustained collaborative efforts and maintaining the momentum to halt the spread of the HIV/AIDS epidemic in the country.

Dr Bishnu Prasad Pandit
Acting Secretary
Ministry of Health and Population

January 2008

Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral
AusAID	Australian Agency for International Development
IBSS	Integrated Behavioural Surveillance Surveys
DACC	District AIDS Coordination Committee
DDC	District Development Committee
DFID	UK Department for International Development
DIC	Drop-in Center
DoE	Department of Education
EHCS	Essential Health Care Services
FHI	Family Health International
FNCCI	Federation of Nepalese Chambers of Commerce & Industry
FP	Family Planning
FSW	Female Sex Worker
GFATM	Global Fund for AIDS, TB and Malaria
HIV	Human Immunodeficiency Virus
HMG	His Majesty's Government
HMIS	Health Management Information System
IDU	Injecting Drug User
IEC	Information, Education and Communication
ICC	Information and Counselling Centre
ILO	International Labour Organisation
INGO	International Non Governmental Organization
LGBTI	Lesbian, gay, bisexual, transgender
LSBI	Life-skills based education
MoHP	Ministry of Health and Population
MSM	Men Who Have Sex with Men
MSW	Male Sex Workers
MTCT	Mother to Child Transmission
NAC	National AIDS Council
NACC	National AIDS Coordination Committee
ORT	Oral Substitution Therapy
NCASC	National Centre for AIDS and STD Control
NASA	National AIDS spending assessment
NCED	National Centre for Educational Development
NCPI	National Composite Policy Index
NGO	Non-Governmental Organization
NHSP-IP	National Health Sector Programme Implementation Plan
OVC	Orphans and Vulnerable Children
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
PMU	Programme Management Unit (UNDP HIV/AIDS)
PRSP	Poverty reduction Strategy
SAE	Semi Autonomous Entity
STD	Sexually Transmitted Disease
SI-TWG	Strategic Information Technical Working Group
STI	Sexually Transmitted Infection
SW	Sex Worker
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
WHO	World Health Organization

Executive summary

The epidemic in Nepal is driven by injecting drug use and sexual transmission. There are numerous social, economical and cultural factors that drive the injecting and sexual behaviours among various most-at-risk groups. Given the nature of Nepal's concentrated HIV epidemic the focus of the response has been maintained with prevention programmes targeting most-at-risk-populations. Over the period, care support and treatment programmes for People Living with HIV and AIDS have also expanded significantly.

Most recent estimates of people living with HIV show that 41% of all HIV cases in Nepal are among seasonal labour migrants, 16% among clients of sex workers and 21% are wives or partners of HIV positive men. Figures indicate a prevalence of 0.48% in the adult population in Nepal.

The responses in the country have progressed fairly steadily despite political instability. Policy and strategy development has been reasonably good. The "Three-year Interim Plan" has accorded HIV high priority. Besides, policies like National Drug Policy, Workplace Policy were also developed in this reporting period. There is significant progress in putting the "three ones" principle in place. The formation of Semi Autonomous Entity with the mandate to develop policy and increase multisectoral engagement will further strengthen national response.

Recent data and information clearly indicate a number of positive trends in the response to the epidemic. Supreme Court has been proactive in guaranteeing the human rights of sexual minorities and disadvantaged group. It has issued directive order to the government to introduce law that provide equal rights to LGBTI as well as mandatory order to maintain confidentiality on all court proceedings and hearing of cases related to girl trafficking, rape, HIV and AIDS related and sexual violence.

Service outlets for VCT, ART, PMTCT, STI and OI treatment have increased so are its utilisation. Now over 1100 people are receiving free ARV from 17 different sites spread over different part of the country.

The HIV prevalence among FSW appeared to have stabilised around 2% and declining trend of HIV prevalence among IDUs from 51% in 2005 to 34% in 2007 is also noteworthy. MSM and returned migrants have 3.3% (2007) and 1.9% (2006) HIV prevalence respectively. All these positive trends can be attributed to the consistent expansion of prevention, treatment and care programme over the period. The challenges however, is to expand the current level of intervention to maintain or improve the current trends. Besides, operational issues like staff turnover, limited capacity both at public and private (including NGOs) sectors needs to be considered.

While the service outlets are increasing, the coverage of programme to needy people varies. In 2006-7, only 38% of FSWs were reached by the programme. Likewise, 76% of IDUs, 48% clients of FSW and 23% of MSM were reached by prevention programme in 2007. Prevention programmes among MSM and migrants are more recent and show lower coverage (only 13.9% of migrants in the Far West were reached) compared to some of the more mature programmes. Data also show about 2% coverage of PMTCT from current 11 sites. The blood safety programme is fairly stable with a total of 115,720 blood units were collected by the blood banks in 2007 in

52 districts (out of 75 districts in the country), and all were screened for HIV resulting in 100% coverage. Besides, by 2010 some 165,000 people will be in need of STI services.

Although general awareness of HIV and AIDS is generally high, comprehensive knowledge on HIV and AIDS, as defined by the UNGASS indicator, remains comparatively low among populations groups, especially those most-at-risk. The condom use however is consistently high among the most at risk population, with 77% of FSW (2006) reporting use of a condom with their most recent clients. Likewise, 93% of MSWs, 71.8% of MSW and 64% of IDUs (2007), reported the same, whereas only 12% (2006) of migrants reported using a condom. Self-reported safe injecting behaviours among IDUs seemed high with 95.6% of IDUs interviewed reporting using a sterile needle the last time they injected. When this figure is further analysed, it revealed that almost two thirds of IDUs (66%) purchased new needles compared to 27.6% who obtained one from NGOs.

The life skills based education programme implemented by the Ministry of Education has expanded in the past two years with support from UNICEF in over 20 districts. In 2007, youth and adolescents were provided life-skills based education (LSBE) through formal curricula and peer education. While 3.1% (880/27,888) of all schools provided LSBE in 2006, this has increased to 5.6% in 2007.

Overall, ART coverage has expanded markedly with over 1100 PLHIV receiving ART now since the last UNGASS reporting period, when only 160 PLHA (of whom 30% were women) were receiving ART. It is envisaged that the recently approved GFATM round 7 proposal will contribute to this expansion and support an increased number of PLHIV on ART.

Overall national composite policy index has improved both in terms of policy development and human rights situation for PLHIV and the vulnerable population. However, policy coordination, donor harmonisation, multisectoral programming and decentralisation are some of the policy related areas that need proper attention.

National response has received strong support from EDPs particularly from UN Agencies, USAID, DFID and The Global Fund. Moreover, the government has also increased its budgetary allocation for HIV and AIDS programme.

I. Status at a glance

A. Preparation of UNGASS progress report 2008

The report was prepared on the basis of an inclusive and consultative process, led by the National Centre for AIDS and STD Control (NCASC), the national agency mandated to lead, manage and coordinate the response on HIV/AIDS and other STDs in Nepal. Support for the report preparation was provided by the Strategic Information Technical Working Group (SI-TWG), comprising civil society, development partners and other technical experts. A range of civil society actors were engaged throughout the process.

In response to a request from the NCASC to initiate the UNGASS Report 2008 development, the SI-TWG in August 2007, drafted a roadmap, identifying overall activities, modalities and roles and outlining data needs, possible data sources and measurement tools required to generate and analyse the data required to report on UNGASS indicators. Responsibilities, technical lead and timelines were also specified. Existing data were carefully reviewed by the SI-TWG and several consultations and meetings were held to discuss data quality and results as well as the implications of the findings. Consultative processes undertaken included the following:

- Briefing meeting of key stakeholders on the way forward to prepare UNGASS 2008 country report.
- NCASC and SI-TWG sub-group meetings to develop roadmap to review data needs and existing data available (There are 2 subgroups, namely: 1) Prevention; and 2) Treatment, Care and Support)
- Meetings of the full SI-TWG (with both sub-groups present) to review methodology and to refine and finalise data and indicators. In addition to government representatives and other development partners, it included civil society members as well as representatives of specific MARP and vulnerable population (eg. IDUs, MSM, FSW, migrants).
- A national consultation meeting to share available data for UNGASS indicators, and offer an opportunity for additional information to be shared, agree on data sources and discuss data quality.
- Formation of an ad-hoc national Task Force including representatives from different ministries, civil society and development partners established to oversee and finalise the UNGASS country reporting.
- National consultation for the National Composite Policy Index (NCPI) and National AIDS Spending Assessment (NASA)

A full report on the process is included in Annex

B. Status of the epidemic (in summary)

The epidemic in Nepal is driven by injecting drug use and sexual transmission. There are numerous social, economical and cultural factors that drive the injecting and sexual behaviours among various most-at-risk groups. Given the nature of Nepal's concentrated HIV epidemic the focus of the response has been maintained with prevention programmes targeting most-at-risk-populations scaled up significantly and roll out of care, support and treatment programmes for People Living with HIV and AIDS also expanded.

Since the first reported case in 1988, a total of 10,369 HIV positive cases had been reported to the National Centre for AIDS and STD control (NCASC) as of November 2007. The largest number of HIV positive cases in the last 18 months was reported among 30-39 and 24-29 years old and 42% of HIV cases reported was among men and women aged 30 to 39 years old while 22% were among young men and women aged 24 to 29 years old. National level cumulative data shows 1578 cases of AIDS and 423 AIDS deaths reported. The sex ratio among HIV positive cases is 2.9:1 (m:f).

While data reported to the NCASC offers some perspective on HIV cases, recent estimates show that 41% of all HIV cases in Nepal are among seasonal labour migrants, 16% among clients of sex workers and 21% are wives or partners of HIV positive men (preliminary data, NCASC, 2007). Figures indicate a prevalence of 0.48% in the adult population in Nepal.

C. Policy and programmatic response; (in summary)

HIV and AIDS has been accorded “priority 1” in the Three Year National Plan (2008 – 2010). It means that line Ministries could submit proposal on HIV/AIDS program to the national government and funding will be provided. Moreover, the National Health Sector Programme Implementation Plan (NHSP-IP 2005), Poverty Reduction Strategy Paper (PRSP) and United National Development Frameworks (UNDAF) have included HIV and AIDS as key component of the plan. The current National HIV and AIDS Strategic plan (2006-2011) is the third strategy in the line. The first effort towards developing strategic approach to the epidemic was started in 1997 with Strategic Planning to HIV/AIDS (1997-2002). There is a significant improvement in the strategy both in terms of participatory process followed during the development and the multi-sectoral emphasis to include non health sectors and traditionally non-health partners. The marked improvement seen at the policy and political level in understanding and realizing the urgent need to implement effective programme, is gradually being translated into action.

Some of the note-worthy initiatives have been taken for development of policies: (1) National Workplace Policy, (2) National Policy on Drug Control (2006), and (3) Established Nepal Policy Advocacy Panel on HIV/AIDS, Nepal Leadership Forums on HIV/AIDS (youth, women and media), HIV/AIDS and Human Rights Forum (some 19 different civil society organisations collaborating) to advocate Human Rights and work as pressure group, Policy Champions – a team of people who are socially influential and recognised as leader in their respective field – who supports policy advocacy in HIV and related issues, are in place in order to strengthen and intensify leadership actions at all levels on the issues around HIV and AIDS. Nepal has also made achievement in some of the legal amendment related to HIV/AIDS. They are: (1) The Supreme Court has ordered the government to promulgate laws to ensure confidentiality in the judicial process for cases involving people living with HIV. Clearly, now the Supreme Court of Nepal has recognized LGBTIs as natural persons. The Court issued directive orders to Nepal government to ensure rights to life according to their own identities and introduce laws providing equal rights to LGBTIs and amend all the discriminatory laws against Lesbian, Gay, Bisexuals, Transgender and Intersexes (LGBTI's).

Overall programme coordination still largely rests on the National Centre for AIDS and STD Control (NCASC)), a centre under the Ministry of Health and Population despite the presence of coordinating bodies like National AIDS Council (Chaired by Prime

Minister) and National AIDS Coordination Committee (Chaired by secretary of Health and Population). Because of structural limitation of the NCASC in multi-sectoral coordination with institutions and programme outside health purview, Government has recently formed a *HIV/AIDS and Sexually Transmitted Disease Control Development Board*, commonly known as Semi Autonomous Entity (SAE) and has mandated, among others, to formulate policy, resource mobilisation, oversee/monitor program implementation, coordinate and manage overall response on AIDS and support a massive awareness and education program on HIV and AIDS.

Nepal's national programme is well-targeted at most-at-risk populations, and in Nepal's context these are: IDUs; MSM, FSW and MSW, clients of FSW, and seasonal labour migrants. Need based and tailored to the specific characteristics of the population group is the main thrust of the programme. Primary prevention is also given a high priority aiming at increasing secondary prevention for those who are already infected. A large part of the prevention programme is currently supported by three major grants from USAID, DFID and the GFATM (Round 2), with activities being implemented by a sizeable number of community based organisations and national NGOs.

Table 1: Budget allocation by categories (2006-2008)

Resources by categories	Budget (US $)	Budget %	Pledged estimate	Gap %
MARPs	28,717,895	44.8	14,122,250	50.8
Youth	10,830,000	16.9	1,990,984	81.6
ARV	3,883,880	6.1	2,783,079	28.3
Gen Population	2,585,900	4.0	595,011	77.0
Capacity	5,033,000	7.9	4,229,394	16.0
Policy, Mgmt	2,658,136	4.1	2,547,624	4.2
PLHAs	4,392,000	6.9	2,660,934	39.4
VCT	2,564,500	4.0	3,245,879	-26.6
Precaution	1,258,700	2.0	332,511	73.6
PMTCT	1,146,276	1.8	573,983	49.9
Children	1,040,000	1.6	283,000	72.8
Total	**64,110,287**	**100**	**33,364,649**	**48.0**

Source: National Action Plan 2006-8

Service outlets have increased noticeably over the period both at the public sector and at the non state sectors (mainly through NGOs). There has been a notable expansion in the numbers of clinics treating Sexually Transmitted Infections (STI) and Voluntary Counselling and Testing (VCT) and ARV centres offering services for key target groups such as FSW and clients, MSW, MSM, IDUs and migrant workers as well as for PLHAs. Given the geographical terrain, compounded by the lack of adequate information about the services greatly limits the access and full utilization of available services.

Two year National Action Plan (2006 – 2008) highlighted the key programmatic needs and available resources (Table 1 above) indicating financing gaps in certain key areas. A note of clarification on higher pledged amount than the budget on VCT allocation is that it also includes some of the treatment and care costs.

D. UNGASS Indicators: Nepal Country Report Overview

Table 2: Country overview in figures

UNGASS Indicator *(main sites)*	**Value (2006-07)** *(age dis-aggregations where available)*
IMPACT	
Most- at- risk populations who are HIV infected *(Indicator 23)*	**FSW-** (1.4%) **MSW**- (2.9%) **IDU-** (34.7%) **MSM**- (3.25%) **Clients of FSW**- (1%) **Migrants**- (1.9%)
Adults and children with HIV still alive and known to be on treatment 12 months after initiation of ART *(Indicator 24)*	(84.86%)
Infants born to HIV infected mothers who are infected *(Indicator 25)*	*(missing data cannot be reported accurately *Loss to follow-up is high **(Important to NOTE for the development of future strategies/NAP)**
PROGRAMME COVERAGE	
Donated blood units screened for HIV in a quality assured manner *(Indicator 3)*	(100%)
Adults and children with advanced HIV infection receiving antiretroviral therapy *(Indicator 4)*	(6.46%)
HIV positive pregnant women who received antiretroviral to reduce the risk of mother-to-child transmission *(Indicator 5)*	(1.61%) 2006 (1.44%) 2007 (Need to address this too, in future NAP)
Estimated HIV-positive incident TB cases that received treatment for TB and HIV *(Indicator 6)*	(5.8%)
Most-at-risk populations that have received an HIV test in the last 12 months and who know their results *(Indicator 8)*	**FSW-** (36.8%) **MSW**- (51.85% **IDU-** (21%) **MSM**- (30%) **Clients of FSW**- (11.1%) **Migrants**- (3.2%)
Most-at-risk populations reached with HIV prevention programmes *(Indicator 9)*	**FSW-** (38.6%) **MSW**- (55.56%) **IDU-** (78.33%) **MSM**- (46.75%) **Clients of FSW**- (48.5%) **Migrants**- (13.9%)

UNGASS Indicator *(main sites)*	**Value (2006-07)** *(age dis-aggregations where available)*
Schools that provided life skills-based HIV education in the last academic year *(Indicator 11)*	(5.67%)
KNOWLEDGE AND BEHAVIOURS	
Most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission *(Indicator 14)*	**FSW-** (30.2%) **MSW**- (40.7%) **IDU-** (66%) **MSM**- (44.5%) **Clients of FSW**- (50.5%) **Migrants**- (19.2%)
Young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and reject major misconception about HIV transmission *(Indicator 13)*	(35.6%)
Female and male sex workers reporting the use of a condom with their most recent client *(Indicator 18)*	FSW- (77.2%) MSW- (93%)
Men reporting the use of a condom the last time they had anal sex with a male partner *(Indicator 19)*	(73.5%)
Injecting drug users reporting the use of a condom the last time they had sexual intercourse *(Indicator 20)*	(37.67%)
Injecting drug users reporting the use of sterile injecting equipment the last time they injected *(Indicator 21)*	(96.33%)

***Note**: due to the change in the UNGASS indicator definition, program coverage for FSWs appears lower than it actually is.*

II. Overview of the AIDS epidemic

Since the first AIDS case was reported in 1988, the HIV epidemic in Nepal has evolved from a "low prevalence" to a "concentrated epidemic". As of 2007, national estimates indicate that approximately 70,000 adults and children are infected with HIV in Nepal, with an estimated prevalence of about 0.49% in the adult population (15-49 years old). As of November 2007, a total of 10,369 cases of HIV, 1578 AIDS cases and 423 AIDS deaths had been reported to the National Centre for AIDS and STD control (NCASC). The sex ratio among HIV positive cases is 2.9:1 (m:f).

Nepal's HIV epidemic, driven by injecting drug use and sexual transmission, is characterized by higher HIV prevalence concentrated among high-risk groups whose sexual or drug use behaviour places them at high risk of infection. Prevalence among IDU is still well above 5% (34% in Kathmandu[1]; 8.7% in Pokhara) while among FSW and their clients, MSW, MSM and returning migrant, it remains above 1.5% *(see detailed breakdown in* Table 3 *below)*.

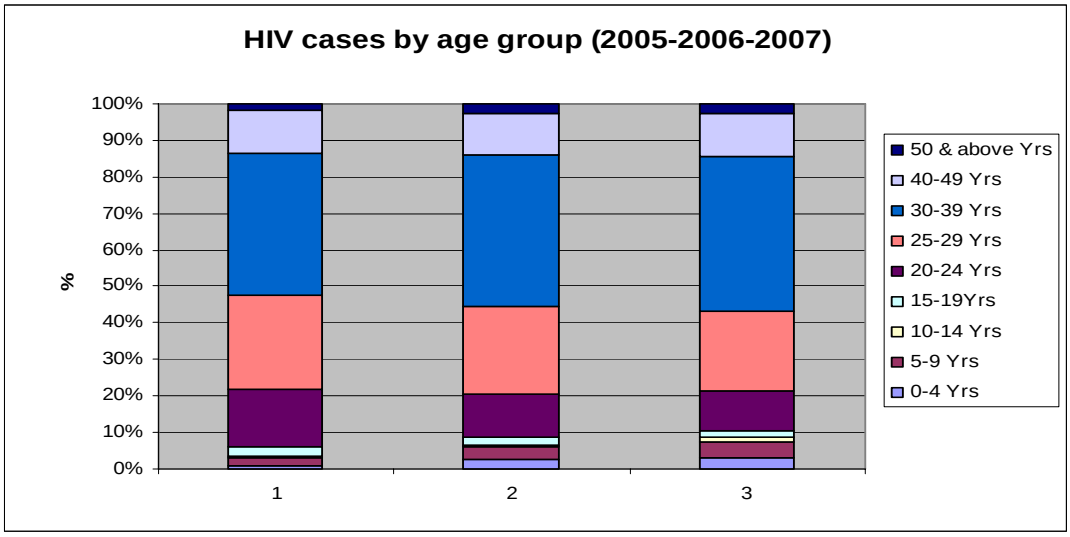
Table 3: HIV prevalence among MARPs

Most at risk populations who are HIV infected: HIV Prevalence *(main sites) (Indicator 23)*					
	2001	**2004**	**2005**	**2006**	**2007**
FSW (Kathmandu)		2		1.4	
MSW (Kathmandu)		4.8			2.9
IDUs (Kathmandu)	68		51.6		34.7
MSM (Kathmandu**)**		3.9			3.25
Clients of sex workers (Terai Highway)		1.7		1	
Returned migrants (West and Mid to West Nepal)				1.9	

Source: IBBS (2001-2007)

The majority of reported HIV infections in the country are among the most productive part of society which is the 25 to 39 age group.

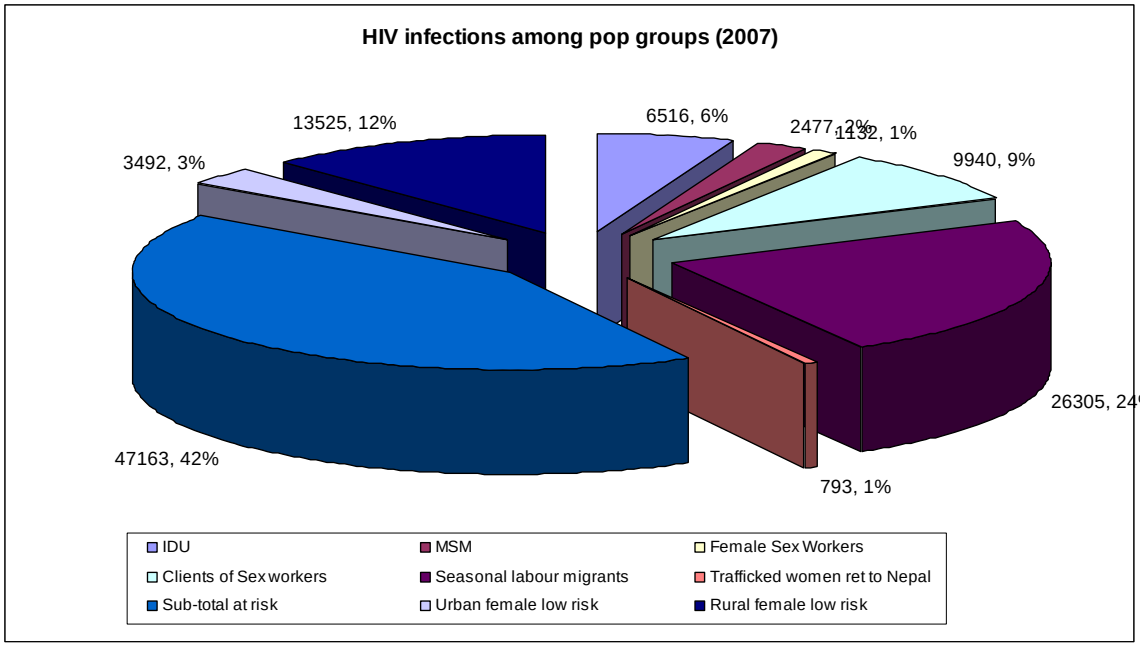
Figure 1: HIV cases by age group



[1] IBBS IDU Kathmandu 2007 (full reference to be provided by FHI)

Similar to other countries in the region, IDUs, MSM and FSW are the groups most at risk (for receiving and further transmitting the HIV virus) with highest HIV prevalence but additional groups in Nepal such as seasonal labour migrants have important bridging role with the general population. Of all adults estimated to be living with HIV, a major proportion of HIV infections has consistently been among migrant workers travelling mostly to India for work. In 2005, 46% of estimated HIV infections in Nepal were among seasonal labour migrants to India and similar pattern is found in 2007. Clients of sex workers account for 19% of HIV infections in 2005 and 16% in 2007. Spouses or female partners of migrant workers and clients of sex workers now account for 26% of all adult infections. A 2006 study among Nepali migrants travelling to Indian cities for work found that 27% of men engaged in high risk sexual behaviours while in India, and frequently visited sex workers.

Figure 2: Estimation of HIV infections (2007)*:*



Source: NCASC, UNAIDS, WHO, USAID/FHI, 2007

Key factors that shape the dynamics of the epidemic include:

- Population mobility and migration: although there is insufficient evidence to say that the in-country conflict has had a direct effect on the risk of HIV, there is evidence that political conflict and economic hardship have placed added burden and strain on already vulnerable households and individuals, leading them to move from their homes within or out side Nepal[2], exposing many to the potential risks of infection.
- Extreme vulnerability of women: the vulnerability of women in rural areas to HIV infection is compounded by low education levels, inferior status in society and difficulties negotiating condom use with spouses returning from overseas work. Estimated HIV cases among low-risk women in rural and urban areas now comprise 21% of all infections. These are largely the spouses or partners of returning migrant workers or clients of sex workers. These women are often the least educated and least empowered and evidence shows that fewer than one out of ten migrants (0.3%) use condoms with their spouses (9.7%).

[2] *HIV and conflict assessment, 2006*

- Trafficking of women and girls to India: large numbers of women are trafficked to work in brothels in India, especially Mumbai. A study indicated 22 to 38% of young Nepalese women trafficked to India and returning to Nepal were found to be HIV positive[3]
- Routine reporting to the NCASC shows an increase in the number of reported AIDS among children from 54 in 2005 to 199 in 2006. Estimates indicate that 2,500 children aged 0-14 are currently infected with HIV,

Spread and impact of the epidemic

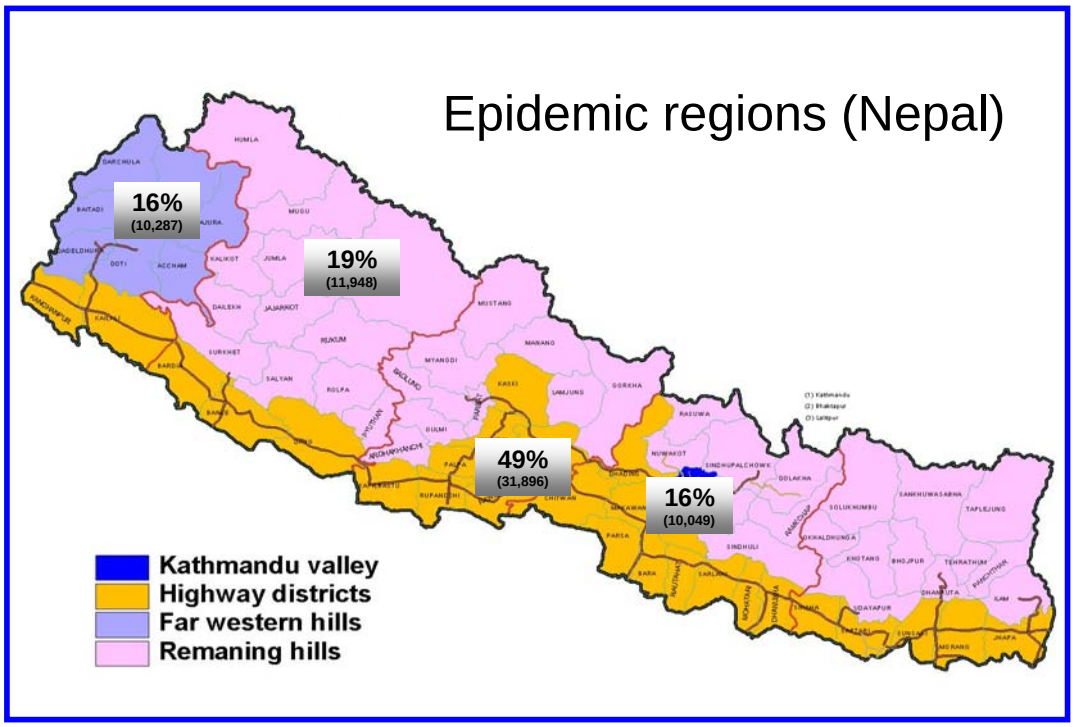
As part of the national HIV surveillance, Nepal tracks the trends of its epidemic in 5 population groups and in 4 distinct epidemic regions/zones, corresponding to differences in the nature of the epidemic and to transmission dynamics.

The four zones are: 1) Kathmandu, capital city where IDUs, FSW, and MSM are sampled every two years (3 districts); 2) Terai highway, a trucking route running the length of the country and linking Eastern parts of India with Darjeeling where data on female sex workers and client is gathered from surveys (22 highway districts); 3) the Far Western hills, where most Nepali migrant workers to India originate from and, 4) 39 remaining districts which are mountainous and more remote areas with lower overall population numbers but from where large numbers of Nepali are said to migrate within Nepal.

The highest burden of the epidemic is shared by the highway districts where 49% (i.e. 31,856 estimated) people with HIV are living followed by Mid Far West region of the country which housed almost 19% of total people living with HIV. The other two regions, East and Far West share equal numbers i.e. 16% (Please refer to map below)

Figure 3: Epidemic regions (Nepal)

[3] *Silverman, 2007*



A. Impact of the response: HIV prevalence among groups at highest risk

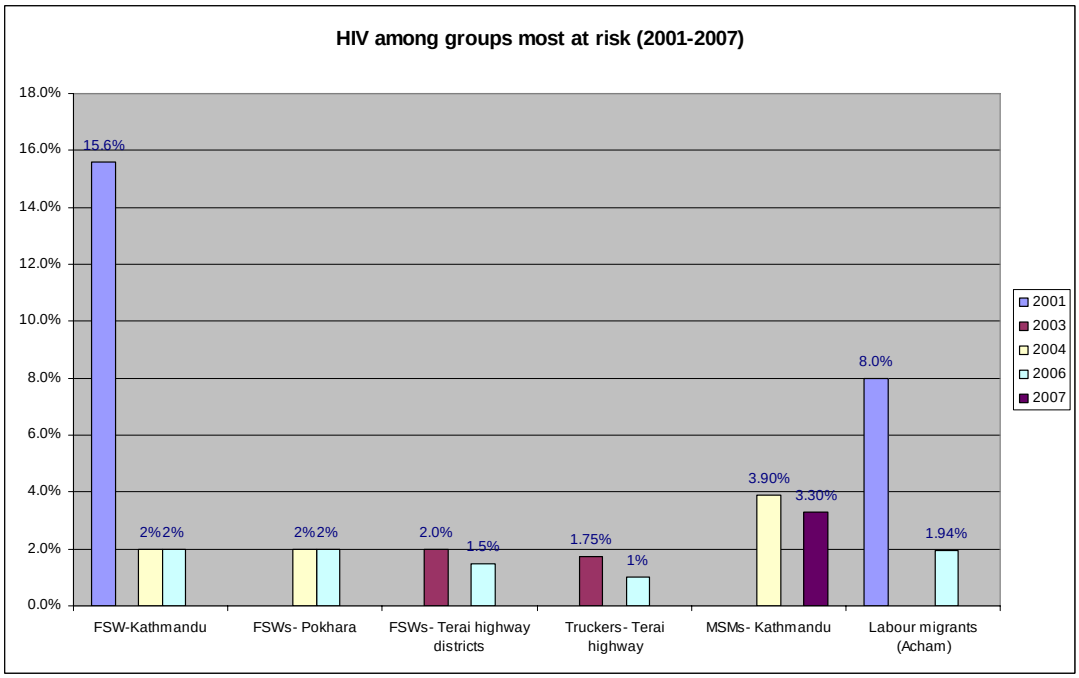
(eg. total of five groups targeted by the response.

(Now we have 5 groups being targeted because MSM and MSW are separated).

For the purpose of this report, IBBS data has been used, keeping in mind limitations highlighted in the Monitoring and Evaluation section (Ch VII) of this report. Recent data in Kathmandu show lower HIV prevalence in four out of five groups most at risk. HIV prevalence levels appear to have reduced among a number of groups at high risk, as summarised in the table below.

The most dramatic change is among IDUs, where there has been a significant drop in HIV prevalence from 68% to 34% over a six-year period. Moreover, IBBS data shows that prevalence rates for FSW have decreased significantly in the 16 eastern Terai highway districts. Exchanging sex for money along the trucking routes are characteristic feature of HIV infection in these plains regions bordering India. In 2006, HIV prevalence among FSW in Kathmandu was 1.4% down from 2% in 2004. A similar fall in prevalence was observed among FSW in the Terai highway districts from 3% in 2003, 2% in 2004 to 1.5% in 2006.

Figure 4: HIV among groups MARPs



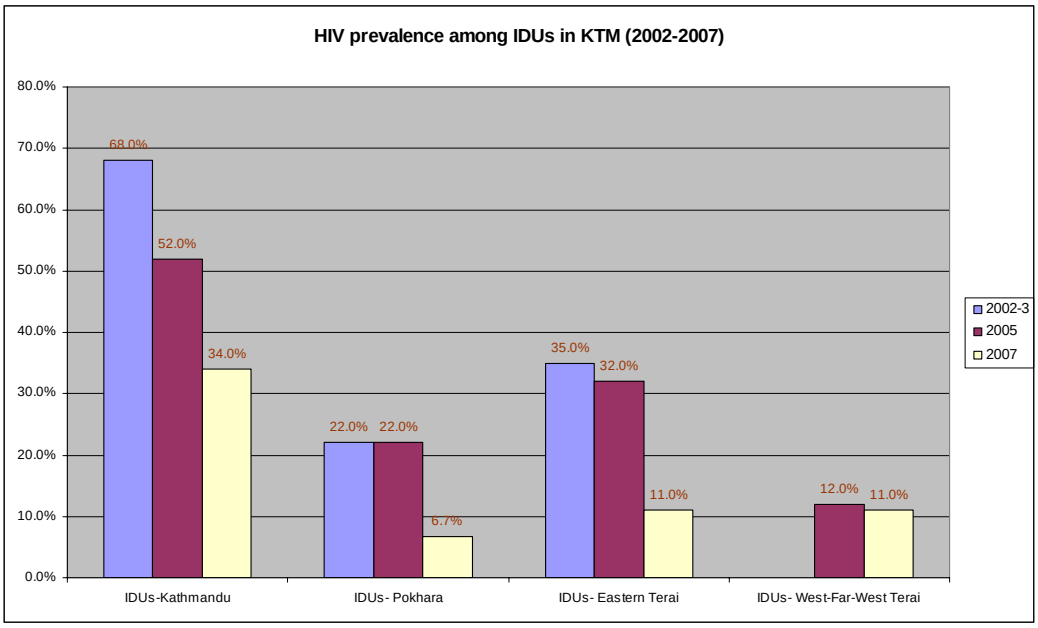
Note:

In the graph above, the FSW data for Kathmandu valley up to 2001 was based on small and purposive sampling and is therefore only for information. Graph should not be compared with IBBS trend shown for later years and any conclusions drawn regarding such differences of data prior to IBBS.

These downward figures correspond to a sizeable expansion of targeted prevention programmes for IDUs, MSM, FSW, clients and migrant workers since 2005.

In view of the consistency in sites sampled and survey methodology used, the dramatic drop could be attributed to this expansion and acceleration of prevention, treatment, care and support activities and targeted-intervention services in the past 2-3 years.

Figure 5: HIV prevalence among IDUs in KTM (2002 – 2007)



B. Impact of the response: Antiretroviral therapy treatment outcomes

The national antiretroviral treatment programme was started late in 2004 in the public sector in Kathmandu. By October 2007, 1142 patients with advanced HIV infection were on treatment in 16 public sector sites across the country, a substantial expansion of ART sites from two at the start of 2004.

By November 2007, a total of 1240 people with HIV eligible for ARV therapy had started treatment, of which 1189 were adults and 51 children. The overall survival within the cohort was 85%. As of November 2007, 185 patients had started on ART and completed 12 months of treatment in the previous 15 months. 157 of these patients were still alive 12 months after initiation of ART. While this is relatively high in the earlier stages of an ART programme, in Nepal, however, because of the strong advocacy of the NGOs and PLHIV, there was CD 4 available early in the treatment course. This may have supported better monitoring and earlier entry to ART, leading to longer survival time. Treatment was initially started in Teku and TUTH hospitals and district hospitals were developed and included in later years.

Following the rapid and considerable expansion of the ART programme in Nepal, achievements will need to be consolidated and the quality or care and monitoring reviewed to increase the chances of patients survivals. While the chances of patients survivals should increase as they start treatment earlier, caution will be required to maintain adherence, standards on rational use of ARVs and continuum of care as well as regular reporting from all sites.
A number of challenges will need to be addressed to further intensify the programme, including staff turnover, continuous capacity development and effective use of strong monitoring and evaluation data to inform programming decisions. The ART recording and monitoring system in Nepal is adapted from standard WHO guidelines and tools. Information was collected from the pre-ART, ART registers and patient records. The data collected covers the period October 2006 to September 2007. Although it does provide dis-aggregation between children and adult patients, reports unfortunately do not fully allow sex or age dis-aggregation. While health workers in all treatment sites have been trained in recording and reporting procedures, improvements are much needed. High and rapid staff turnover and fast expansion of ART services result in less or non- internalization of this recording and reporting. Regular follow up, supervision and mentoring will continue to be important to ensure that strategic information is not only available but more importantly also for quality primary patient care and proper planning (clinical management and drug stocks) at site level.

While significant progress has been made in the supply, management and logistics related to HIV commodities (ARVs, STI drugs, condoms etc.) with the setting up of a system for the management of supply and commodities (supported by USAID), the consolidation and further expansion of the ART programme will require increased attention to a systematic and sustainable forecasting of the drug supply.

III. National response to the AIDS epidemic

A. National Commitment and Action

Substantial progress was made in this reporting period with respect to national commitment and strengthened and accelerated response to address the HIV epidemic in the country. Major highlights include:

- HIV and AIDS have been recognised as a priority in the new interim three year development plan.(National Interim Plan, National Planning Commission 2008 – 2010)
- Significant progress made in adopting the "Three Ones" principles, namely one agreed HIV/AIDS action framework, one national AIDS coordinating authority, and one country level monitoring and evaluation system.
- Strengthening of institutional arrangements to support the national HIV/AIDS response, including the establishment of several technical working groups, such as SI-TWG (with 2 subgroups), management of logistics and supplies, and Harm Reduction. Plans are underway to form working groups for treatment and care and for prevention.
- Substantial scaling up of treatment, care, support and prevention programmes.
- Securing of increased financial resources for the sector as indicated by (an increased commitment in government budget) and a successful application to the Global Fund, Round 7. GFATM Round 7 grant amounts to 36.6 million $US for HIV and covers gaps identified in the response, such as expansion of prevention among migrants, MSM and IDUs, treatment care and support as well as health sector strengthening.
- Progress made in strengthening capacity, especially related to development of enhanced and accelerated national leadership among women, youth and national policy makers.
- Formation and registration of networks of MARP, e.g. sex worker organisations, network of positive persons, organization of women living with HIV, etc.

Adopting the "Three Ones"

With respect to the "First One" which is the one agreed HIV/AIDS action framework, the Government of Nepal developed a comprehensive new national HIV/AIDS strategy (2006-2011). The new Strategy builds on the previous national strategy (2002-06) and outlines enhanced and more focussed commitment for tackling the HIV/AIDS epidemic, consistent with Universal Access targets and Millennium Development Goals. The new strategy was developed with participation of key stakeholders, including development partners and civil society. The main goals targeted by 2011include:

- ensure coverage of 70-80% of most at risk populations (injecting drug users, sex workers, men who have sex with men, migrants and STI patients) with prevention programs and reduce the number of new HIV infections occurring among the general population,
- ensure universal access to quality treatment, diagnostics, care and support services for infected, affected and vulnerable groups in Nepal within the context of a comprehensive response to HIV and AIDS,

- implement a comprehensive legal framework on HIV/AIDS to promote human rights and establish HIV/AIDS as a development agenda,
- enhance leadership and management at national and local levels for an effective response to HIV and AIDS,
- improve data systems, compilation and use of strategic information to support decision-making, planning and implementation for an effective response,
- increase sustainable financing and effective utilization of funds.

The six key programme areas and strategic outcomes identified within the strategy include:

a). Prevention

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

b). Treatment care and support

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

c). Advocacy, policy and legal reform

- HIV/AIDS prioritized as national development agenda and included in 11th Five Year Plan as program under the social sector,
- Rights of infected, affected and vulnerable groups insured through an effective legislative framework,
- Networks of PLHA and most at risk populations operational,
- HIV response decentralized and coordinated, and
- Multi-sectoral response to HIV/AIDS strengthened and expanded.

d). Leadership and management

- operationalised national strategy through the National Action Plan,
- active champions and leaders at the societal, institutional and individual levels for the HIV/AIDS response,
- mainstreamed HIV/AIDS programs in selected development sectors,
- enhanced social inclusion, equitable access and gender equality to AIDS services,

- coordinated and decentralized response to HIV/AIDS.

e). Strategic information

- trends and changes in HIV prevalence and HIV and STI related risk behaviours among different risk groups tracked over time and across regions in Nepal;
- effectiveness of HIV prevention and care interventions and activities monitored and evaluated;
- all aspects of key programme service delivery areas effectively monitored and evaluated;
- programme coverage and service delivery assessed by target group; and
- resources inputs and outputs contributing to the programme monitored.

f). Finance and resource mobilisation;

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

To support the implementation of the national strategy, a *National Consolidated HIV/AIDS Work Plan, 2006-2008* was developed. The work plan outlines resource needs, current commitment from various partners and resource gaps for individual strategic actions. It also includes agreed core national monitoring indicators. The plan allows for a more coordinated and harmonised national response.

Major progress has been made with respect to putting in place the "Second One" – one national AIDS coordinating authority. Although, the NCASC, has remained the main coordinating body during this reporting period, the Government of Nepal has committed to the establishment of a new body called the HIV/AIDS and STD Control Development Board 2064 (2007 AD) also referred to as the Semi-autonomous Entity" (SAE)). This body will have enhanced status and authority, including a greater multisectoral remit and financial powers. This will enable better capacity to lead and manage an effective and sustained national response.

This period also reports substantial progress towards achievement of the "Third One" – one agreed country level Monitoring and Evaluation system. The *Monitoring and Evaluation Guidelines for HIV and AIDS in Nepal* were developed under the technical guidance of a monitoring and evaluation technical working group formed in May 2006 (the M&E and surveillance technical working groups were merged into a SI-TWG in early 2007). The guidelines outline a framework and main elements of an integrated national M&E system. This includes an agreed set of core indicators and system needed for generating the required data, including data sources and information flow, methods for quality control of information, roles and responsibilities at different levels, and finally capacity needs. The Guidelines also include a costed monitoring and evaluation plan specifying the steps required to put in place such an integrated national M&E system. The core national indicators have been included in the national work plan

2006-08, and partners have agreed to report progress on the basis of these new indicators. Baseline data have been established for each indicator. There is a good degree of harmony with selected national indicators and the UNGASS monitoring indicators.

As a result of the standardisation of indicators in 2006, a number of surveys now include questions that generate data required by the country to report on UNGASS (e.g. knowledge indicator in the DHS, coverage and behaviour indicators in Integrated Bio-Behavioural Surveys). A detailed implementation plan is being developed in collaboration with the NCASC to operationalise the M&E system, including pilot-testing of the M&E system in selected districts before roll out.

B. National Programmes

Given the nature of Nepal's concentrated HIV epidemic, the focus of the response has been maintained with prevention programmes targeting MARPs scaled up significantly, and roll out of care, support and treatment programmes for PLHIV also expanded.

Despite delays in endorsing the new National Strategy 2006-11 and Work Plan 2006-8, they have extensively guided the programmatic response over this reporting period. A recent analysis carried out in early 2007 for the development of the GFATM Rd7 proposal also identified programmatic gaps that will be addressed with support from, among others, the GFATM in the Round 7 grant.

1. Prevention programme: Coverage

As mentioned earlier, HIV prevention has remained a high priority in Nepal. Overall, the national programme is well-targeted to most-at-risk populations with a focus on IDUs; MSM, FSW and MSW, clients of FSW, and seasonal labour migrants. Primary prevention is given a high priority aiming at increasing secondary prevention for those who are already infected. Prevention program for people living with HIV has also now been introduced. Targeted interventions for most at risk populations accounted for 44% *(source: NAP 2006 -2008)* of the national HIV/AIDS budget over this period. A large part of the prevention programme is currently supported by three major grants from USAID, DFID and the GFATM (Round 2), with activities being implemented by a sizeable number of community based organisations and national NGOs. Other development partners like GTZ, INGOs and UN agencies support selected prevention services. Condom promotion and distribution, behaviour change communication, STI treatment and VCT for high-risk groups are implemented by over 200 national NGOs and networks.

There has been a notable expansion in the number of clinics managing Sexually Transmitted Infections and Voluntary Counselling and Testing centres offering services for key target groups such as FSW and clients, MSW, MSM, IDUs and migrant workers. 106 VCT centres now operate in the NGO and public heath sector, up from 7 in 2005. STI service delivery has also expanded from 132 (57 NGO-based and 75 public sector sites) in 2006 to 155 (80 NGO and 75 public sector sites) in November 2007.

The treatment of STI in Nepal is also provided by NGOs, the private and informal sector, including pharmacies and the public sector. A total of 60,096 clients were treated for STIs in the past year (2007) with 40,456 reported treated in the NGO sector and 19,640 cases reported by the public sector services. Female Sex workers and female and male clients in the mid-western region accounted for 76% (30,521 cases) of all STI cases treated in the non-government sector.

Table 4: Unmet need for STI services

	Programmatic Gap Analysis							
	Actual		Anticipated					
	2005	2006	2007	2008	2009	2010	2011	2012
TOTAL UNMET NEED: STI								
Unmet need for STI services	15,629	152,535	54,730	77,964	13,6010	164,540	192,980	196,280

Source: GFATM Round 7 Proposal (successful proposal) June 2007

Most NGO-run STI clinics are generally equipped with trained service providers and have in place mechanisms to report STI cases regularly (to their funding agency). Additionally, STI drugs, condoms, laboratory tests, education and counselling are available to STI patients at most NGO facilities, which also conduct outreach and peer education activities targeted at most at-risk populations (MARP). Existing public health infrastructure serves a large part of the general population including the poor and marginalised. A review in 2006 revealed key areas where the National STI Programme should be strengthened:

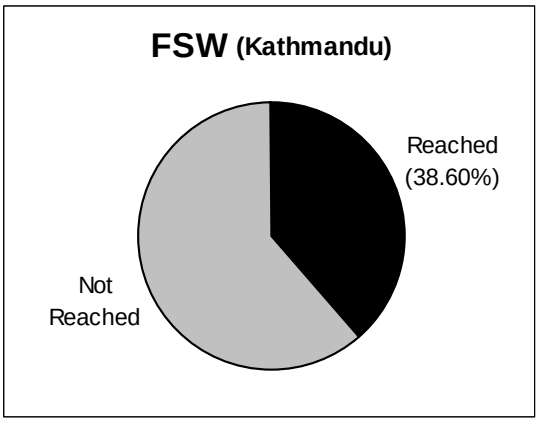
1. Increase government's political and financial commitment for the STI programme as a government priority
2. Strengthen public health sector delivery in STI management including training, facilities, logistics including STI drugs and condoms
3. Strengthen STI as an essential entry point for HIV prevention and integration with reproductive health, primary health care, family planning and related services
4. Develop effective monitoring and evaluation system
5. Support networks and coordination among service providers in other sectors
6. Ensure standard documentation and reporting system for national STI surveillance is in place.

The NCASC retains the responsibility of leading and guiding the STI programme planning and programming to provide quality treatment for low- and high- risk populations, while giving special attention to exit/transition strategies in order to improve sustainability and gradually reduce reliance on external support at all levels.

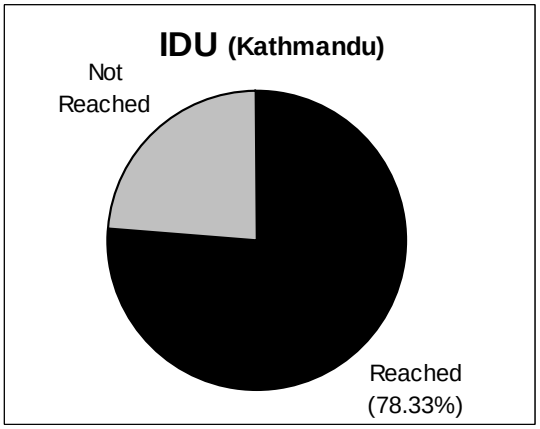
Key measures of progress in the HIV response are the degree to which programmes reach those groups at highest risk with prevention program, in particular. For female sex workers, clients, migrants and MSM, this includes among others, receiving condoms and information on confidential HIV testing. For IDUs, it likewise includes receiving clean needles and syringes.

Comparison of MARPs Reached with HIV Prevention Programmes *(Main Sites)*
Source: NCASC, USAID/FHI, NEW ERA, USAID (2006-07)

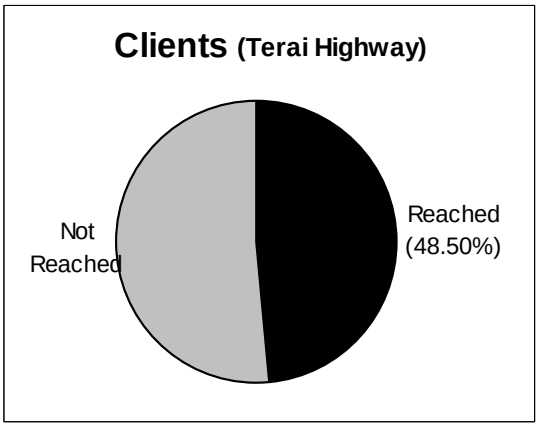
Figure 6: MARPs reached with prevention programme (=received condoms, knowing where to get HIV test and for IDUs only, received clean injecting equipment)



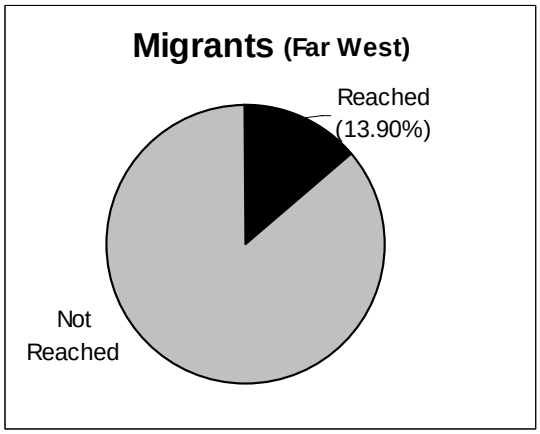
(33.8<25 yrs and 47.7% >25 yrs)



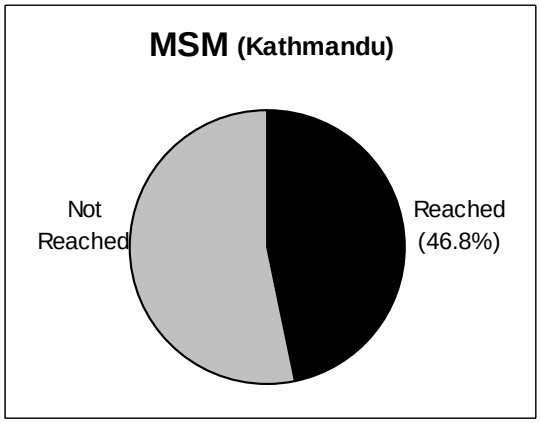
(72.7%<25 yrs and 82.6% >25 yrs)



(38.2<25 yrs and 53.1% >25 yrs)



Mid West: (4.8% <25 **and** 9.3% >25)
Far west: (20.7% <25 and 20.4% >25)



(45.3 %<25 yrs and 48.4%>25 yrs)

While it is generally accepted that coverage for female sex worker has increased, the figure of 38% from the 2006 IBBS in Kathmandu was thought to be in line with the 27-36% range obtained from nationwide routine data reporting.

Prevention programmes among MSM and migrants are more recent and show lower coverage compared to some of the more mature programmes. The 14% coverage among migrants highlights the need to significantly expand prevention and develop better strategies to reach larger numbers of Nepali migrants travelling to India for work. Coverage of prevention for MSM as reported in the 2007 IBBS shows a significant increase, from 10.3% in 2004 to 47.75% in 2007. Figures derived from routine reporting showed a national coverage ranging from 12% to 35.9% for the same group. It is useful to note that coverage among MSW was higher (55.7) than of MSM (46.75).

Dis-aggregation of this data below shows differences in programme coverage by age group. Coverage is higher for FSW above 25 years, as well as clients of sex workers above 25 years as they may often be more "established" and easier for programmes to engage with and reach. There is less disparity of service coverage between older and younger IDUs, MSM and migrants. Dis-aggregation by age group was not yet available for 2007 surveys due to specific analyses required for Respondent Driven Sampling methodology used.

Table 5: MARPs reached with prevention programme

MARPs Reached with HIV Prevention Programmes *(Indicator 9, UNGASS 2008 definition)*				
	2004	**2005**	**2006**	**2007**
FSW (Kathmandu)			33.8%<25 yrs 47.7%>25 yrs	
MSW (Kathmandu)				55.56%
IDUs (Kathmandu)		48%<25 yrs 54.3 > 25 yrs		78.33%
MSM (Kathmandu)	11.3 <25 yrs 9.3% > 25 yrs			45.75%
Clients of sex workers (Terai Highway)	38.2% <25 yrs 53.1% > 25 yrs			
Migrants to India (Far West and Mid West region)			**Mid West:** **Far west:** 4.8% <25 20.7%<25 9.3% >25 20.4% >25	

Source: IBBS, 2004, 2005, 2006 and 2007

Another key measure of progress in the response is the degree to which programmes reach those groups at highest risk by providing VCT for HIV. There is general evidence of an increase in coverage for all groups at risk, which has corresponded to an increase in resources generally available for HIV prevention and care services in Nepal and to the increase in availability of VCT centres throughout the country. The scale of the increase in coverage however is open to discussion. Unsurprisingly, the increase is more visible among well-defined population groups targeted by the response such as FSW (36.8%), IDUs (21%), MSWs (58.8%) and MSM (12.5%).

On the other hand, the much lower percentages reached among migrants (3.3%) and clients (11.1%) highlight the colossal challenges of reaching individuals in larger less well defined group as well as the need to develop more effective strategies to reach them.

MARPs who received an HIV test in the last 12 months and know their results *(Main Sites)*
Source: NCASC, USAID/FHI, NEW ERA, USAID (2006-07)

Figure 7: MARPS who are tested and know their results

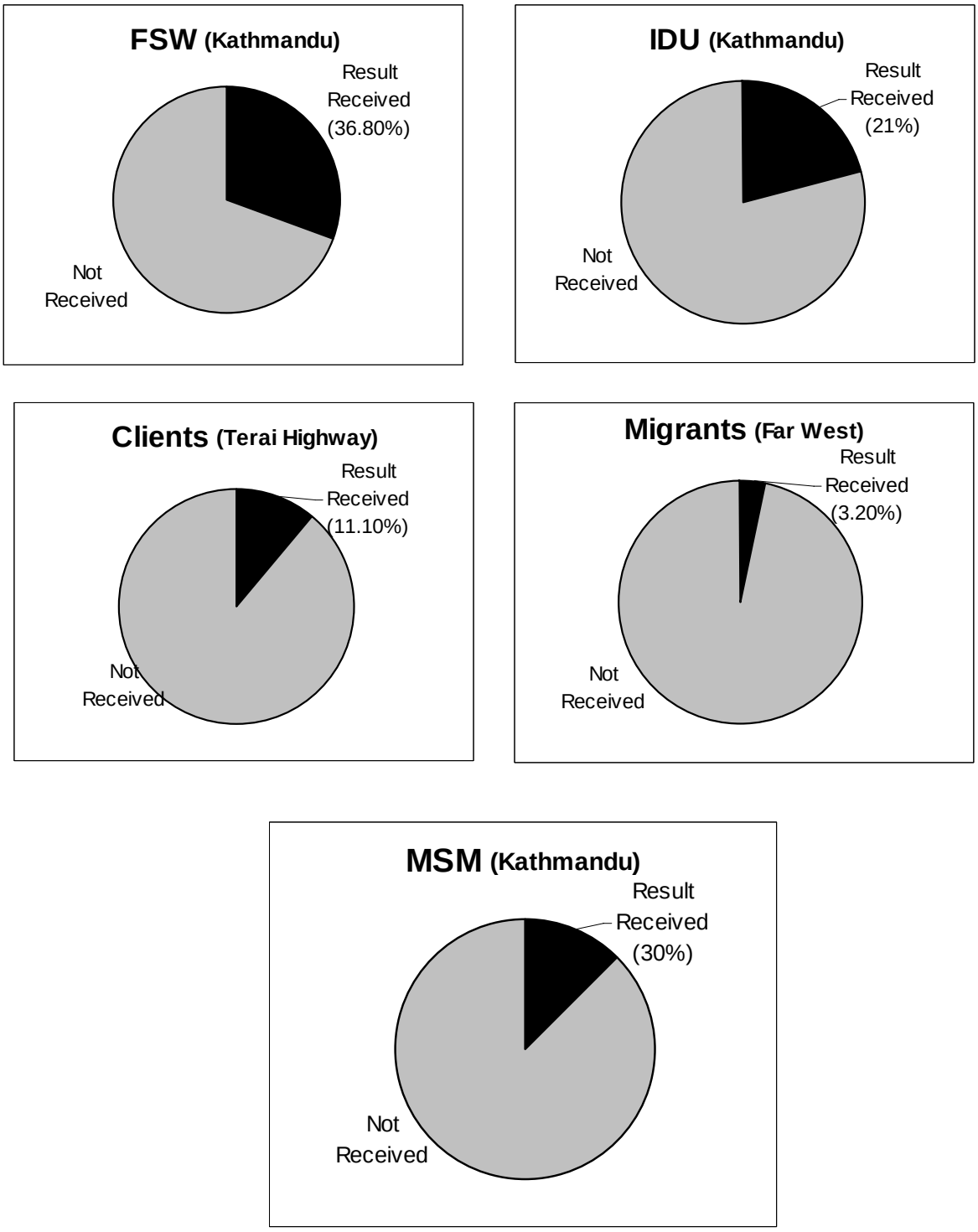


Table 6: MARPs tested and who know their results

MARPs who received an HIV test in the last 12 months and know their results *(Indicator 8)*				
	2004	2005	2006	2007
FSW			36.8%	
MSW	13.5%			51.85%
IDUs		5.23%		21%
MSM	7%			30%
Clients of sex workers		0.21%	11.1%	
Returned migrants		0.03%*	3.2%	

** UNGASS 2005 used routine data.*

Female Sex Workers

Programmes targeting FSWs are more mature and developed than other prevention programmes, targeting MARP both with respect to duration and reach. Activities include peer led education and behaviour change communication, STI service provision, and condom promotion and distribution.

The estimated number of female sex workers in Nepal is approximately 30,000. However, of these, almost a third (28%) or 8,500 are believed to be 'hidden' populations, very difficult to reach due to their remote geographical location or tenuous links with existing networks. These sex workers spread across isolated parts of the country and geographically remote areas might be receiving services in less "public' ways and may not be part of large networks. Therefore are likely to remain very vulnerable and exposed to STI including HIV infection. There is an agreement among the partners that discussions and estimates of national coverage need to reflect all individuals at risk and not only those who are visible or reachable.

Measuring national coverage of HIV prevention among groups at risk

National-level consultations and action planning in Nepal have considered different measures of coverage towards Universal access for high risk groups. While targets used at the national-level are the total population of high risk group members, many programmes focus on the more visible and reachable portions of these population groups.

For completeness, the country report attempts to include both perspectives, using both survey and routine data. This allows significant achievements as well as the major gaps to be reflected and reported. In Kathmandu for example, good progress has been observed with higher knowledge among FSWs and falling sero-prevalence rate. 2006 IBBS data shows a 100% of FSWs knowing about condom use and condom use with the last client was quite high (77%). Less than 1.0% did not know where to get a condom and 92% knew how/where to get one in under 10 minutes, while 65% knew where to get one in under 5 minutes.

At the same time coverage in Kathmandu, calculated using the new UNGASS definition shows 35% of FSW reached versus using the former definition.

"While coverage measurement according to the new indicator definition appears to show low coverage, this is not actually the case in Nepal. The new indicator definition uses "having been given a condom and knowing where to get an HIV test" (for FSW). Every national programme does not necessarily provide all condoms free but if vulnerable groups know that they should be using condoms and they know where to get one and are actually using them, then that demonstrates a fair degree of success and programme reach/coverage".

Comment from Development partner

International non-government organizations in general and Family Health International (FHI) in particular, have been supporting prevention interventions targeting female sex workers in urban areas and along the major trucking routes in about 30 districts.

Approximately 50 civil society and local non-government organizations are supported to implement these programmes. The coordination of activities has also been supported through the development of a sex worker network. To date, there are 2 registered FSW networks registered as NGOs, Society for Women Awareness in Nepal (SWAN) and Jagriti Mahila Samuha.

There has been good progress with consistent services and lower prevalence confirmed among FSW in all sites in Nepal. Coverage of prevention is good in the sites where highest levels of HIV transmission occur; these are the areas where prevention efforts are focused. However, the challenge will be to maintain these achievements on knowledge, behaviours and sero-prevalence, while ensuring expansion and increased access to services for more hidden and less visible groups of female sex workers. Maintaining the level of programmes for FSW will remain a challenge when considering the relatively high numbers of young sex workers entering the trade each year[4]. Different strategies will need to be developed to address the specific needs of these groups.

Men who have Sex with Men

Prevention activities for Men who have sex with men (MSM) include condom and lubricant promotion and distribution, behaviour change communication (BCC), treatment for STI and VCT. The current services are located in 7 urban districts in 4 regions of Nepal and largely supported by DfID funding. The past two years have seen the expansion of services with a number of centres and services being set up across the country and providing much needed services and coverage in those areas. The coverage of 10% for Kathmandu in 2004 and 66% in 2007 shows a significant expansion but also highlights the need to further expand national coverage and ensure the availability of prevention services for the estimated 135,000 (68,000 to 202,000) MSM in Nepal.

Prevention activities tailored and targeted to MSM have been gradually expanding with more dedicated services in the past two years. In addition, a law recently passed by Supreme Court of Nepal recognises the rights of people with different sexual identities and constitutes a major step towards promoting a conducive environment where MSM are more likely to take up both preventive and curative HIV services. While prevalence would appear to have stabilised, coverage of prevention needs to be expanded to improve knowledge and address high risk behaviours among MSM. Additionally, mapping and qualitative studies are planned to provide better information on knowledge, attitudes and risk behaviours among MSM sub-groups for programming.

Injecting Drug Users

The harm reduction programme for IDU in Nepal has been in existence for some time but has only recently benefited from notable increases in support, technical as well as financial, leading to an increased focus on harm reduction, HIV prevention and oral substitution.

Reviews of the programme highlighted the need for quality improvement through standardized operational procedure and technical assistance to move interventions largely focusing on “awareness” into behaviour change, including the provision of clean needles and syringes.

Behaviour change communication, condom promotion and outreach services (incl. needles and syringe exchange) are provided from eighteen Drop In Centres (DIC) in 18 districts of Nepal. These Drop-In-Centres currently provide services to 9,097

[4] FSW IBBS 2006.

injecting drug users and a total of 988,000 needles and syringe were distributed to IDUs in 2006 and 245,649 in 2007, compared to an estimated national need of 21,000,000 needles and syringes, equivalent to less than 5% of the total requirement in 2006. The decrease number of distributed needle and syringe is due to reduction of partners and gap in the reporting, not necessarily the actual reduction.

Free detoxification is currently provided in at least 18 rehabilitation centres in different districts in Nepal through community-based organisations and NGOs. In 2006, oral substitution therapy was re-introduced in Nepal, first with buprenorphine in two community settings and in 2007, then with methadone substitution which was re-started at the Teaching Hospital in Kathmandu in September 2007. As of November 2007, a total of 61+ IDUs were on methadone and 31 on buprenorphine.

HIV prevention and care for IDUs has made significant progress with enhanced strategies in prevention, including outreach, behaviour change communication and needle and exchange programmes. Major progress has also been made in the re-introduction of Oral Substitution Therapy (OST). Evidence shows the effectiveness of needle and syringe access in reducing drug-related HIV risks[5], confirmed in the drop in HIV prevalence. Accessibility of quality services such as needle and syringe access need to be expanded to the largest numbers of IDUs if gains are to be consolidated and prevalence levels reduced or maintained.

Labour migrants

Short term, seasonal labour migration of young men to urban areas of Nepal, India and other countries is increasingly common, and has emerged as a major factor driving the HIV epidemic in Nepal as in other countries in the region. Mobility and migration are not direct risk factors for HIV but create the conditions that can increase people's vulnerability to HIV. HIV transmission largely occurs through commercial sex which places both male clients and subsequently their wives at increased risk of infection from HIV. Integrated Bio-Behavioural Survey data show that 67.5% of youth in the Far West migrate before the age of 20[6]. Recent data also shows that 27% of migrants engage in high-risk sexual behaviours in India and as a result, this group now accounts for 41% to 46% of all HIV infections in Nepal with numbers of HIV cases also increasing among wives and partners. Improvement in reaching this population group becomes all the more pressing to reduce further transmission.

Most programmatic efforts have been directed at the Terai and highway districts of the country. Main strategies include raising awareness on HIV through community orientation, district information centres and peer education program, condom promotion, STI services and VCT referral as a comprehensive package. New innovative approaches include: pre-departure orientation along with safe travel kits (containing information leaflets, condoms, antiseptic cream), and integrating education on HIV and AIDS into the training programmes of manpower recruitment organisations.

In the past two years, a better understanding and acceptance of the need for intensified prevention among migrants and their families has been gained with better quality research available to guide prevention efforts. While prevalence is relatively high for this group it is not as high as previously expected, yet highlights the need to expand coverage in a strategic manner to address knowledge and risk behaviours among migrant and their families.

[5] Preventing HIV infection among injecting drug users in high-risk countries: an assessment of the evidence. Institute of Medicine of the National Academies. 2006

[6] Reference? IBBS 2006 among migrants?

Comments from stakeholders

Nepal has good data on its HIV epidemic and response, including survey data (e.g. DHS and IBBS) now better harmonised for UNGASS reporting. During consultations both routine and IBBS survey data were shared and discussed. It was generally felt that survey data overestimated coverage among high risk groups.

As a result of concerns raised by stakeholders, routine programme data was re-analysed to correspond with survey sites (i.e. Kathmandu for FSW, MSM, and IDU). The findings were shared again but there was agreement that results were no longer meaningful because of possible overlaps and double counting. This confirmed that even though the IBBS data may not ideally sample or reflect hidden population groups, it provides a indication of trends.

A recent gap analysis done during GFATM proposal preparation in June 2007, suggested that there are about 21,500 sex workers who can be reached by prevention programs (e.g. they are not hidden populations). Of this, about 12,000 are currently being reached. There is agreement that with current level of continued funding from donors to carry on current efforts, the universal target of reaching 80% of sex workers with prevention programs by 2011 is likely to be met.

However, substantial efforts are required to meet coverage targets for migrants and their spouses, MSM and IDUs. A large part of the new Global Fund programme to start in 2008 will be used to scale up targeted interventions for these 3 groups. Part of the program is to support capacity of multiple and newly formed NGOs to effectively implement prevention program. In particular management capacity needs to increase to ensure key functions such as coordination, quality assurance, and monitoring and evaluation are translated into practice on the ground.

Challenges in reaching MARPs

Expand on:

- Vulnerability to HIV is exacerbated by social stigma and discrimination against certain MARPs, particularly IDUs, FSW, and MSM.
- Reaching the un-reached …. Hidden populations including Prison Population
- Geographical mountainous terrain physically making it difficult to reach MARPs Nature of MARPs like FSW- “on” and “off/part-time SW; high-turn-over; high mobility of SW
- Prevailing stigma and discrimination- negative attitude towards MARP

2. Prevention programme: Knowledge and Behaviours

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

Although general awareness of HIV and AIDS is generally high, comprehensive knowledge on HIV and AIDS, as defined by the UNGASS indicator, remains comparatively low among populations groups, especially those most-at-risk. Knowledge among migrants and female sex workers appear to be the lowest while clients of sex workers show higher levels of comprehensive knowledge of HIV. The comparatively low level of knowledge among FSW is surprising given that intense programme efforts have been directed to this group. However, the reportedly high

turnover of FSW entering and leaving the trade may explain some of these differences and further emphasise the need to maintain the intensity of the programme in order to maintain knowledge levels stable (or increasing).

Table 7: Knowledge about HIV/AIDS (MARPs)

Most at risk populations who both correctly identify ways of preventing sexual transmission of HIV and who reject major misconceptions about HIV transmission *(Indicator 14)*				
	2004	2005	2006	2007
FSW (Kathmandu)		*6.8%	30.2%	n/a
MSW (Kathmandu)		n/a	n/a	40.6%
IDUs (Kathmandu)		53%	n/a	66%
MSM (Kathmandu)		*25.3%	n/a	44.4%
Clients of sex workers (Kathmandu)		n/a	50.5%	n/a
Returned migrants (Far West)		*26.68%	19.2%	n/a

*Source: IBBS and Routine Data (*UNGASS 2005): No sex/age disaggregation*

However, comprehensive knowledge does not necessarily result in behaviour change. Surprisingly, despite relatively low coverage and levels of knowledge, condom use among female sex workers and male sex workers seem comparatively high at 74% in 2004 and 77% in 2006 and 67% in 2004 and 93.1% in 2007 for male sex workers in Kathmandu, respectively.

Table 8: FSW reporting use of condom

Female and Male Sex workers reporting use of a condom with their most recent client *(Indicator 18)*				
	2004	2005	2006	2007
FSW	74%		77.2%	
MSW	66.7%			93.1%

Source: IBBS surveys, NCASC, New ERA, USAID/FHI and USAID
No sex/age disaggregation available

Table 9: Men reporting use of condom

Percentage of men reporting the use of a condom the last time they had anal sex with a male partner *(Indicator 19)*		
	2004	2007
MSM	43.5% <25 39.0% >25	73.5%

Source: IBBS surveys
Age dis-aggregation only for 2004

Data from the 2005 Kathmandu IBBS survey shows that 2 out of every 3 IDUs used a condom the last time they had sexual intercourse. In spite of limitations in coverage of IDU interventions, condom use at last sex is reportedly 60.5%.

Condom use among IDUs have slightly declined from 60.5% (2005) to 58.03% (2007) but dis-aggregation reveals differences in condom use according to the type of partner at last sex. While 81% of IDUs reported use of a condom the last time they had sex with a sex worker, highlighting some awareness of the risk of sexual transmission, only 56% of IDUs used a condom last time they had sex with a non-regular female partner and 35% with a spouse. Although this trend is not unusual, it highlights the emphasis on self-protection versus protection of a spouse and the need to use condom regularly and consistently.

Table 10: IDUs reporting use of condom

Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse *(Indicator 20)*		
	2005	2007
With regular female partner, or	40.3%	(35.7%)
With non-regular female partner, or	64.7%	(56.6%)
With FSW	75%	(81.8%)
Average	60.5%	(58.03%)

*Source: IBBS 2005, (***66.7%** <25 and **56.8%** >25); *IBBS 2007, (***xx%** <25 and **xx%** >25)

Self-reported safe injecting behaviours among IDUs seemed high with 95.6% of IDUs interviewed reporting using a sterile needle the last time they injected. Nonetheless, when this figure is broken down, it shows that almost two thirds of IDUs purchase new needles (66%) than obtained clean ones from NGOs (27.6%).

Routine 2006 data showed that 980,000 needles and syringes had been distributed to IDUs and in 2007, this figures was 245,649. This indicates either a shortfall when compared to the estimated need of 21,000,000 or that IDUs have been buying large numbers of needles and syringes from private pharmacies despite the legal implications. More operational and evaluative research is required to inform this area.

Although survey data shows that the proportion provided by NGOs has increased since 2005, it raises questions on the role of the DICs, the quality and monitoring of interventions, whether sufficient numbers of needle and syringe are provided to IDUs free from the NGOs and whether the programme could be further improved.

Table 11: IDUs reporting use of sterile injecting equipment

Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected *(Indicator 21)*		
	2005	2007
Used a purchased new needle	69%	(63%)
Used new needle given by NGO	13.3%	(32.6%)
Used new needle given by friend	N/A	n/a
Total	82.3%	(95.6%)

*Source: IBBS (***84.3%** <25 and **80.9%** >25); *IBBS 2007, (***xx%** <25 and **xx%** >25)

2006 data from surveys show that 27% of Nepali Migrant workers to India engage in high-risk sexual behaviour and visit sex workers while in India. Although programmes are now in place, levels of knowledge and condom use however are still insufficient,

particularly with sex Workers in Nepal and their spouses, indicating the need for intensified prevention in this group.

Table 12: Migrants reporting use of condom

Migrant workers to India reporting use of a condom at last sex *(Indicator 18)*				
		Migrants (Western)	Migrants (Far-Western)	**2006** Total
Use of condom at last sex with sex worker in Nepal		12.5%	50%	
Use of condom at last sex with sex worker in India		63%	71%	
Use of condom at last sex with spouse		12.9%	12%	

Source: IBBS surveys, NCASC, New ERA, USAID/FHI and USAID
No sex/age disaggregation available

Comments from Civil society

There was agreement throughout the national consultations that survey data available (eg. IBBS, DHS etc…) does to a large extent provide a reasonable picture of behavioural change, as sampling sites are consistent and undertaken where there are programmes.

When analysing data on prevalence, coverage etc, it is important to keep in mind concerns raised by Civil Society. Falling numbers of populations at risk or decreasing rates of prevalence are of concern to those who fear a potential impact on funding and resource allocation.

Links between existing policy environment, implementation of HIV programmes, verifiable behaviour change and HIV prevalence as supported by the UNGASS indicator data.

There are some inconsistencies between findings in service coverage, verifiable behaviour change and HIV prevalence for different MARPs. FSW for example shows the drop in prevalence and high self-reported use of condoms appears disproportionate compared with programme coverage. For IDUs, the data show high prevalence rates, relatively low programme reach but high use of sterile needles and condoms. Analysis of findings by stakeholders during the national consultation meeting suggested some inconsistencies may be related to the following:

- Possible over reporting of safe practices by high risk groups interviewed in surveys leading to reporting biases
- Acquisition of commodities (namely, sterile needle and condoms) from private sources rather then from Drop In Centres or outreach programmes. Indeed this is backed up by IBBS finding that 66-69% of IDU respondents purchased a needle from private outlets, while only 13-32.6%% received them from an NGO programme.
- Low knowledge levels seem unrelated to high condom use but may be explained by the fact that most respondents are familiar with the condom statement but not with other parts of the question.

Among MARPs, the coverage of services such as reach of VCT and STI treatment remains highest among FSW and lowest among migrants.

Coverage as indicated by the routine programme data shows much lower coverage than that indicated by IBBS data. While Nepal has maintained the focus of the response to its concentrated epidemic on groups at highest risk, a number of efforts are under way to increase awareness of HIV, especially among young people. UNFPA has supported advocacy events to scale up HIV/AIDS and Sexual and Reproductive Health (SRH) programme for youth, youth summit, operations research on sex workers developing guidelines for sex workers and some targeted interventions in selected districts to address the needs of young people in SRH and HIV/AIDS.

Table 13: Knowledge about HIV/AIDS (youth aged 15-24)

Young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission *(Indicator 13)*		
	2007	
	Female	Male
15-19 years	29.1	45.3
20-24 years	25.8	41.1
Total (15-24 years)	27.6	43.6

Nepal Demographic Health Survey, 2006;

Relatively low numbers of young people engage in high risk behaviours, nevertheless their entry into adulthood renders some vulnerable. Comprehensive knowledge of HIV is now regularly measured in surveys carried out in Nepal (e.g. DHS 2006) as it is the first element reflecting prevention efforts. Results on comprehensive knowledge show consistently lower figures with higher number for males than females. The 15-19 age group appears to have been more exposed and exhibit higher knowledge on modes of transmission and rejects misconceptions.

Table 14: Schools providing life skills education

Schools that provided life-skills based HIV education within the last academic year *(Indicator 11)*	# of School	# of School with LSBE (2007)	% of School with LSBE (2007)
Number of schools (all schools combined)	29,448	1,670	5.6%
Number of Primary school	13,833	1,035	8.43%
Number of Secondary school	15,615	635	4.06%

Source: MoE/UNICEF (2007)

The life skills based education programme implemented by the Ministry of Education has expanded in the past two years with support from UNICEF. In 2007, youth and adolescents were provided life-skills based education (LSBE) through formal curricula and peer education. While 3.1% (880/27,888) of all schools provided LSBE in 2006, this has increased to 5.6% in 2007.

In-school LSBE was implemented in 20 districts using UNICEF's existing district structure and in collaboration with National Centre for Educational Development (NCED)/ Department of Education (DoE). A pool of 200 regional and district level trainers were prepared to train down the line district level school teachers. Over

516,278 children (grade 1-10) received life skills based education from 1,966 trained teachers from 1,670 public schools. Similarly, a total of 19,802 out of school youth and adolescents were reached through peer education programme.

3. Care, Treatment, and Support

By 2005, the treatment, care and support programme in Nepal had strengthened, providing a better basis on which to base the introduction and roll out of antiretroviral treatment programme. The national ART programme was started in 2004 in the public sector in Kathmandu and by October 2007, about 1189 adults and 51 children with advanced HIV infection were receiving ART in 17 public sector sites across the country. This rapid expansion from 2 sites to 16 sites now is very encouraging and a clear indication of the capacity and commitments of the public sector. The country anticipate about 2500 people in need of ART by 2008 (GFATM proposal Round 7) and will be more afterward. It clearly illustrates the challenge ahead for scaling up services to meet country-agreed universal access targets.

Overall, ART coverage has expanded markedly since the last UNGASS reporting period, when only 160 PLHA (of whom 30% were women) were receiving ART. It is envisaged that the recently approved GFATM Round 7 proposal will contribute to this expansion and support an increased number of PLHIV on ART.

In 2007, an estimated 13% of people with HIV knew their status as a result of increased availability of confidential counselling and testing services. The rapid expansion of VCT services has also become a point of entry for PLHIV to access treatment and care. Information and counselling services through fixed-site NGO centres (Information and Counselling Centres (ICCs) has been the main approach adopted. However, there is a plan to modify this by more closely linking with outreach services and on-site VCT.

Estimated HIV positive incident TB cases that received treatment for TB and HIV *(Indicator 6)*

Globally it is estimated that 50 % of people with advanced HIV infection who qualify for ART are in need of treatment for Tuberculosis (TB). In Nepal, between October 2006 and November 2007, 45.7% (321/702[*]) of people with advanced HIV infection and active TB received treatment for TB. This figure is likely to be under reported due to some incomplete data and ART registers collected during site visits and reporting for this round of UNGASS reporting.

Challenges to scaling up

It is essential that high quality and standards are assured during the scale up plan. This will ensure that new services fit with national roll-out plans, use national guidelines and have appropriately trained staff in place. Health systems weaknesses, such as poor infrastructure, staff turnover and absenteeism and poor management of logistics and supplies have hindered the capacity to scale up treatment, care and support services.

Conversely, the improved funding environment for HIV and AIDS programmes provides an opportunity to ensure that new resources are effectively used to strengthen the overall health system. Forthcoming funds secured from Global Fund, round 7 will also be used to support overall health systems strengthening.

[*] following estimated number of HIV positive TB cases from the WHO Stop TB Department 2006 report for Nepal

A major challenge for treatment and care lies in the remote geographical location where the large numbers of those infected and affected migrants and/or spouses originate from. These areas have limited access to health care and innovative and practical strategies need to be developed to reach them. This in addition, also implies the need to scale up PMTCT.

Percentage of donated blood units screened for HIV in a quality assured manner *(Indicator 3)*

The blood safety system in Nepal is the responsibility of the Nepal Red Cross Society (NRCS) which runs 58 blood banks (blood transfusion centres) in 43 districts of Nepal that include 17 hospital units in 41 districts. In order to respond during emergency situations, 15 emergency blood transfusion service centres have been set-up throughout the country[7] (*Nepal Red Cross annual report, August 2006-July 2007)*.

A total of 115,720 blood units were reported to have been collected by the blood banks in 2007 in 52 districts (out of 75 districts in the country), and all were screened resulting in 100% coverage. Although 100% of blood units have been screened in a quality assured manner at available sites, the overall reach of services is still quite limited. The expansion of safe blood services to more parts of the country remains urgently needed.

Percentage of HIV positive pregnant women who received antiretroviral drugs to reduce the risk of mother to child transmission *(Indicator 5)*

Of an estimated total 1,600 HIV positive pregnancies in 2007, 76 were identifies at 11 PMTCT sites and only 46 HIV infected pregnant women delivered. New born child received anti-retroviral therapy (single dose Nevirapine). It is worth noting that of 46 women who delivered, 10 women arrived in the second stage of delivery or were seen by staff unaware of the programme.

Results show approx 2% coverage, highlighting the pressing need to increase the availability of services to prevent Mother to Child Transmission of HIV. Of those pregnant women in need of PMTCT, many are from vulnerable groups such as FSW, wives or partners of IDUs and wives of migrants. Good strategies need to be developed to effectively reach the 98% of women and children in need of PMTCT who are harder to access due to geographical constraints (e.g. remote regions), low ANC coverage or these women's status in society.

C. National Composite Policy Index (NCPI)

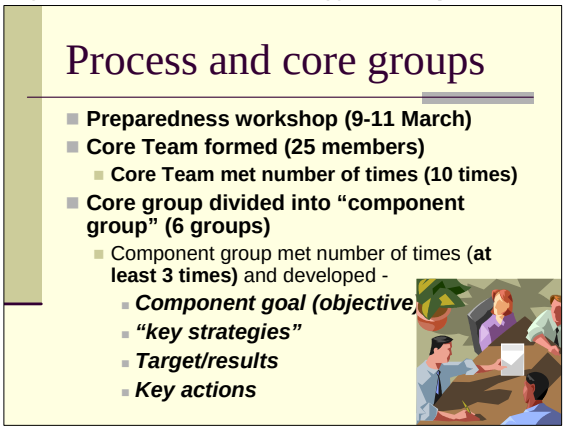
I. Strategic Plan

HIV and AIDS has been accorded high priority in Three Year National Plan (2007 – 2010) as a "Priority 1". Besides, National Health Sector Programme Implementation Plan (NHSP-IP 2004), PRSP and UNDAF have included HIV and AIDS as a key component of the plan. The current National HIV and AIDS Strategic plan (2006-2011) is 3rd strategy in the line. There is a significant improvement in the strategy in terms of civil society participation during the development and the multi sectoral emphasis on the non health sectors" The Strategy has emphasised on Universal Access Targets and the "Three Ones' principles. Besides, vulnerable population and

[7] The central blood transfusion service and NRCS manages the reported numbers of donated blood units screened for HIV in blood centres/blood screening laboratories that 1) followed documented standard operating procedures and 2) participated in an external quality assurance scheme.

most at risk groups are clearly identified based on evidences available at the time of preparing the strategy. Based on national strategy, a two year costed national action plan (2006-2008) and budget was developed where programme goal and strategic outcome indicators have been defined. The strategy was developed in a highly participatory way with the involvement of civil society within and outside the capital city, government line agencies, EDPs and other stakeholders (glimpse of process in the box).

Figure 8: Process of strategy development



While there is reasonably high degree of harmonisation at the policy and planning level, the full harmonisation at the implementation level is yet to be achieved. Strategy and costed action plan has been the basis of resource allocations by EDPs and for the development of new proposals (i.e. GFATM Round 7 proposal). Next round of two years costed plan is expected to be developed by June 2008 with specific targets to be achieved in the plan period.

II. Political Support

While there are many improvements in the political support received for the effective response to HIV and AIDS in the country, there are areas for improvement for better political support.

Some of the note-worthy initiatives on political support are: (1) National Workplace Policy (October 2007), (2) National Policy on Drug Control (2006), and (3) Establishment of Nepal Policy Advocacy Panel on HIV/AIDS, (4) Nepal Leadership Forums on HIV/AIDS (youth, women & media), HIV/AIDS and Human Rights Forum (some 19 different civil society organisations collaborating) to advocate Human Rights and work as pressure group, Policy Champions – a team of people who are socially influential and recognised as leader in their respective field – who supports policy advocacy in HIV and related issues, are in place in order to strengthen and intensify leadership actions at all levels on the issues around HIV and AIDS.

Currently there are three main structures for policy development, programme coordination, harmonisation and coordinating political support. They are National AIDS Council (NAC) – chaired by Prime Minister, National AIDS Coordination Committee (NACC) – chaired by minister of health and Country Coordination Mechanism (CCM) – chaired by secretary of health. CCM is a more active mechanism than the other two in terms of coordination, policy development and programme implementation. In other words, the CCM appeared to have over shadowed the role of the other two mechanisms. The members in all three structures are primarily either the same persons or representatives from the same constituency, therefore once they meet regularly in the CCM whether for a different purpose, the need for other meetings in the pretext of another forum is really not valued. Moreover, in the context of "concentrated epidemic" where true multi sectoral engagement is limited, the importance, need and functions of multi sectoral coordination body like NACC is rather undervalued. Except CCM, the other coordinating bodies have no terms of reference, no action plans, no functional secretariat and do not meet regularly.

At the local level, for political support and coordination of local responses to HIV, the District AIDS Coordination Committee (DACC) was formed and is chaired by the Chairperson of District Development Committee. Because there are no elected representatives at the district level for quite a time now, the leadership required to activate and motivate DACC is lacking. Keeping in view the changing context at the local level where more responsibilities and challenges are to be entrusted, DACC structure revision process has already begun so that DACC can function more effectively at the local level.

NACC, NAC

1. Internalization of the issues is limited among the members representing non health and non government sectors
2. No regularity of meetings, and often low attendance in the meeting,
3. Inadequate representation as newly emerged networks and groups are yet to be included as member
4. Consistency and continuity of the members in the meeting is low. Turnover of the members attending the meeting from the same organization is very high, resulting into communication gap and limited contribution in the decision making process
5. No secretariat means maintaining regular communication with members and flow of information to members are limited.
6. Role of such two high level body not very clear

Recently, the government approved a Semi Autonomous Entity (SAE) formally called "The HIV/AIDS and STI control Development Board 2064 (2007)" for expanded and multi-sectoral response to epidemic in the country. It is formed to overcome the current limitations encountered for rapid and expanded responses in multi-sectoral way with mobilisation of internal and external resources as well as partners. The entity is also mandated to develop policies and strategies for HIV prevention, treatment care and support. The challenges however is to redesign the role and responsibilities of the existing coordinating bodies like National AIDS Council, National AIDS Coordination Committee in relation to the specific roles of SAE (i.e. governance and programme management) and NCASC. Moreover, making it functional and capable is a short term challenge of the entity.

NACC and DACC are the structures envisioned in the National HIV/AIDS Policy (1995), while NAC and SAE are the bodies formed through the order of the cabinet as per the felt need. The 1995 Policy needs a thorough revision to make it more comprehensive in line with the current dynamics of the epidemic in the country, national and international commitments and responses including GIPA, MIPA, MDGs, Universal access and UNGASS and also to guide the linkages and coordination among the different national bodies.

III. Human Rights

There is general consensus that while there are either no specific laws and regulation to protect and promote human rights or that current laws presents obstacles, the overall human rights situation *vis a vis* HIV prevention, treatment and care has improved in the country. This is echoed both by civil society members and government officials. Moreover, the current interim constitution has clearly mentioned about the fundamental rights of all the citizens to receive basic health care services. Based on this, other major policy/strategy documents like Nepal Health Sector Programme – Implementation Plan (NHS-IP 2005) and UNDAF have amply included HIV as a crucial area for intervention. A HIV/AIDS Bill which emphasise the protection of rights of PLHIV and vulnerable people is in process to be submitted at the parliament for endorsement.

Nevertheless, cases of discrimination of serious nature, tortures, denial of property rights, and expulsion of affected children from school are regularly reported by media and HIV activists.

Two recent verdicts of Supreme Courts have further strengthened the human rights situation. The first one is a directive to the government to introduce laws that provides equal rights of sexual minorities (refer to the Box) and the second one was the imperative order to maintain strict confidentiality of all court proceeding and hearings for the cases relating to sexual violence, girl trafficking, HIV/AIDS and children. This move not only indicates the progressive nature of the judiciary system in the country, but also a reflection of social acceptance of sexual minorities. However, changing long traditions and belief of society take a long time.

After having three hearing at Supreme Court over the last few months, Supreme Court of Nepal has recognized LGBTIs today as natural persons. It is believed that LGBTI will enjoy, today onward, all the rights according their sexual and gender identities as other genders enshrined by the Constitution of Nepal and human rights conventions in which Nepal is a State Party. On 21 December 2007, the Court issued directive orders to Nepal government to ensure rights to life according to their own identities and introduce laws providing equal rights to LGBTIs and amend all the discriminatory laws against LGBTI's rights as well.

On the issue of same sex marriage, The Court has also issued directive order to form a 7 member committee (Doctor appointed by Health Ministry, one representative from National Human rights commission, law Ministry, socialist appointed by government of Nepal, representative from Nepal police, representative from Ministry of population and environment and one advocate as a representative from the LGBTI community) to conduct study about the other countries'/international practice on the same sex marriage. Based on the 7 member committee recommendation government will make appropriate law.

(Source: Press release by BDS an organisation advocating rights of sexual minorities in Nepal, 22 December 2007)

IV. Civil Society Participation

HIV and AIDS is such a sector that probably engages largest number of civil society organisations in the country. Government is now much open and accommodative to civil society at all levels i.e. policy to implementation levels. For example, in all national coordination and policy development bodies (NAC, NACC, CCM) representation of civil society organisation is almost one third. Besides, CSOs are regular features in policy and proposal development process. Although a precise figure is yet to be calculated, it is estimated that almost all CSOs are regular features in policy and proposal development process. This view is equally expressed by both the civil society organisations themselves as well as EDPs and government agencies who are directly involved in HIV and AIDS programme.

Furthermore, the fact that mandatory instruction from government to INGOs to implement programme at the field only through civil society organisation (interchangeably used with NGOs) has further strengthened the role of civil society organisations in the implementation front. Currently there are over 140 INGOs working in the country. Most of them do have HIV/AIDS either as focused intervention or as cross cutting theme integrated into other development activities. Overall contributions and financial allocation of INGOs though are not documented and available; their contribution in HIV/AIDS can not be undermined.

Out of the over 140 INGOs operational in Nepal, about 10% are very active and have specific interventions on HIV and AIDS. Nonetheless, most of the INGOs do have HIV as a cross cutting issue mainstreamed in other development activities. Though Social Welfare Council is the coordinating and regulating body for NGOs and INGOs, there is a general lack of functional information unit which has all the information about NGOs and their programmes. As a result, the contribution and financial allocation on HIV and AIDS activities of many NGOs are not centrally recorded and

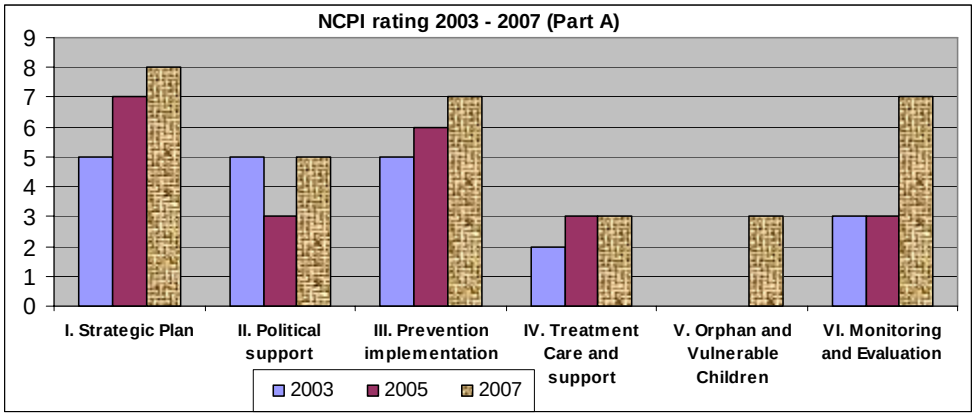
available. Despite the willingness and the capacity of INGOs in participating in the HIV and AIDS responses in the country, strengthening the linkages and collaborating with government programme is still a challenge.

The Advocacy efforts of civil society organisations have substantially contributed in the policy formulation process in the country. Some examples of civil society contribution are; formation of new drug control policy of Ministry of Home Affairs, where drug users are no more termed as “addicted” and initiation of Oral Substitution Therapy in one of the public hospital. Another example is the recent court order in relation to sexual minority (please refer to Human Rights section above). Besides, quite a few civil society organisations were able to access fund directly from external sources, though details of such resources are often not available.

With a caveat on civil society participation, all CSOs are not fully capable and are not able to contribute critically on the HIV response in the country. As the civil society by nature rightfully advocate for their own constituency, it often leads to a situation where the strong and vocal gets higher shares both in terms of participation and access to resources. Less vocal and field based organisation despite their dire need of resources and attention are not getting enough support and encouragement. Creating a balance between small field based organisation and big capital based organisation both in terms of representation and resource allocation; recognition and building of unregistered groups and networks; and channelling fund through organisations are some of the challenges facing civil society participation. CSOs in remote districts outside the capital are not easily accessing resources for HIV and AIDS activities.

V. Overall responses trend

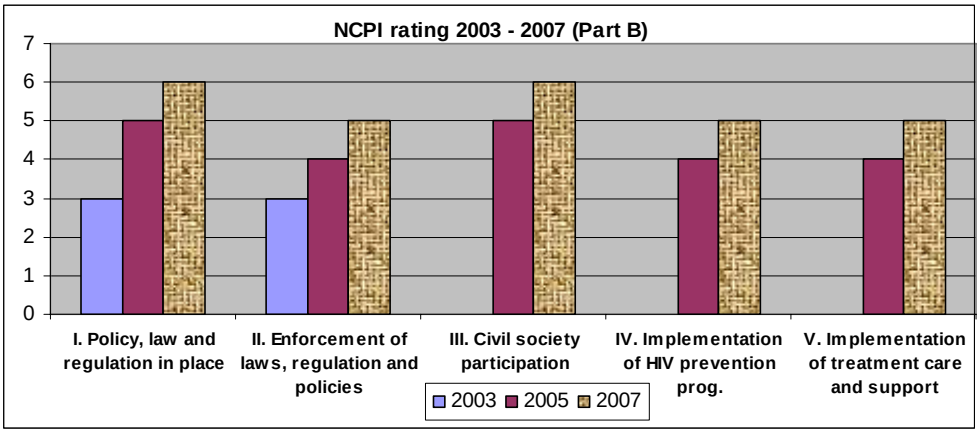
Figure 9: NCPI rating (Part A)



Comparison of responses on part A of NCPI indicators for the last three years shows an improving trend in most of the critical areas of policy index except in “political support” in 2005. This is the reflection of political conflict which had reached its height in 2005 where major political attention was on conflict resolution. The responses for treatment care and support clearly indicates the necessity of further effort in meeting the need for treatment and care.

The responses on part B of NCPI also indicate overall improvement on most of the critical areas.

Figure 10: NCPI rating (Part B)



Generally, there are similar responses and ratings on many aspects of policy index among representatives of NGOs (Part B) and government (Part A), but in one aspects view differed. In contrast to government officials rating somewhat low on treatment, care and support, Civil Society Organisation are generally rated higher for the same, indicating that treatment care and support is better now and more accessible than before. The government officials low rating is due to the fact that the targets of government programme is generally high and have not yet met all the targets. For examples, VCTs in all 75 districts and making ART and OI available from all district hospitals are not yet met therefore the low rating accorded to the treatment and care aspect of the policy index.

D. AIDS Spending in Nepal

An AIDS spending assessment was conducted for the first time in Nepal as part of the country reporting process to the UN General Assembly Special Session on HIV and AIDS (UNGASS) 2008. This was done using the standard NASA tools as indicated in the UNGASS and NASA guidelines). While a full National AIDS Spending Assessment (NASA) is planned for 2008 ahead of the National Action Plan development, this “mini-NASA” provides an opportunity to initiate the analysis and discussion on AIDS Spending and priorities in Nepal.

Due to the time factor and the country context, it was agreed by partners in Nepal that a rapid assessment would be conducted. In this regard, major funding sources and agents were included in the data collection representing the majority of AIDS spending. For the mini-NASA, service providers and beneficiaries were not included due to the time frame but will be in the full National AIDS Spending Assessment (NASA) planned for 2008.

Fourteen major sources and agents were identified and a data collection tool was distributed for them to report all HIV and AIDS *expenditures* for the fiscal year 2007. After an initial briefing, follow-up visits to offices, telephone calls and electronic communication were made. Further explanation, reviews and orientations were conducted as required by the respondent source or agent organisations. Source and agents were informed of the need to report actual expenditures and not budgets or commitments. A total of 12 sources and agents provided HIV and AIDS expenditure data for the national spending matrix below. Data were reviewed for accuracy,

double counting and category of classification and compiled and collated before being structured in the standard NASA reporting matrixes for analysis.

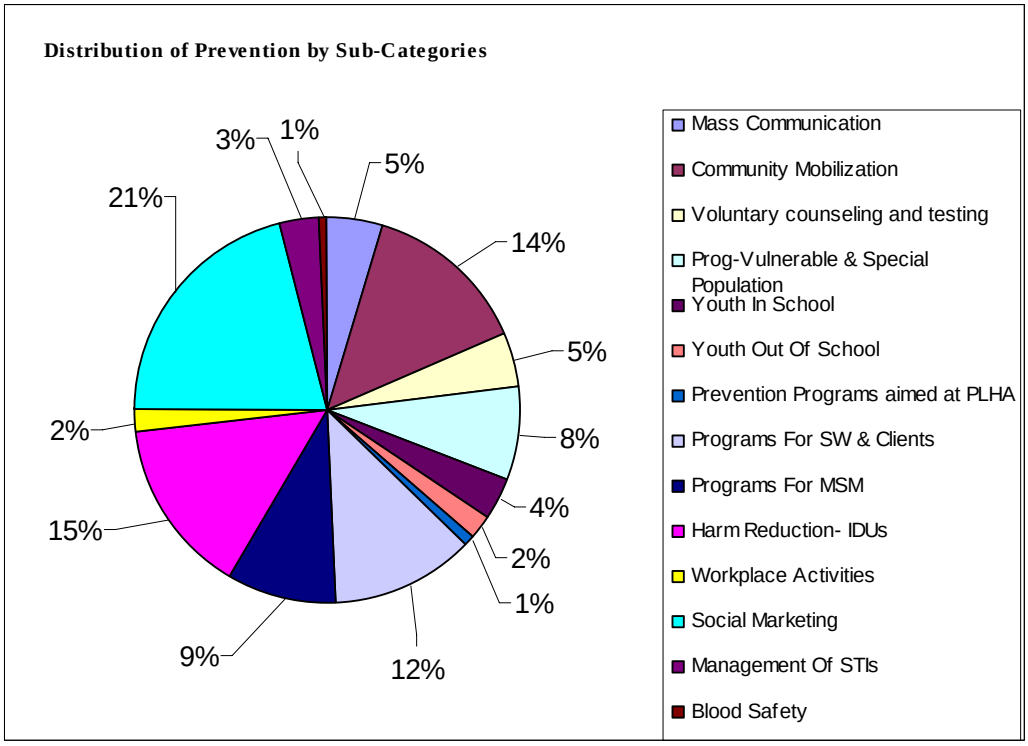
Table 15: Expenditure by Source and Agents

Source and Agents	Spending	Percentage
MoHP	680,289	8%
DFID (UNDP)	2,635,265	28%
USAID (FHI/ASHA	2,160,221	23%
USAID (AED)	1,326,338	15%
WHO	420,397	5%
UNICEF	411,221	5%
GFATM (UNDP)	688,609	8%
UNODC	268,542	3%
DFID (FHI)	197,062	2%
ILO	116,969	1%
UNAIDS	144,276	2%
UNFPA	40,485	0%
GTZ	NR	
SDC	NR	
TOTALS	**$9,089,674**	**100%**

The NASA includes 8 broad spending categories and 81 sub-categories. The broad spending categories include: 1. Prevention, 2. Treatment and care, 3. Orphans and Vulnerable Children, 4. Programme Management and Administration strengthening, 5. Incentives for Human resources, 6. Social protection and social services (excl. orphans and vulnerable children), 7. Enabling Environment and community development, 8. Research excluding operations research). It is important to note that the analyses only cover actual spending and neither budget allocation nor obligations.

In 2007, a total USD million 9,089,000 (refer to Table 15 above) was spent on HIV and AIDS in Nepal with preliminary data showing the largest proportion of expenditure dedicated to *prevention* 69% and 13% on *treatment, care and support*. Spending on the *enabling environment and community development*, and *programme management and strengthening of administration* amounted to 4% and 11% respectively. Spending on *social protection and social services* was approximately 1%.

Figure 11: AIDS spending by category



Almost three quarters of the total spending on targeted prevention was spent on 1) social marketing (21%), 2) harm reduction for Injecting Drug Users (15%), 3) prevention for vulnerable and special population groups (8%), 4) prevention among female sex workers and their clients (12%), 5) prevention among MSM (9%) and Community mobilization (14%). These preliminary results are consistent with the need for well targeted prevention in a concentrated epidemic, as recognized and stated in the National Strategy (2006-2011). A number of other prevention areas are reflected in the remaining 21% and include prevention for out of school youth, voluntary counselling and testing, workplace activities and community mobilization.

Despite constraints, the mini-NASA conducted for the country report provides an initial analysis and findings on 2007 AIDS spending in Nepal, which will be taken forward in the full NASA. Data was only collected for a period of one year and as a result, comparative or trend analyses were not yet possible at this stage.

Timing the NASA with the national action planning (2009-11) process provides the opportunity to ensure that programmes further align with national priorities as programme cycles are underway. The NASA provides an opportunity to build capacity, leadership and ownership by analyzing resources information and gaps in the response. It also presents a great opportunity to guide information processing within agencies so as to facilitate better data collection and analysis for future NASA exercises.

This first exercise faced some constraints and challenges, including:

- Of four major bilateral sources of funds in Nepal, only one provided the data required.
- Consistency due to differences in the coding of programmatic interventions across the sources and agents – this proved a major obstacle in collating and analyzing the data.

- The terminology used across sources and agents are varied and requires harmonization for future NASA exercises.

In order to enhance the accuracy and usefulness of the full NASA, high level advocacy will be conducted with government departments to increase ownership of the NASA and leadership in taking its findings and recommendations forward. Capacity will need to be built to ensure a full understanding of the NASA and maximize sources, agents, providers and beneficiaries' compliance and contribute to the process. Training should increase compliance and responses.

IV. Best practices

[Instructions: This section should cover detailed examples of what is considered a best practice in-country in one or more of the key areas (such as political leadership; a supportive policy environment; scale-up of effective prevention programmes; scale-up of care, treatment and/or support programmes; monitoring and evaluation, capacity-building; infrastructure development. The purpose of this section is to share lessons learned with other countries.]

Best practice/Success stories:

1. Community mobilisation and networks for better programming and policy development.

There are 9 formal and informal networks operational in the country, they are National Association of Positive People in Nepal (NAP+N), Federation of Women Living with HIV in Nepal, Recovering Nepal (network of IDUs), Federation of Third Gender and Sexual Minority in Nepal (MSM network), two Sex workers' Network, National Association of NGO Group working against AIDS in Nepal (NANGAN), National Harm Reduction Council (NHRC), National Alliance against HIV and AIDS (NEHA) and NESFADA (Networks of sports organization).

It is encouraging to note that all these networks are actively advocating on behalf of their own issues related to HIV/AIDS and human rights, gender, stigma and discrimination and working as pressure groups for gaining access to preventive, curative and supportive services and also communicating and reaching out their peers at the grass-roots to prevent and control HIV/AIDS. In preparing this report the representative from almost all these networks are actively involved as the task force members in various issues (National HIV/AIDS strategy development core group, National HIV/AIDS policy development task force, SIT-WG, UNGASS national report preparation task force, project steering committee for workplace programme, development of operational manuals and guidelines team are few to name)

2. Partnerships for Joint programme reviews

In 2006 and 2007, a number of collaborative national review processes were carried out in an attempt to inform relevant programme areas critical to the HIV response. They included a joint review of the national STI programme (November 2006), a joint review of HIV surveillance (January 2007) and joint national review of the PMTCT programme (May 2007).

These reviews were led by the NCASC with strong in-country support from technical partners both international and national (e.g. WHO, UNICEF, UNAIDS, UNFPA, FHI,

USAID, Institute of Medicine, Bir Hospital) in consultation with other national experts and stakeholders. In addition, selected international experts took part in these processes to facilitate discussions and share best practices from the region.
All three reviews included a mix of central and district level participants, with a focus on district-level implementation issues and challenges.

The results and recommendations of these reviews were incorporated into the National action plan for HIV and the gaps identified included into the GFATMRd7 proposal. Some funds were rapidly allocated from existing grants to priority areas (eg. STI drugs and training)

Having strong national participation ensured national ownership, on-going capacity-building and developed stronger partnerships which will help develop sustainability in the long-run. Cost-effectiveness was ensured by using mostly in-country technical and financial resources. The partnerships established in the process will make it easier to replicate for future reviews.

V. Major challenges and remedial actions

[**Instructions: This section should focus on:**
(a) progress made on key challenges reported in the 2005 UNGASS Country Progress Report, if any;
(b) challenges faced throughout the reporting period (2006-2007) that hindered the national response, in general, and the progress towards achieving the UNGASS targets, in particular; and,
(c) concrete remedial actions that are planned to ensure achievement of agreed UNGASS targets.]

While the response to HIV remain well targeted to populations groups most at risk of HIV infection, a major challenge remains to strengthen the public sector service delivery as an important point of entry for individuals in the general population who do not identify with a particular group at risk and may seek anonymity when consulting for STIs for example. This includes clients of sex workers in Nepal as well as returning Nepali migrants or even their wives in Nepal in need of treatment. Public Health services are generally well attended but have not received equal attention in providing and delivering quality services for STI[8]. These gaps have been identified and are reflected in the GFATMRd7 proposal document.

Moreover, efforts to roll out ART have been challenged by fundamental weaknesses in the health systems in terms of trained human resources, staff turnover, quality of trainings and generally ART recording and monitoring at the district level.

The multiplicity of different actors in the HIV response in Nepal constitutes both an asset and a major challenge to coordination. Efforts towards establishing the Three Ones in Nepal are well under way but there are still a number of partners operating outside of the national framework and not reporting to the NCASC. There is a need for

[8] Report of a Joint review of the STI programme in Nepal, NCASC, WHO, UNAIDS, IOM, FHI, USAID (2006).

a strong coordinating and governance mechanism to ensure that core data is gathered from NGOs and private organisations funded from external sources.

VI. Support from the country's development partners

[**Instructions: This section should focus on (a) key support received from and (b) actions that need to be taken by development partners to ensure achievement of the UNGASS targets.]**

Overall good and coordinated support but needs more platforms for coordination at technical level

VII. Monitoring and evaluation environment

[Instructions: This section should provide (a) an overview of the current monitoring and evaluation (M&E) system; (b) challenges faced in the implementation of a comprehensive M&E system; and (c) remedial actions planned to overcome the challenges, and (d) highlight, where relevant, the need for M&E technical assistance and capacity-building. Countries should base this section on the National Composite Policy Index.]

The Government of Nepal recognises the need to further improve monitoring and evaluation of the overall HIV response and to significantly strengthen the systems that inform and shape the national response. In 2006, a national Monitoring and Evaluation Technical group was formed under the leadership of the NCASC. The TWG guided the development of an agreed core set of indicators relevant to Nepal's epidemic and response as well as a national M&E Framework and guidelines developed to strengthen Surveillance and M&E and provide aggregated data at the national level. The strategy also included feedback mechanisms to disseminate major finding and results to the district level.

Over the last 20 months, significant strides have been made in establishing coordination on Surveillance and M&E and to strengthen relevant systems. With support from UNAIDS and other development partners, NCASC has led the following areas with results becoming apparent.

- April-June, 2006 – A situation analysis of monitoring and evaluation systems was conducted by UNAIDS, NCASC and WHO.
- July, 2006 – A performance review of the Global Fund grant managed by UNDP was carried out, employing the Global Fund monitoring and evaluation assessment tool, adapted for the local context.
- May, 2006 -- A technical working group was formed to review and guide monitoring and evaluation activities in Nepal and make recommendations.
- May-September 2006 – Selection of core indicators for the national response and development of an action plan (a work plan that was later integrated into the monitoring and evaluation guidelines).
- May–November 2006 – Development of a national M&E strategy and guidelines, including tools for implementation (used extensively in drafting GFATM Round 7 proposal and subsequent documents).
- November, 2006 -- Joint review of the STI program by a range of partners including NCASC, WHO, UNFPA, UNAIDS, USAID, FHI, IOM and others.
- January, 2007 –Training of Trainers (TOT) on Monitoring and evaluation conducted.

- February, 2007 – Joint national review of Second Generation Surveillance partners NCASC, WHO, UNAIDS, FHI.
- May 2007 – M&E TWG merged with Surveillance working group to form Strategic Information TWG (SI-TWG).
- August-December 2007 - 2007 Estimations of HIV Infections
- October 2007- January 2008 – SI-TWG support in preparation of UNGASS country report.

The establishment of a Strategic Information Unit within the NCASC to steer and lead the development of a robust M&E system and operationalise the national M&E framework and guidelines has started but the unit has already suffered severe staff turnover. Plans are under way to staff the unit with a dedicated surveillance officer, and two monitoring and evaluation officers and equipment (basic computer and communications facilities).

Reliability of data

Nepal in recent years has strengthened HIV surveillance through surveys among populations at risk, such as IDU, MSM, FSW and their clients, as well as migrants. There is a good impact level data but availability of routine data at the central level needs to be improved. As a result, the 2008 UNGASS report benefits from more robust and valid data, especially for prevalence and behaviours among high risk groups. Some data sources were not previously available for the 2005 report which drew largely on routine data collection processes. It therefore did not fully meet UNGASS requirements as indicators were not always harmonised with UNGASS definitions.

Following the review and harmonisation of core HIV indicators for Nepal's response by the Strategic Information-Technical Woking Group, led by the NCASC, the methodology and definitions for core indicators have been harmonised and standardised. As a result, Integrated Bio-Behavioural Surveys in 2006 and 2007 incorporate standard indicator definitions for all groups at risk.

At the same time, discussion within the SI-TWG and in national consultations recognised and acknowledged that these surveys may not always accurately reflect national coverage among most at risk groups as they are largely conducted in intervention areas and do not take into account areas that are not reached with interventions. They therefore tend to overestimate coverage.

In the absence of other sources of reliable data, there was agreement to use IBBS data for the purpose of trend analysis and to report on UNGASS. Despite methodological limitations, HIV routine data collected will also be reflected in the UNGASS report to put survey data into the broader national context.

Challenges in Monitoring and Evaluation

While positive steps have moved the Surveillance and M&E agenda forward setting elements of the system in place, a number of gaps still remain to fully operationalise the national system:

- There is a lot of impact level data generated through IBBS and other surveys among high risk groups, yet there is still a lack of routine program monitoring data and systems within the NCASC
- The HMIS contains four HIV related indicators but can not easily absorb additional ones, which is why a separate monitoring and evaluation system for HIV and AIDS needs to be operationalised by the NCASC.
- Efforts are fragmented and sufficient information does not flow to the national system. For example, VCT sites have only now begun to provide complete reports to the NCASC.
- ART recording and monitoring needs significant strengthening to ensure regular reporting from the district level on ART patient cohorts, consolidation at the centre and analysis.
- Tools exist for many areas of work, yet they have not been fully operationalised at the district level.
- Capacity to conduct an in-depth analysis of strategic information available to effectively use it in program designs and in advocacy initiatives.

VIII. ANNEXES

Annex 1: UNGASS Indicator 1: AIDS spending

EXPENDITURE BY AIDS SPENDING CATEGORY	AMOUNT AND PERCENTAGE OF TOTAL	
Mass Communication	289,229.00	3.18%
Community Mobilization	870,379.00	9.58%
Program -Vulnerable & Special Population	478,160.00	5.26%
Voluntary counseling and testing	280,663.00	3.09%
Youth In School	226,458.00	2.49%
Youth Out Of School	121,416.00	1.34%
Prevention Programs aimed at PLHA	62,627.00	0.69%
Programs For SW & Clients	740,938.00	8.15%
Programs For MSM	562,304.00	6.19%
Harm Reduction- IDUs	923,334.00	10.16%
Workplace Activities	116,969.00	1.29%
Social Marketing	1,326,338.00	14.59%
Management Of STIs	193,695.00	2.13%
Blood Safety	42,432.00	0.47%
Prevention	6,234,942.00	68.59%
Outpatient Care	23,762.00	0.26%
Provider Initiated Testing and Counseling	52,742.00	0.58%
Antiretroviral	13,289.00	0.15%
Palliative Care	22,216.00	0.26%
Nutritional Support	850,744.00	9.36%
Specific HIV Lab Monitoring	3,481.00	0.04%
Home Based Care	201,903.00	2.22%
Opportunistic Infection (OI) Treatment	31,746.00	0.35%
Care and Treatment	1,199,883.00	13.20%
Education	22,315.00	0.25%
Orphans and Vulnerable Children	22,315.00	0.25%
Program Management	174,284.00	1.92%
Planning & Coordination	285,642.00	3.14%
Monitoring & Evaluation	81,106.00	0.89%
Serological Surveillance	192,916.00	2.12%
Drug Supply System	4,064.00	0.04%
Information Technology	61,650.00	0.68%
Upgrading Lab. Infrastructure	14,561.00	0.16%
Construction of New Health Centres	147,364.00	1.62%
Program Management & Adm. Strengthening	961,587.00	10.58%
Training	247,309.00	2.72%
Incentives for Human Resources	247,309.00	2.72%
Income Generation	14,922.00	0.16%
Social Protection & Social Protection excluding OVC	14,922.00	0.16%
Advocacy & Strategic Communication	155,624.00	1.71%
AIDS specific programs for women	8,386.00	0.09%
Aids-Specific Institutional Development	213,947.00	2.35%
Enabling Environment & Community Dev.	377,957.00	4.16%
Epidemiological Research	2,517.00	0.03%
Social Science Research	15,854.00	0.17%
Behavioural Research	12,388.00	0.14%
Research excluding Operation research	30,759.00	0.34%
Grand Total	$ 9,089,674.00	100.00%

Appendix 7: National Composite Policy Index (NCPI) 2007

COUNTRY: Nepal

Name of the National AIDS Committee Officer in charge: **National AIDS Coordination Committee (NACC)**

Signed by:

Dr. Bishnu Prasad Pandit,

Act. Secretary, Ministry of Health and Population; Chair- NACC; Member HIV/AIDS and STD Control Development Board

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Date of submission: 30 January 2008

Background

The following instrument measures one of the National Commitment and Action indicators, the National Composite Policy Index (NCPI), designed to assess progress in the development and implementation of national AIDS policies and strategies. **It is an integral part of the list of core UNGASS indicators and is to be completed and submitted as part of the 2007 UNGASS Country Progress Report.**

This third version of the NCPI has been updated to reflect new AIDS programmatic guidance and to be consistent with new and agreed to policy and implementation measurement tools[9]

NCPI data were also submitted in previous UNGASS reporting rounds in 2003 and 2005. Countries are strongly advised to conduct a trend analysis on the key questions and include a description of the findings in the 2007 Country Progress Report.[14]

STRUCTURE OF THE QUESTIONNAIRE

The NCPI is divided into two parts:

Part A to be administered to government officials.

Part A covers five areas:

1. Strategic plan
2. Political support
3. Prevention
4. Treatment, care and support
5. Monitoring and evaluation

Part B to be administered to representatives from nongovernmental organizations, bilateral agencies, and UN organizations.

Part B covers four areas:

1. Human rights
2. Civil society involvement
3. Prevention
4. Treatment, care and support

The overall responsibility for collating and submitting the information requested in the NCPI lies with the National Governments, through officials from the National AIDS Committee (NAC) (or equivalent) with support from UNAIDS and other partners.

PROPOSED STEPS FOR DATA GATHERING

1. **Designation of two technical coordinators for the study (one for part A; one for part B)**

   Technical coordinators should be given responsibility to undertake the desk review and carry out interviews to answer specific questions. Preferably, the technical coordinator for Part A should be from the NAC (or equivalent) and for Part B should be a person outside the government. These persons should ideally be familiar with the issues and have a monitoring and evaluation background, and may request the assistance of consultants with a similar background.

2. **Data gathering**

   Each section should be completed by (a) desk review and (b) interviewing key people most knowledgeable about that topic:

   - *Strategic Plan and Political Support:* the Director or Deputy Director of the National AIDS Programme or National AIDS Council, the Heads of the AIDS Programme at provincial and at

9 [1]Policy and Planning Effort Index or children orphaned and made vulnerable by HIV/AIDS, UNICEF 2005; Scaling up Towards Universal Access, UNAIDS 2006; Setting NationalTargets for MovingTowards Universal Access, UNAIDS 2006; Practical Guidelines for Intensifying HIV Prevention; UNAIDS 2007

14see Guidelines on construction of core indicators, UNAIDS 2002 and UNAIDS 2005, respectively, for the key questions in previous NCPI questionnaires

district levels and UNAIDS

- *Monitoring and Evaluation:* Officers of the National AIDS Committee or equivalent, Ministry of Health, HIV focal points of other ministries.
- *Human rights:* Ministry of Justice officials, human rights commissioners, and representatives of human rights and other relevant nongovernmental organizations and legal aid centres/institutions, persons living with HIV.
- *Civil society participation:* key representatives of major civil society organizations working in the area of HIV, persons living with HIV.
- *Prevention and Treatment care and support:* Ministries and major implementing agencies/organizations in those areas, including nongovernmental organizations and persons living with HIV.

3. Data entry, analysis and interpretation

Once the NCPI is fully completed, the technical coordinators need to carefully review all responses to determine if additional consultations or review of more documents are needed. It is important to analyze the data for each of the NCPI sections and include a write-up in the Country Progress Report in terms of progress made in policy/strategy development and implementation of programmes to tackle the country's AIDS epidemic. Comments on the agreements/discrepancies between overlapping questions in Part A and Part B should also be included, as well as a trend analysis on the key NCPI data since 2003, where available. The NCPI findings need to be presented, discussed and agreed during the national UNGASS consultation workshop (see 4 below). It is strongly encouraged to enter the final agreed data in the Country Response Information System (CRIS). If this is not possible, an electronic version of the completed questionnaire should be submitted as an annex to the Country Progress Report.

4. Consultation workshop organized by the NAC (or equivalent)

It is strongly recommended that the NAC (or equivalent) organizes a one-day broad consultation forum to discuss and endorse the major findings of the UNGASS Country Progress Report, including the results from the NCPI. It is expected that civil society organizations, including faith-based organizations, people living with HIV, gender equality groups, women's rights groups, human rights/legal advocacy organizations, and other major nongovernmental organizations are invited to participate.

NCPI Respondents

[Indicate all respondents whose responses were compiled to fill out (parts of) the NCPI in the below table; add as many rows as needed]

NCPI - PART A [to be administered to government officials]

Organisation	Name/Position	Respondents to Part A [indicate which parts each respondent was queried on]				
		A.I	A.II	A.III	A.IV	A.V
Ministry of Education & Sports	Soviet Man Shrestha, Under Secretary	✓	✓	✓	✓	✓
Ministry of Home	Pratap Pathak, Joint Secretary	✓	✓	✓	✓	✓
Ministry of Labour and Transport Management	Girija Sharma Under Secretary	✓	✓	✓	✓	✓
Ministry of Women, Children and Social Welfare	Khum Kanta Acharya	✓	✓	✓	✓	✓
National Planning Commission	Gyanendra Shrestha Under Secretary	✓	✓	✓	✓	✓
National Planning Commission	Bhupa Nath Sharma Joint Secretary	✓	✓	✓	✓	✓
Ministry of Finance	Lal Shankar Ghimire, Under Secretary	✓	✓	✓	✓	✓
Ministry of Health & Population	Babu Ram Marasini Sr. Medical Officer	✓	✓	✓	✓	✓
Cabinate Secretriate	Mithu Thapa	✓	✓	✓	✓	✓
Ministry of Local Development	Bharat Mani Pandey Section Officer	✓	✓	✓	✓	✓
Ministry of Agriculture & Cooperatives	Surendra Kumar Subedi Sr. Agriculture Economist	✓	✓	✓	✓	✓
Ministry of Culture, Tourism & Civil Aviation	Narayan Prasad Acharya	✓	✓	✓	✓	✓
Ministry of Local Development	Surya Badana Pandit Section Officer	✓	✓	✓	✓	✓

NCPI - PART B [to be administered to nongovernmental organizations, bilateral agencies, and UN organizations]

Organisation	Name/Position	Respondents to Part B [indicate which parts each respondent was queried on]			
		B.I	B.II	B.III	B.IV
Save the Children US	Lokraj Bhatta	✓	✓	✓	✓
Save the Children Norway	Nur Pant	✓	✓	✓	✓
Nepal Harm Reduction Alliance	Rishi Ojha	✓	✓	✓	✓
NAPN	Basanta Chhetri	✓	✓	✓	✓
FHI/Constella	Nirmal Panday	✓	✓	✓	✓
USAID	Devendra Karki	✓	✓	✓	✓
Recovering Nepal	Roshan Sapkota	✓	✓	✓	✓
Nepal Red Cross Society	Bipul Neupane	✓	✓	✓	✓
FWLD	Rupnarayan Shrestha	✓	✓	✓	✓
NAPN	Rajiv Kafle	✓	✓	✓	✓
UNODC	Olivier Lermet	✓	✓	✓	✓
UNICEF	Sanju Bhattarai	✓	✓	✓	✓
UNFPA	LN Thakur	✓	✓	✓	✓

Note: In the NCPI answers, N/A stands for "Not Applicable"

[To be administered to government officials]

I. Strategic plan

1. Has the country developed a national multisectoral strategy/action framework to combat AIDS?

(Multisectoral strategies should include, but are not limited to, those developed by Ministries such as the ones listed under 1.2)

Yes ✓	Period covered [2006-2011]	Not Applicable (N/A)	No

IF NO or N/A, briefly explain

***IF YES*, complete questions 1.1 through 1.10; otherwise, go to question 2.**

1.1 How long has the country had a multisectoral strategy/action framework? Number of Years: **2002 to 2011 (10 yrs, two strategic periods)**

1.2 Which sectors are included in the multisectoral strategy/action framework with a specific HIV budget for their activities?

Sectors included	Strategy/Action framework		Earmarked budget	
Health	Yes ✓	No	Yes ✓	No
Education	Yes ✓	No	Yes ✓	No
Labour	Yes ✓	No	Yes ✓	No
Transportation	Yes ✓	No	Yes ✓	No
Military/Police	Yes ✓	No	Yes ✓	No
Women	Yes ✓	No	Yes ✓	No
Young people	Yes ✓	No	Yes ✓	No
Other*: *[write in]*	Yes	No	Yes	No

* Any of the following: Agriculture, Finance, Human Resources, Justice, Minerals and Energy, Planning, Public Works, Tourism, Trade and Industry.

IF NO earmarked budget, how is the money allocated?

1.3 Does the multisectoral strategy/action framework address the following target populations, settings and cross-cutting issues?

Target populations	
a. Women and girls	a. Yes✓ No
b. Young women/young men	b. Yes✓ No
c. Specific vulnerable sub- populations[15]	c. Yes✓ No
d. Orphans and other vulnerable children	d. Yes✓ No
Settings	
e. Workplace	e. Yes✓ No
f. Schools	f. Yes✓ No
g. Prisons	g. Yes✓ No
Cross-cutting issues	
h. HIV, AIDS and poverty	h. Yes✓ No
i. Human rights protection	i. Yes✓ No
j. PLHIV involvement	j. Yes✓ No
k. Addressing stigma and discrimination	k. Yes✓ No
l. Gender empowerment and/or gender equality	l. Yes✓ No

1.4 Were target populations identified through a process of a needs assessment or needs analysis?

Yes ✓	No

IF YES, when was this needs assessment /analysis conducted? **Year: situation and response assessment 2000, other studies 2006 (during strategy development)**

IF NO, how were target populations identified?

[15] Sub-populations that have been locally identified as being at higher risk of HIV transmission (injecting drug users, men having sex with men, sex workers and their clients, cross-border migrants, migrant workers, internally displaced people, refugees, prisoners, etc.).

1.5 What are the target populations in the country? *[write in]*

MARPS

Female/male sex workers
Injecting Drug Users
Men having sex with Men
Mobile (including both external and internal migrants) populations and their spouse

At risk population

Prison population
Youth (10 -24 yrs)
Uniformed Services
Trafficked Girls

Vulnerable population

OVC
Street children

PLHAs

1.6 Does the multisectoral strategy/action framework include an operational plan?

Yes ✓	No

1.7 Does the multisectoral strategy/action framework or operational plan include:

a. Formal programme goals?	Yes✓	No
b. Clear targets and/or milestones?	Yes✓	No
c. Detailed budget of costs per programmatic area?	Yes✓	No
d. Indications of funding sources?	Yes✓	No
e. Monitoring and Evaluation framework?	Yes✓	No

1.8 Has the country ensured "full involvement and participation" of civil society[16] in the development of the multisectoral strategy/action framework?

Active involvement ✓	**Moderate involvement**	**No involvement**

IF active involvement, briefly explain how this was done:

- Civil Society were members in Strategy Development Task Force: 7 members from civil society out of 25 members
- Additional civil society were members in Strategy Development Subgroups (i.e. Prevention, Treatment etc) during the strategy development
- Wider civil society organizations were involved during national consultations, mini consultations, and during regional consultations.
- Active involvement during drafting period and reviewing the draft before finalization.

IF NO or MODERATE involvement, briefly explain:

1.9 Has the multisectoral strategy/action framework been endorsed by most external Development Partners (bi-laterals; multi-laterals)?

Yes ✓	No

[16] Civil society includes among others: Networks of people living with HIV; women's organizations; young people's organizations; faith-based organizations; AIDS service organizations; Community-based organizations; organizations of key affected groups (including MSM, SW, IDU, migrants, refugees/displaced populations, prisoners); workers organizations, human rights organizations; etc. For the purpose of the NCPI, the private sector is considered separately.

1.10 Have external Development Partners (bi-laterals; multi-laterals) aligned and harmonized their HIV and AIDS programmes to the national multisectoral strategy/action framework?

Yes, all partners	Yes, some partners ✓	No

IF SOME or NO, briefly explain

Most EDPs have harmonized their HIV and AIDS programme to National Strategy and some are in process of harmonizing and aligning their programme to national action framework

2. Has the country integrated HIV and AIDS into its general development plans such as: a) National Development Plans, b) Common Country Assessments/ United Nations Development Assistance Framework, c) Poverty Reduction Strategy Papers, d) Sector Wide Approach?

Yes ✓	No	N/A

2.1 ***IF YES***, in which development plans is policy support for HIV and AIDS integrated? a)_National Interim Plan (3Yr) b) UNDAF b. UNDAF c)_____ d) Sector wide approach (Health)____ e) other (Ministry of Home policy document)

2.2 ***IF YES***, which policy areas below are included in these development plans? ✓ Check for policy/strategy included

Policy Area	**Development Plans**				
	a)	b)	c)	d)	e)
HIV Prevention	✓	✓		✓	✓
Treatment for opportunistic infections		✓		✓	
Antiretroviral therapy				✓	
Care and support (including social security or other schemes)				✓	
AIDS impact alleviation					
Reduction of **gender** inequalities as they relate to HIV prevention/treatment, care and/or support	✓			✓	
Reduction of **income** inequalities as they relate to HIV prevention/ treatment, care and /or support					
Reduction of stigma and discrimination					
Women's economic empowerment (e.g. access to credit, access to land, training)					
Other: *[write in]*					

3. Has the country evaluated the impact of HIV and AIDS on its socio-economic development for planning purposes?

Yes	No ✓	N/A

3.1 ***IF YES***, to what extent has it informed resource allocation decisions?

Low					High
0	1	2	3	4	5

4. Does the country have a strategy/action framework for addressing HIV and AIDS issues among its national uniformed services such as military, police, peacekeepers, prison staff, etc?

Yes ✓	No

4.1 ***IF YES***, which of the following programmes have been implemented beyond the pilot stage to reach a significant proportion of one or more uniformed services?

Behavioural change communication	Yes ✓	No
Condom provision	Yes ✓	No
HIV testing and counselling*	Yes	No
STI services	Yes ✓	No
Treatment	Yes	No
Care and support	Yes	No
Others: *[Referral to ART services]*	Yes ✓	No

What is the approach taken to HIV testing and counseling? Is HIV testing voluntary or mandatory (e.g. at enrolment)? Briefly explain
HIV testing is voluntary after the joining the job

5. Has the country followed up on commitments towards universal access made during the High-Level AIDS Review in June 2006?

Yes ✓	No

5.1 Has the National Strategic Plan/operational plan and national AIDS budget been revised accordingly?

Yes ✓	No

5.2 Have the estimates of the size of the main target population sub-groups been updated?

Yes ✓	No

5.3 Are there reliable estimates and projected future needs of the number of adults and children requiring antiretroviral therapy?

Estimates and projected needs ✓	Estimates only	No

5.4 Is HIV and AIDS programme coverage being monitored?

Yes ✓	No

(a) ***IF YES***, is coverage monitored by sex (male, female)?

Yes ✓	No

(b) ***IF YES***, is coverage monitored by population sub-groups?

Yes ✓	No

IF YES, which population sub-groups?

- Sex workers
- MSMs
- IDUs
- Mobile/migrants polulation

(c) ***IF YES***, is coverage monitored by geographical area?

Yes	No ✓

IF YES, at which levels (provincial, district, other)?

5.5 Has the country developed a plan to strengthen health systems, including infrastructure, human resources and capacities, and logistical systems to deliver drugs?

Yes ✓	No

Overall, how would you rate *strategy planning efforts* in the HIV and AIDS programmes in 2007 and in 2005?

2007	Poor									Good	
0	1	2	3	4	5	6	7	**8**	9	1	0
2005	Poor									Good	
0	1	2	3	4	5	6	**7**	8	9	1	0

Comments on progress made since 2005:
The strategy development process was inclusiveness, comprehensiveness, participatory, informed decision and based on best practices within country and outside.

Target setting, action plan and resource allocation are based on standard and agreed procedures

II. Political Support

Strong political support includes government and political leaders who speak out often about AIDS and regularly chair important meetings, allocation of national budgets to support the AIDS programmes and effective use of government and civil society organizations and processes to support effective AIDS programmes.

1. Do high officials speak publicly and favourably about AIDS efforts in major domestic fora at least twice a year?

President/Head of government	Yes✓	No
Other high officials	Yes✓	No
Other officials in regions and/or districts	Yes✓	No

2. Does the country have an officially recognized national multisectoral AIDS management/coordination body (National AIDS Council or equivalent)?

Yes ✓	No

IF NO, briefly explain:

2.1 ***IF YES***, when was it created? Year: *National AIDS Council - created in 2002*

2.2 ***IF YES***, who is the Chair? [write in name and title/function] *chaired by Prime minister*

2.3 ***IF YES***, does it:

have terms of reference?	Yes	No ✓
have active Government leadership and participation?	Yes	No ✓
have a defined membership?	Yes ✓	No
include civil society representatives?	Yes ✓	No
IF YES, what percentage? ***[30]***		
include people living with HIV?	Yes ✓	No
include the private sector?	Yes ✓	No
have an action plan?	Yes	No ✓
have a functional Secretariat?	Yes	No ✓
meet at least quarterly?	Yes	No ✓
review actions on policy decisions regularly?	Yes	No ✓
actively promote policy decisions?	Yes	No ✓
provide opportunity for civil society to influence decision-making?	Yes	No ✓
strengthen donor coordination to avoid parallel funding and		
duplication of effort in programming and reporting?	Yes	No ✓

3. Does the country have a national AIDS body or other mechanism that promotes

interaction between government, people living with HIV, civil society and the private sector for implementing HIV and AIDS strategies/ programmes?

Yes ✓	No

3.1 ***IF YES***, does it include?

Terms of reference	Yes ✓	No
Defined membership	Yes ✓	No
Action plan	Yes	No ✓
Functional Secretariat	Yes	No ✓
Regular meetings Frequency of meetings: NACC (2/yr), CCM (4/yr), NAC (1)	Yes ✓	No

IF YES, What are the main achievements?
(Mainly of CCM)

1. Harmonisation and coordination
2. Resource mobilization
3. Fulfillment of national and international commitments

If Yes, What are the main challenges for the work of this body?

(Mainly of NACC, NAC)

7. Internalization of the issues is limited among the members representing non health and non government sectors
8. No regularity of meetings and often low attendance in the meeting,
9. Inadequate representation as newly emerged networks, and groups are yet to be included as member
10. Consistency and continuity of the members in the meeting is low. Turnover of the members attending the meeting from the same organization is very high, resulting into communication gap and limited contribution in the decision making process
11. No secretariat means maintaining regular communication with members and flow of information to members are limited.

4. What percentage of the national HIV and AIDS budget was spent on activities implemented by civil society in the past year?

Percentage: **approximately 80%**

5. What kind of support does the NAC (or equivalent) provide to implementing partners of the national programme, particularly to civil society organizations?

Information on priority needs and services	Yes	No ✓
Technical guidance/materials	Yes	No ✓
Drugs/supplies procurement and distribution	Yes	No ✓
Coordination with other implementing partners	Yes	No ✓
Capacity-building	Yes	No ✓
Other: *[write in]*		

6. Has the country reviewed national policies and legislation to determine which, if any, are inconsistent with the National AIDS Control policies?

Yes	No ✓

6.1 ***IF YES***, were policies and legislation amended to be consistent with the National AIDS Control policies?

Yes	No

6.2 ***IF YES***, which policies and legislation were amended and when?

Policy/Law	Year

List as many as relevant]

Overall, how would you rate the political support for the HIV/AIDS/AIDS programme 2007 and in 2005?											
2007	Poor									Good	
0	1	2	3	4	**5**	6	7	8	9	1	0
2005	Poor									Good	
0	1	2	**3**	4	5	6	7	8	9	1	0

Comments on progress made since 2005:

1. Commitment on national and international policy and declarations (MDGs, UNGASS)
2. Harmonization and alignment by most EDPs
3. Endorsement of Semi Autonomous Entity for the effective implementation of HIV/AIDS

III. Prevention

1. Does the country have a policy or strategy that promotes information, education and communication (IEC) on HIV to the *general population*?

Yes	No ✓	N/A

1.1 ***IF YES***, what key messages are explicitly promoted? ✓

Check for key message explicitly promoted

Be sexually abstinent	
Delay sexual debut	
Be faithful	
Reduce the number of sexual partners	
Use condoms consistently	
Engage in safe(r) sex	
Avoid commercial sex	
Abstain from injecting drugs	
Use clean needles and syringes	
Fight against violence against women	
Greater acceptance and involvement of people living with HIV	
Greater involvement of men in reproductive health programmes	
Other: *[write in]*	

1.2 In the last year, did the country implement an activity or programme to promote accurate reporting on HIV by the media?

Yes	No ✓

2. Does the country have a policy or strategy promoting HIV-related reproductive and sexual health education for young people?

Yes ✓	No

2.1 Is HIV education part of the curriculum in

primary schools?	Yes	No ✓
secondary schools?	Yes ✓	No
teacher training?	Yes ✓	No

2.2 Does the strategy/curriculum provide the same reproductive and sexual health education for young men and young women?

Yes ✓	No

2.3 Does the country have an HIV education strategy for out-of-school young people?

Yes	No ✓

3. Does the country have a policy or strategy to promote information, education and communication and other preventive health interventions for vulnerable sub-populations?

Yes ✓	No

IF NO, briefly explain:

3.1 ***IF YES***, which sub-populations and what elements of HIV prevention do the policy/strategy address? ✓ Check for policy/strategy included

	IDU	MSM	Sex workers	Clients of sex workers	Prison inmates	Other subpopulations* *Mobile popln*
Targeted information on risk reduction and HIV education	✓	✓	✓	✓	✓	✓
Stigma & discrimination reduction	✓	✓	✓	✓	✓	✓
Condom promotion	✓	✓	✓	✓	✓	✓
HIV testing & counseling	✓	✓	✓	✓	✓	✓
Reproductive health, including STI prevention & treatment	✓	✓	✓	✓	✓	✓
Vulnerability reduction (e.g. income generation)	N/A	N/A		N/A	N/A	
Drug substitution therapy	✓	N/A	N/A	N/A	N/A	
Needle & syringe exchange	✓	N/A	N/A	N/A	N/A	

Overall, how would you rate *policy efforts* in support of HIV prevention in 2007 and in 2005?

2007 Poor Good											
0	1	2	3	4	5	**6**	7	8	9	1	0
2005 Poor Good											
0	1	2	3	**4**	5	6	7	8	9	1	0

Comments on progress made since 2005:

1. Policy level support for harm and risk reduction programme (OST, needle syringe exchange programme)
2. Coordination among the key ministries and stakeholders improved
3. Cases of stigma and discrimination reduced
4. More P+ group and networks of vulnerable groups are emerging as a result of Policy support

4. Has the country identified the districts (or equivalent geographical/ decentralized level) in need of HIV prevention programmes?

Yes ✓	No

IF NO, how is HIV prevention programmes being scaled-up?

IF YES, to what extent have the following HIV prevention programmes been implemented in identified districts* in need? ✓ Check the relevant implementation level for each activity or indicate N/A if not applicable

HIV prevention programmes	The activity is available in		
	all districts* in need	*most* districts* in need	*some* districts* in need
Blood safety	✓		
Universal precautions in health care settings			✓
Prevention of mother-to-child transmission of HIV			✓
IEC on risk reduction			✓
IEC on stigma and discrimination reduction			✓
Condom promotion		✓	
HIV testing & counselling		✓	
Harm reduction for injecting drug users		✓	
Risk reduction for men who have sex with men		✓	
Risk reduction for sex workers		✓	
Programmes for other vulnerable sub populations			✓
Reproductive health services including STI prevention & treatment			✓
School-based AIDS education for young people		✓	
Programmes for out-of-school young people			✓
HIV prevention in the workplace			✓
Other *[write in]*			

** Districts or equivalent geographical/de-centralized level in urban and rural areas*

Overall, how would you rate the efforts in the implementation of HIV prevention programmes in 2007 and in 2005?											
2007 Poor										Good	
0	1	2	3	4	5	6	**7**	8	9	1	0
2005 Poor										Good	
0	1	2	3	4	5	**6**	7	8	9	1	0
Comments on progress made since 2005: 1. *Number of service sites (VCT, PMTCT) increased* 2. *Number of schools for health education programme increased*											

IV. Treatment, care and support

1. Does the country have a policy or strategy to promote comprehensive HIV treatment, care and support? (Comprehensive care includes, but is not limited to, treatment, HIV testing and counseling, psychosocial care, and home and community-based care).

Yes ✓	No

1.1 ***IF YES***, does it give sufficient attention to barriers for women, children and most-at-risk populations?

Yes ✓	No

2. Has the country identified the districts (or equivalent geographical/ decentralized level) in need of HIV and AIDS treatment, care and support services?

Yes ✓	No

IF NO, how are HIV and AIDS treatment, care and support services being scaled-up?

IF YES, to what extent have the following HIV and AIDS treatment, care and support services been implemented in the identified districts* in need?

✓ Check the relevant implementation level for each activity or indicate N/A if not applicable

HIV treatment, care and support services	The service is available in		
	all districts* in need	*most* districts* in need	*some* districts* in need
Antiretroviral therapy		✓	
Nutritional care			✓
Paediatric AIDS treatment			✓
Sexually transmitted infection management		✓	
Psychosocial support for people living with HIV and their families		✓	
Home-based care			✓
Palliative care and treatment of common HIV – related infections			✓
HIV testing and counselling for TB patients			✓
TB screening for HIV-infected people		✓	
TB preventive therapy for HIV-infected people			NA
TB infection control in HIV treatment and care facilities		✓	
Cotrimoxazole prophylaxis in HIV- infected people		✓	
Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape)		✓	
HIV treatment services in the workplace or treatment referral systems through the workplace			✓
HIV care and support in the workplace (including alternative working arrangements)			✓

Other programmes: *[Opportunity infection treatment]*		✓	

**Districts or equivalent de-centralized governmental level in urban and rural areas*

3. Does the country have a policy for developing/using generic drugs or parallel importing of drugs for HIV?

Yes	No ✓

4. Does the country have access to regional procurement and supply management mechanisms for critical commodities, such as antiretroviral drugs, condoms, and substitution drugs?

Yes	No ✓

4.1 IF YES, for which commodities? *[write in]*

5. Does the country have a policy or strategy to address the additional HIV- or AIDS-related needs of orphans and other vulnerable children (OVC)?

Yes	No ✓	N/A

5.1 ***IF YES***, is there an operational definition for OVC in the country?

Yes	No

5.2 ***IF YES***, does the country have a national action plan specifically for OVC?

Yes	No

5.3 ***IF YES***, does the country have an estimate of OVC being reached by existing interventions?

Yes	No

IF YES, what percentage of OVC is being reached?

Overall, how would you rate the efforts to meet the needs of orphans and other vulnerable children?											
2007 Poor										Good	
0	1	2	**3**	4	5	6	7	8	9	1	0
2005 Poor										Good	
√	**0**	1	2	3	4	5	6	7	8	9	1	0

Comments on progress made since 2005:

1. *NGO and INGOs more active providing additional support to OVCs (school fees, nutritional support, social support etc)*
2. *Care home for Children initiated*
3. *OVC and Care of children included in national CHBC manuals*
4. *Initiated activities for Children Affected by HIV and AIDS (CABA)*
5. 92% of children under ART *[55 under treatment, out of projected 60]*

V. Monitoring and Evaluation

1. Does the country have *one* national Monitoring and Evaluation (M&E) plan?

Yes √	Years covered:[2006 - 2007]	In progress	No

1.1. ***IF YES***, was the M&E plan endorsed by key partners in M&E?

Yes √ **(SITWG)**	No

1.2. ***IF YES***, was the M&E plan developed in consultation with civil society, including people living with HIV?

Yes √	No

1.3. ***IF YES***, have key partners aligned and harmonized their M&E requirements (including indicators) with the national M&E plan?

Yes, all partners	Yes, most partners√ Harmonization carried in 2006 but it takes time for all data collection tolls and instrument to be fully harmonized	Yes, but only some partners	No

2. Does the Monitoring and Evaluation plan include?

a data collection and analysis strategy	Yes√	No
behavioural surveillance	Yes√	No
HIV surveillance	Yes√	No
a well-defined standardized set of indicators	Yes√	No
guidelines on tools for data collection	Yes√	No
a strategy for assessing quality and accuracy of data	Yes√	No
a data dissemination and use strategy	Yes √ **(partially)**	No

3. Is there a budget for the M&E plan?

Yes√	Years covered: [2006-2007	In progress	No

3.1 ***IF YES***, has funding been secured?

Yes√ **(mostly)**	No

4. Is there a functional M&E Unit or Department?

Yes	In progress√	No

IF NO, what are the main obstacles to establishing a functional M&E Unit/Department?

1. Insufficient commitment and understanding of M & E and surveillance for HIV
2. No sanctioned government staff dedicated to M & E, Surveillance with appropriate training
3. Lack of physical facilities
4. Turnover of the staff

4.1 ***IF YES***, is the M&E Unit/Department based

in the NAC (or equivalent)?	Yes	No
in the Ministry of Health?	Yes	No
√ elsewhere? **[*National Centre for AIDS and STI Control]***		

4.2 ***IF YES***, how many and what type of permanent and temporary professional staff are working in the M&E Unit/Department?

Number of permanent staff:		
Position: *[Senior Public Health Officer]*	Part time√?	Since when?
Position: *[M & E Assistant]*	Full time√ ?	Since when?: *Feb 2007*
Position: *[write in]*	Full time / Part time?	Since when?:
Position: *[write in]*	Full time / Part time?	Since when?:

Etc.

Number of temporary staff:	N/A

4.3 ***IF YES***, are there mechanisms in place to ensure that all major implementing partners submit their M&E data/reports to the M&E Unit/Department for review and consideration in the country's national reports?

Yes√ **partially**	No

IF YES, does this mechanism work? What are the major challenges?

1. Only mechanism in place is for VCT and ART
2. M & E data collection forms not fully implemented
3. Limited leadership capacity on M & E
4. Currently UNAIDS implementing operationalisation of M & E data reports from partners
5. Insufficient staff at NCASC to operationalise system and collect data
6. Lack of well trained monitoring officers at the district
7. Insufficient understanding and commitment to M & E data collection
8. Challenges in VCT reporting
9. Misconception that existing HMIS offers sufficient scope for HIV M &E

4.4 ***IF YES***, to what degree do UN, bi-laterals, and other institutions share their M&E results?

Low					High
1	2	3	4√	5	6

5. Is there a M&E Committee or Working Group that meets regularly to coordinate M&E activities?

No	Yes, but meets irregularly	Yes, meets regularly √

IF YES, Date last meeting: ***[20 December 2007]***

5.1 Does it include representation from civil society, including people living with HIV?

Yes√	No

IF YES, describe the role of civil society representatives and people living with HIV in the working group?

1. As other members they provide advice and guidance to the National responses on Strategic information
2. Currently NGO members are from IDU community and have shared relevant inputs from the community in the UNGASS reporting and other tasks
3. Share and disseminate decision points to other partners

6. Does the M&E Unit/Department manage a central national database?

Yes √ **partially**	No	N/A

6.1 ***IF YES***, what type is it? *[Excel Spread sheet]*

6.2 ***IF YES***, does it include information about the content, target populations and geographical coverage of programmatic activities, as well as their implementing organizations?

Yes	No√

6.3 Is there a functional* Health Information System?

National level	Yes√	No
Sub-national level ***IF YES***, at what level(s)? *[write in]*	Yes √	No

*(*regularly reporting data from health facilities which are aggregated at district level and sent to national level; and data are analysed and used at different levels)*

6.4 Does the country publish at least once a year an M&E report on HIV, including HIV surveillance data?

Yes	No √

7. To what extent is M&E data used in planning and implementation?

Low					High
1	2	3	4√	5	6

What are examples of data use?

1. The data are used in National Planning (e.g. M & E database and M&E framework for NSP, HIV mapping, HIV fact sheet, Press releases (world AIDS Days, HIV and Migration etc)
2. Data are used for the development of National action plan (2006 -08), training, National estimations of HIV infection, National reviews such as Second Generation Surveillance and STI reviews and importantly to mobilize additional resources (e.g. used in GFATM Round 7 proposal development and World Bank concept note)

What are the main challenges to data use?

1. Lack of trained staff
2. Centralized data base to be established

8. In the last year, was training in M&E conducted

At national level?	Yes√	No
IF YES, Number of individuals trained: ***[28]***		

At sub-national level?	Yes	No √
IF YES, Number of individuals trained: *[in progress]*		
Including civil society?	Yes √	No
IF YES, Number of individuals trained: ***[18]***		

Overall, how would you rate the *M&E efforts* of the AIDS programme in 2007 and in 2005?											
2007 Poor										Good	
0	1	2	3	4	5	6	**7**	8	9	1	0
2005 Poor										Good	
0	1	2	**3**	4	5	6	7	8	9	1	0

Comments on progress made since 2005:

1. *M and E component included in other trainings (VCT, PMTCT, ART, etc)*
2. *National monitoring/review conducted in VCT, PMTCT, ART)*
3. *Situation analysis of monitoring and evaluation systems was conducted by UNAIDS, NCASC, and WHO (April – June 2006)*
4. *Performance review of the Global Fund grant managed by UNDP was carried out, employing the Global Fund monitoring and evaluation assessment tool, adapted for the local context (July 2006)*
5. *Technical working group formed to review and guide monitoring and evaluation activities (May 2006)*
6. *Selection of core indicators of the national response and development of an action plan (a work plan that was later integrated into the monitoring and evaluation guidelines)*
7. *Development of a national M&E strategy and guidelines, including tools for the implementation (used extensively in drafting GFATM Rd 7 proposal and subsequent documents)*
8. *Joint review of the STI programme by a range of partners including NCASC, WHO, UNFPA, UNAIDS, USAIDS, FHI, IOM and others (Nov 2006)*
9. *Training of Trainers on M & E (Jan 2007)*
10. *Joint national review of Second Generation Surveillance partners NCASC, WHO, UNAIDS, FHI (Feb 2007)*
11. *M&E TSG merged with Surveillance working group to form Strategic Information TWG (May 2007)*
12. *2007 National estimation of HIV infection (Aug – Dec 2007)*
13. *UNGASS country Report 2008 preparation (Oct – Jan 2008)*

Part B

[to be administered to representatives from nongovernmental organizations, bilateral agencies, and UN organizations]

I. Human rights

1. Does the country have laws and regulations that protect people living with HIV against discrimination? (such as general non-discrimination provisions or provisions that specifically mention HIV, focus on schooling, housing, employment, health care etc.)

Yes	No √

1.1 ***IF YES***, specify: *[write in]*

2. Does the country have non-discrimination laws or regulations which specify protections for vulnerable sub-populations?

Yes	No √

2.1 ***IF YES***, for which sub-populations?

Women	Yes	No
Young people	Yes	No
IDU	Yes	No
MSM	Yes	No
Sex Workers	Yes	No
Prison inmates	Yes	No
Migrants/mobile populations	Yes	No
Other: *[write in]*		

IF YES, Briefly explain what mechanisms are in place to ensure these laws are implemented:
IF

YES, Describe any systems of redress put in place to ensure the laws are having their desired effect:

3. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for vulnerable sub-populations?

Yes √	No

3.1 ***IF YES***, for which sub-populations?

Women	Yes	No √
Young people	Yes	No √
IDU	Yes √	No

MSM	Yes √	No
Sex Workers	Yes √	No
Prison inmates	Yes √	No
Migrants/mobile populations	Yes	No √
Other: *[write in]*		

IF YES, briefly describe the content of these laws, regulations or policies and how they pose barriers:

MSM: Section 1 and 4 of the Chapter on Bestiality in the Country Code, 2020 (1963) prohibits acts of "unnatural sex", with a provision for punishment of up to one-year imprisonment. It is assumed that the mentioned term "unnatural sex" also covers same sex relationship and can be used to prosecute men who have sex with men.

Section 1 and 4 of the Chapter on Bestiality in the Country Code, 2020 (1963) prohibits acts of "unnatural sex", with a provision for punishment of up to one-year imprisonment. It is assumed that the mentioned term "unnatural sex" also covers same sex relationship and can be used to prosecute men who have sex with men. Laws related with rape i.e. Chapter on Rape in the Country Code does not recognize that rape may occur to men.

The Interim Constitution of Nepal prohibits discrimination among citizens on grounds of religion, race, sex, caste, tribe, or ideological conviction or any of these; however it doesn't specifically mention sexual orientation as a ground of non-discrimination.

Also, Draft Penal Code, 2059 (2002) proposes penalizing consensual homosexual practice and proposes for up to 3 months imprisonment. They are also being harassed by police as same ways like that of Sex Workers. Recently Supreme Court of Nepal (December 21st, 2007)issued a directive to government of Nepal to introduce laws and policies to protect the rights of sexual and gender minorities and also form a committee to study current situation on same sex marriage and laws related to it.

IDU: National Narcotic Drug Policy (2006) includes rights based approach for IDU related programmes which includes service of OST, Needle syringe exchange and rights to choose treatment procedure. This policy has accepted the Drug Users not as Addicted, but as "Users" However the major regulating laws regarding to drug users i.e. Drug Control Act (2035 BS) does not recognised Drug Users as "Users" continue to use the word "Addicted'.

Government has started OST service (Teaching Hospital) and also allowed NGOs for OST services

Further, the Infectious Disease Control Act has conferred powers on His Majesty's Government to issue any order on general people or a group of people in order to prevent transmission of and to cure infectious diseases.10 This provision may be used against any specific most-at-risk groups and therefore may affect effective HIV prevention and care.
Sex worker: Supreme Court of Nepal has interpreted sex work as a profession and there is no specific laws that penalize sex work in Nepal. However, in the absence of special protection to sex workers, law dealing with public order and obscenity i.e. Some Public (Offence and Punishment) Act, 2028 (1971) is being used by police time and again to arrest, harass and prosecute sex workers. The harassment from the law enforcement agencies discourages sex workers to seek HIV prevention and care programs and therefore is an obstacle in HIV prevention and care for this group.

[10] Section 2 (1) of the Infectious Diseases Control Act, 2020 (1963).

4. Is the promotion and protection of human rights explicitly mentioned in any HIV policy or strategy?

Yes √	No

5. Is there a mechanism to record, document and address cases of discrimination experienced by people living with HIV and/or most-at-risk populations?

Yes	No √

IF YES, briefly describe this mechanism

6. Has the Government, through political and financial support, involved most-at-risk populations in governmental HIV-policy design and programme implementation?

Yes √	No

IF YES, describe some examples

Strategy development
Action Plan
Policy revisions
GFATM proposal preparation and implementation
UNGASS reporting

7. Does the country have a policy of free services for the following:

HIV prevention services	Yes √	No
Anti-retroviral treatment	Yes √	No
HIV-related care and support interventions	Yes √	No

IF YES, given resource constraints, briefly describe what steps are in place to implement these policies:

HIV prevention service is an essential part of basic health care package of Nepal Health Sector Programme – Implementation Plan. The basic health care package should be available through all government health institutions through out the country. The recent free health service programme implementation procedure (2064) has also mentioned HIV prevention service as freely available services from all public health institutions.

Government had announced in 2005 for free ARV treatment to all those who need it. The national HIV/AIDS Strategy Plan has also underscored the free ARV treatment. As for the Care and Support, all OI including TB treatment are free.

8. Does the country have a policy to ensure equal access for women and men, to prevention, treatment, care and support? In particular, to ensure access for women outside the context of pregnancy and childbirth?

Yes	No √

9. Does the country have a policy to ensure equal access for most-at-risk

populations to prevention, treatment, care and support?

Yes√	No

9.1 Are there differences in approaches for different most-at-risk populations?

Yes√	No

IF YES, briefly explain the differences:

Drop In Centres for IDUs, treatment rehabilitation, OST
ICC for migrants
Dedicated VCT and prevention services for MSM, FSWs
Targeted intervention for most-at-risk populations
Universal Access approach
Targeted IEC for different vulnerable groups

10. Does the country have a policy prohibiting HIV screening for general employment purposes (recruitment, assignment/relocation, appointment, promotion, and termination)?

Yes √	No

11. Does the country have a policy to ensure that AIDS research protocols involving human subjects are reviewed and approved by a national/local ethical review committee?

Yes √	No

11.1 ***IF YES***, does the ethical review committee include representatives of civil society and people living with HIV?

Yes√	No

IF YES, describe the effectiveness of this review committee

No PLHIV or other vulnerable group in the ethical review committee

The National Ethical Guidelines for Health Research in Nepal, enacted as per the Nepal Health Research Council Act, 1991 has criteria for specific provisions related to ethical guidelines for health-related research in Nepal. The Guidelines have criteria for the research proposal,11 ongoing review of research, and termination or suspension of approved research.12 The Guidelines have established an Ethical Review Board (ERB) in order to carry out these activities.13

However, the Guidelines do not have any specific provisions with regard to HIV and AIDS research protocols involving human subjects

12. Does the country have the following human rights monitoring and enforcement mechanisms?

– Existence of independent national institutions for the promotion and protection of human rights,

[11] Such as minimization of risk of subject, informed consent, confidentiality, mechanism for compensation, and withdrawal from research at any time without fear of any action.
[12] Such as suspension and termination of research work, if conducted against the ERB's requirement, and possibilities of unexpected serious harm to participants.
[13] Section B of the National Ethical Guidelines for Ethical Research in Nepal, Nepal Health Research Council, Kathmandu, 2001.

including human rights commissions, law reform commissions, watchdogs, and ombudspersons which consider HIV-related issues within their work

Yes √	No

- Focal points within governmental health and other departments to monitor HIV-related human rights abuses and HIV-related discrimination in areas such as housing and employment

Yes √	No

– Performance indicators or benchmarks for

a) compliance with human rights standards in the context of HIV efforts

Yes	No √

b) reduction of HIV-related stigma and discrimination

Yes	No √

IF YES, on any of the above questions, describe some examples:

The Human Rights Commission Act, 2053 (1996) has established a National Human Rights Commission to protect and promote human rights. The Commission has the mandate to work on all aspects of human rights; It has a separate desk to deal with human rights violations in relation to HIV and AIDS. However the Desk is not fully functional.

13. Have members of the judiciary (including labour courts/ employment tribunals) been trained/sensitized to HIV and AIDS and human rights issues that may come up in the context of their work?

Yes √	No

14. Are the following legal support services available in the country?

– Legal aid systems for HIV and AIDS casework

Yes √	No

– Private sector law firms or university-based centres to provide free or reduced-cost legal services to people living with HIV

Yes √	No

– Programmes to educate, raise awareness among people living with HIV concerning their rights

Yes √	No

15. Are there programmes designed to change societal attitudes of stigmatization associated with HIV and AIDS to understanding and acceptance?

Yes √	No

IF YES, what types of programmes?

Media	Yes √	No
School education	Yes √	No
Personalities regularly speaking out	Yes √	No

Other: *[write in]*
Policy champions for legal aids and human 26 person including parliamentarians, Speakers of house, Justice of supreme courts, top level civil servants, youth leaders and celebrities.

APLF in four sectors (Policy, Media, youth, Vulnerable groups)

Overall, how would you rate the *policies, laws and regulations* in place to promote and protect human rights in relation to HIV and AIDS in 2007 and in 2005?

2007 Poor Good

0	1	2	3	4	5	**6**	7	8	9	10

2005 Poor Good

0	1	2	3	4	**5**	6	7	8	9	10

Comments on progress made since 2005:
HIV and AIDS prevention, control and rights protection Bill now in Parliamentary committee
National Workplace Policy on HIV and AIDS in place (2007)
Narcotic Drug Control Policy 2006 in place
National HIV and AIDS Strategy 2006 – 2011 with emphasis on Human Rights and Multi sectoral response

Overall, how would you rate the *effort to enforce* the existing policies, laws and regulations in 2007 and in 2005?

2007 Poor Good

0	1	2	3	4	**5**	6	7	8	9	10

2005 Poor Good

0	1	2	3	**4**	5	6	7	8	9	10

Comments on progress made since 2005:
Policy Advocates at all level
Semi Autonomous Entity established as single coordinating authority
Reducing stigma and discrimination
Vulnerable groups are more organized and active, emerging new groups of vulnerable people and PLHAS

II. Civil society[14] participation

1. To what extent has civil society contributed to strengthening the political commitment of top leaders and national policy formulation?

[14] Civil society includes among others: Networks of people living with HIV; women's organizations; young people's organizations; faith-based organizations; AIDS service organizations; Community-based organizations; organizations of vulnerable sub-populations (including MSM, SW, IDU, migrants, refugees/displaced populations, prisoners); workers organizations, human rights organizations; etc. For the purpose of the NCPI, the private sector is considered separately.

Low					High
1	2	3√	4	5	6

2. To what extent have civil society representatives been involved in the planning and budgeting process for the National Strategic Plan on AIDS or for the current activity plan (e.g. attending planning meetings and reviewing drafts)

Low					High
1	2	3	4√	5	6

3. To what extent are the services provided by civil society in areas of HIV prevention, treatment, care and support included

a. in both the National Strategic plans and national reports?

Low					High
1	2	3	4√	5	6

b. in the national budget?

Low					High
1√	2	3	4√	5	6

Government budget – 1

Overall national fund - 4

4. Has the country included civil society in a National Review of the National Strategic Plan?

Yes √	No

IF YES, when was the Review conducted? Year: *[2006]*

5. To what extent is the civil society sector representation in HIV-related efforts inclusive of its diversity?

Low					High
1	2	3	4√	5	6

List the types of organizations representing civil society in HIV and AIDS efforts:

- Networks of vulnerable groups and NGOs (IDUs, MSMs, FSWs, PLHAs , Drug Recovering groups)
- Federations (Industry and commerce, Sports)
- Trade Unions,
- Alliances (HIV/AIDS related)
- Associations
- Community Support Groups (CBOs, Mothers Groups, local clubs)
- Care homes (care centres providing psychosocial and other care and treatment related supports)

Almost in all the structures and task forces civil societies are included

6. To what extent is civil society able to access

a. adequate financial support to implement its HIV activities?

Low					High
1	2	3√	4	5	6

b. adequate technical support to implement its HIV activities?

Low					High
1	2√	3	4	5	6

Overall, how would you rate the efforts to increase *civil society participation* in 2007 and in 2005?

2007 Poor										Good	
0	1	2	3	4	5	**6**	7	8	9	1	0
2005 Poor										Good	
0	1	2	3	4	**5**	6	7	8	9	1	0

Comments on progress made since 2005:
Networks empowered- skills,
Supports groups growing into NGOs
MARPs – well organized and advocating for their own rights
Capacity development
Financially strengthened, access to resources increased, able to handle comprehensive programme/projects

III. Prevention

1. Has the country identified the districts (or equivalent geographical/ decentralized level) in need of HIV prevention programmes?

Yes √	No

IF NO, how are HIV prevention programmes being scaled-up?

Being a country with concentrated epidemic, the HIV prevention programme is focused on those areas where high risk behaviours occur. For example, the districts with high mobility where possibility of sex trade is high. The country has number of districts where specific programme intervention is intensively implemented taking into consideration occurrence of risk behaviours. As such, following are the key areas where programme is being scaled up. This is also reflected while developing proposals like Global Fund Round 7.

- High migrating district sending labour migrants particularly to major Indian cities
- Districts connected with major truck route where sex trade is high
- Districts particularly closer to Indian border where illicit drug trade is high and where presence of IDUs are high.
- Though identifying the district with high number of MSM is not practical, some strategic districts where MSMs are likely to access services

IF YES, to what extent have the following HIV prevention programmes been implemented in identified districts in need?

✓ Check the relevant implementation level for each activity or indicate N/A if not applicable

HIV prevention programmes	The service is available in		
	all districts* in need	*most* districts* in need	*some* districts* in need
Blood safety	✓		
Universal precautions in health care settings		✓	
Prevention of mother-to-child transmission of HIV			✓
IEC on risk reduction		✓	
IEC on stigma and discrimination reduction			✓
Condom promotion		✓	
HIV testing & counselling		✓	
Harm reduction for injecting drug users		✓	
Risk reduction for men who have sex with men		✓	
Risk reduction for sex workers		✓	
Programmes for other most-at-risk populations			✓
Reproductive health services including STI prevention & treatment			✓
School-based AIDS education for young people	✓		
Programmes for out-of-school young people			✓

HIV prevention in the workplace			✓
Other programmes: *[write in]* OVC Prevention for sports personnel			✓ ✓

**Districts or equivalent geographical/de-centralized levels in urban and rural areas*

Overall, how would you rate the efforts in the *implementation* of HIV prevention programmes in 2007 and in 2005?											
2007 Poor Good											
0	1	2	3	4	5	**6**	7	8	9	1	0
2005 Poor Good											
0	1	2	3	**4**	5	6	7	8	9	1	0
Comments on progress made since 2005: *More civil societies mobilized* *More resources available from internal and external sources* *More area reached/covered* *National Strategy recognizing Universal Access and three "Ones"*											

IV. Treatment, care and support

1. Has the country identified the districts (or equivalent geographical/ decentralized level) in need of HIV and AIDS treatment, care and support services?

Yes ✓	No

IF NO, how are HIV and AIDS treatment, care and support services being scaled-up?:

IF YES, to what extent have the following HIV and AIDS treatment, care and support services been implemented in the identified districts* in need?

✓ Check the relevant implementation level for each activity or indicate N/A if not applicable

HIV and AIDS treatment, care and support services	**The service is available in**		
	***all* districts* in need**	***most* districts* in need**	***some* districts* in need**
Antiretroviral therapy		✓	
Nutritional care			✓
Paediatric AIDS treatment			✓
Sexually transmitted infection management		✓	
Psychosocial support for people living with HIV and their families		✓	
Home-based care			✓

HIV and AIDS treatment, care and support services	The service is available in		
	***all* districts* in need**	***most* districts* in need**	***some* districts* in need**
Palliative care and treatment of common HIV – related infections			✓
HIV testing and counseling for TB patients			✓
TB screening for HIV-infected people			✓
TB preventive therapy for HIV-infected people			✓
TB infection control in HIV treatment and care facilities		✓	
Cotrimoxazole prophylaxis in HIV-infected people		✓	
Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape)			✓
HIV treatment services in the workplace or treatment referral systems through the workplace			✓
HIV care and support in the workplace (including alternative working arrangements)			✓
Other programmes: *[write in]*			

**Districts or equivalent geographical de-centralized governmental levels in urban and rural areas*

Overall, how would you rate the efforts in the *implementation* of HIV treatment, care and support programmes in 2007 and in 2005?											
2007 Poor										Good	
0	1	2	3	4	**5**	6	7	8	9	1	0
2005 Poor										Good	
0	1	2	3	**4**	5	6	7	8	9	1	0

Comments on progress made since 2005:
ARV started and expanded- now a total of 17 ART centres are providing ARV and OI services from 2 sites since 2005
VCT expanded to 106 sites (through government and non government sectors) from 5 sites in 2005
PMTCT expanded – now 11 sites providing service. There were three trial sites (Kathmandu, BPKHIS, Bheri Zonal Hospital.) in 2005

2. What percentage of the following HIV programmes or services is estimated to be provided by civil society?

Prevention for youth	<25%	25-50%	50-75%	>75%
Prevention for vulnerable sub-populations				
- IDU	<25%	25-50%	50-75%	
- MSM	<25%	25-50%	50-75%	
- Sex workers	<25%	25-50%	50-75%	>75% >75% >75%

Counseling and Testing	<25%	25-50%	50-75%	>75%
Clinical services (OI/ART)*	<25%	25-50%	50-75%	>75%
Home-based care	<25%	25-50%	50-75%	>75%
Programmes for OVC**	<25%	25-50%	50-75%	>75%

**OI Opportunistic infections;*
***OVC Orphans and other vulnerable children*

3. Does the country have a policy or strategy to address the additional HIV- and AIDS-related needs of orphans and other vulnerable children (OVC)?

Yes	No ✓	N/A

5.1 ***IF YES***, is there an operational definition for OVC in the country?

Yes	No

5.2 ***IF YES***, does the country have a national action plan specifically for OVC?

Yes	No

5.3 ***IF YES***, does the country have an estimate of OVC being reached by existing interventions?

Yes	No

IF YES, what percentage of OVC is being reached? % *[write in]*

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

The preparation of the Nepal UNGASS report 2008 was led by the National Centre for AIDS and STI Control (NCASC), which is the main government body reponsible for leading and coordinating the national response on HIV and AIDS. Initial work for the UNGASS report compilation began in August 2007 when the SI-TWG was requested by the NCASC to start reviewing data needs, requirements, availability and quality.

This process included:

1. A briefing with the NCASC to share UNGASS country commitment and reporting objectives, including requirements for report preparation (Aug, 2007).
2. The mobilization of the existing national-level Strategic Information Technical Working Group (SI-TWG) to guide the review of data sources and validation and to provide technical support during the process. Membership includes: NCASC, NGOs and civil society, I/NGOs, research organisation, Institute of Medicine, bilaterals and UN agencies
3. Two SI-TWG meetings to review and discuss data available and issues and challenges surrounding it (14-15 Nov, 2007).
4. UNGASS reporting and steps shared in National meeting for the dissemination of the National Strategic Plan, M&E guidelines and Semi-Autonomous Entity.
5. A national consultation was held with a much broader audience to review all available data (both survey and routine data presented) and provide an opportunity for discussion. This consultation was also an opportunity to discuss the implications of reporting specific findings and to present any additional studies or data which had not been previously considered (23 Nov, 2007).
6. The formation of a Task Force to lead on report compilation (23 Nov, 2007) with inclusive civil society representation. Start drafting report (26-30 Nov, 2007).
7. Two meeting of the Task Force to discuss membership, TORs and roles (29 Nov 07 and 5 Dec 07).
8. A briefing was held on the National Composite Policy Index (NCPI) and National AIDS Spending Assessment (NASA) at the NCASC (14 Dec, 2007).
9. Two meetings and consultations held 1) with government and 2) civil society, I/NGOs, development partners and the UN; to review the NCPI and NASA indicators (planned for 19 Dec and 20th Dec, 2007).
10. Final qualitative analysis for NCPI, and Final review (25 Jan 2008).
11. Submission to UNAIDS in Geneva for inclusion in regional submissions (30 Jan 2008)

Nepal like a number of countries committed to reporting every two years on the Declaration of Commitment at the United Nations General assembly Special Session on HIV and AIDS in 2001. The 2008 country report is also seen as an opportunity to provide a bi-annual national update on status of the HIV epidemic and the national response, particularly to discuss progress made, future challenges, and any corrective actions required in terms of policy and programmes. In addition, the report will be used to showcase available data, inform future programmes and advocate further strengthening of monitoring and evaluation in Nepal.

As technical support for UNGASS 2007, an existing national SI-TWG first outlined a roadmap, which identified the types of data required to address indicator, the sources of data and required analyses. Following a review and analysis of indicator data used for HIV in Nepal, more data is available to report on UNGASS, but a number of sources still needed to be reviewed or altered. The plan also specified timelines, degree and type of technical suppport as well as roles and responsibilities. The detailed road map for each UNGASS indicator identified the:

- Specific data source and measurement tool (e.g survey, bio-behavioural survey, routine programme reports, key informant interviews etc)
- Agency/Organization who would provide technical support for indicator collection and analysis (e.g. UNAIDS, WHO, FHI, UNICEF)
- Remarks on availbility of data, and/or how it would be developed/generated (eg. routine vs. survey).

A national consultation meeting was held in the last week of November, 2007 to review the data available from recent surveys and discuss the implications of reporting these figures. The meeting had several objectives:

- To provide information on UNGASS reporting process, and feedback received from UNAIDS, Geneva on Nepal's last UNGASS report for 2006.
- To present the draft indicator data and sources used.
- For each most at risk group, discuss with stakeholders whether other data is available, consistency of findings and possible linkages between findings on impact, coverage, and kowledge and reported safe practices.

It was agreed at the national consultation meeting (23rd Nov 2007) that a Task Force be established to provide oversight for finalisation of the report.

Task Force membership proposed included: NANGAN; NAPN; BDS federation; Recovering Nepal; HIV/AIDS alliance; FSWs to be represented by SWAN; Ministry of Home; Ministry of health and population; Ministry of Labour and Transportation; Ministry of Education and sports; World Vision international

Specific tasks in the Task Force TORs were to:

1. Provide overall oversight on the UNGASS reporting process.
2. Provide technical and substantive guidance on content.
3. Review draft and final report and provide comments.
4. Facilitate national/government endorsement on UNGASS report.

(These tasks were replaced in 5 Dec Taskforce meeting)

Two Task Force meetings were held on 29 November and 5 December 2007 to review the draft TORs, membership and work plan for the Task Force.

Modified TORs:

1. provide oversight on the development of the coordinated country report on 'UNGASS 2008 reporting'.
2. ensure participation of different constituencies in the consultation meeting for development on UNGASS reporting.
3. support in the dissemination and plan for the use of 'UNGASS 2008 Reporting'

(Please fill in any other process activities undertaken up to Jan 15th 2008, e.g. final meeting to share report and findings, peer review processes etc)

The process for preparation of Nepal's UNGASS report 2008 has been inclusive and participatory. Civil society in particular has had substantial opportunities for

involvement in the preparation of the report. Specific inputs (through membership on the SI-TWG, task force, consultation meetings, involvement in data collection etc.) include provision of information, sharing of experiences and views, analysis and interpretation of indicator data, completion of the NCPI and review of the draft country report. As a result, there is an invisible ownership of the report among stakeholders and civil society groups. Moreover, participation has resulted in broader understanding and technical grasp of monitoring and evaluation (M&E) needs for HIV/AIDS. In addition, UNGASS reporting increases awareness and provides an opportunity to strengthen the national M&E system, as well as strengthening the overall national response.

Nb: UNAIDS regional office provided the services of a consultant (from a pool of regional consultants available and trained to provide support to UNGASS reporting 2008) to provide the following support:

- *Review data analysed and ensure final consistency with UNGASS specifications.*
- *Begin to draft the narrative report, incorporating the qualitative notes arising from consultative meetings (namely SI-TWG and the national consultation).*
- *Provide training to NCASC in data entry in Excel format for the UNGASS indicator file.*

Annex 4: Routine programme monitoring data

Compare figures with those from routine programme monitoring sources *(do not report in excel indicator file).*

Percentage of MARPs reached with HIV prevention programmes *(Indicator 9 -using routine data)*			
	2005	2006	2007
FSW	35%	37.49%	23.98%
IDU	8.6%	12.57%	24.54%
MSM	0.04%	0.46%	0.36%
Migrants	0.04%	4.45%	33.3%

Source: 2006 and 2007 routine programme data and national estimates

MARPs that received an HIV test in last 12 months and who know their results (routine data-UNGASS # 9)			
	2005	2006	2007
FSW	3.07%	4.07%	5.83%
IDUs	NA	5.55%	6.75%
MSM	0.04%	0.06%	0.36%

Source: Routine programme reporting (not available for Migrants or Clients)

Annex 5: List of contributors

The members of the UNGASS Task force formed for the UNGASS Country Report included:

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The on-going work to strengthen Strategic Information in Nepal and contributions from members of the Strategic Information Technical Working Group were instrumental in generating and reviewing country data. These included:

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Annex 6: References

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