INTRODUCTION
Nepal has been producing country HIV estimates since 2003. These are updated every two years. The current estimates are the fifth, using data until the end of 2011. With the improvement of estimation methods as well as increased availability of good quality data, the estimates are becoming more and more robust. The National Centre for AIDS and STD Control (NCASC) is leading this process with support from its technical partners, notably UNAIDS, WHO and FHI360. These estimates are useful for understanding the HIV epidemic in the country, as well as providing an update on key parameters for estimating HIV service and programme needs, and for setting national targets.

EPIDEMIC SITUATION
HIV related data are collected regularly through programme monitoring and surveys, particularly the Integrated Bio-behavioural Surveys (IBBS) that are carried out routinely. The IBBS provides the most updated information. Recent data from the IBBS (2009-11) in Nepal suggests that HIV is continuing to be confined within key affected population groups.

People who inject drugs (PWIDs), gay men and other men who have sex with men (MSM), sex workers (both male and female), male labour migrants (particularly to India, where they likely visit sex workers) are at the centre of the epidemic, with a higher risk of acquiring HIV. Overall, the epidemic is largely driven by sexual transmission that accounts for more than 85% of the total new HIV infections. According to the new estimates, there are around 50,000 people living with HIV in Nepal with an overall national HIV prevalence of 0.3% (Figure 1) among adults aged 15-49 years.
DATA AND METHODS

The latest Spectrum software (version 4.50) with the built-in Estimation and Projection Package (EPP)\(^1\) was used to generate the 2011 HIV estimates of Nepal. Spectrum/EPP is a tool for country-level estimations and short-term projections, based on fitting observed HIV prevalence data from surveillance. Nepal used the Workbook method for its first three rounds of HIV infection estimations, up to 2007 (NCASC 2010). Since 2009, Nepal has been using EPP/Spectrum concentrated template for its estimations. This is considered more robust than Workbook. The EPP/Spectrum model uses more data points, including the use of repeated rounds of surveys, from IBBS, programme data (ART and PMTCT) and improved methods of analysis.

Furthermore, EPP/Spectrum model was recommended by UNAIDS, for countries with concentrated epidemics that have adequate data on their key population groups, as required by the model.

Data on HIV prevalence among key population groups from various surveillance sites over the years (1999-2011) are used in the Spectrum/EPP model. Key population groups that are considered for estimation include PWIDs, Male Sex Workers (MSW) and TGs and their clients (MTCs), other men who have sex with men (MSM), Female Sex Workers (FSWs), Clients of FSWs, Male Labour Migrants. Besides HIV prevalence data, population size of all the above key population groups (HSCB/NCASC 2011) and number of people currently on ART (2004-11) and number of mothers currently receiving PMTCT services (2006-11) are included in the model. PMTCT programme data were used as a proxy for the remaining male and female population. Curve fitting was run independently by fitting the model to all data. Calibration was done for different population subgroups based on the other available data and experience of the HIV programme in the country. The epidemic curve was calibrated downwards as per the assumptions and programme experiences to make the projection more realistic. This curve, along with national population estimates and epidemiological assumptions is the input for calculating key parameters, including HIV incidence, number of people living with HIV (PLHIV), AIDS deaths, ART and PMTCT needs and AIDS orphans among others.

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\(^1\) Spectrum is a suite of easy to use policy models which provide policymakers with an analytical tool to support the decision making process. For more information please review UNAIDS/WHO Global Reference Group on HIV and STI Surveillance. Available at: http://www.unaids.org/en/dataanalysis/datatools/spectrumepp2011/
RESULTS

The total number of people living with HIV for 2011 is estimated at 50,200 with an overall national HIV prevalence of 0.3 per cent. This is a decline from 2010 national prevalence of 0.38 per cent. Out of the total estimated infections, 3,805 are children in the 0-14 year’s age group (7.6%). The remaining 46,484 are adults 15 years and above (92.4%) (Figure 2). It must be noted that 3,246 infections are amongst people over the age of 50 years (6.5%). By sex, more than two-thirds of the infections have occurred among males (66.5%). 33.5% of infections are in women, out of which around 84% are in the reproductive age group of 15-49. It is also noteworthy that there has been a decline of HIV prevalence among youth, aged 15 to 24 (Figure 3).

FIGURE 2: Estimated HIV infections by age groups, 2011

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Estimated number of infections</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-14 years</td>
<td>1,953, 1,852</td>
</tr>
<tr>
<td>15-24 years</td>
<td>3,023, 2,095</td>
</tr>
<tr>
<td>25-49 years</td>
<td>26,028, 12,091</td>
</tr>
<tr>
<td>50+ years</td>
<td>2,444, 802</td>
</tr>
</tbody>
</table>

---


[Graph showing estimated HIV infections and prevalence from 1985 to 2015]
The estimates show that females account for approximately 27.3% of the total infections, followed by male labour migrants, remaining males, other MSMs, MTCs, clients of FSWs, PWIDs and FSWs with 27.0%, 14.0%, 7.2%, 4.4%, 2.2% and 1.5% respectively (Figure 4 and 5).

If this trend continues the number of people living with HIV in Nepal is projected to fall from the current (2011 estimate) of 50,200 to 42,750 in 2015 (Figure 5).

The model suggests that the new infections will decrease by more than half from 1,437 in 2011 to 534 in 2015 (Figure 6). This suggests
that Nepal will achieve the HLM target of 50% reduction in new HIV infection earlier (NCASC 2012).

The estimated number of annual AIDS deaths of all ages is projected to decrease from the current 2011 estimate of 4,722 to 1,576 in 2015. This decline is most likely due to the increase of the number of people on antiretroviral treatment (Figure 7).

The treatment needs were estimated (using CD4 count <350) at 27,288 (adults: 25,169, children: 2,119) in 2011. These numbers are projected to rise to 28,791 (adults: 26,896, children: 1,896) in 2015 (Table 7).

Additionally, it was found that 933 pregnant women are in need of PMTCT services. This number is likely to decline by one third by 2015, to 599, if the current epidemic scenario continues (Table 7).
METHODOLOGICAL LIMITATIONS

A large part of the epidemiological assumptions are based on global proxies due to lack of Nepal-specific data, which may not best fit in our national scenario. Findings are not comparable with previous estimations due to updates on the estimation tool -EPP/ SPECTRUM on every round of projections. Furthermore, mobility due to conflict after the census in 2001 might have impact the current projections, especially among migrants, because the 2001 population census data was used to project the population data. Another limitation is that most of the HIV prevalence data came from areas where prevention programmes exist. These figures are, therefore, not representative of the wider population of the country. Lack of sufficient data disaggregated at the sub-national level to fit the curves from EPP is also a limitation. Since HIV population-wide prevalence data are not available, PMTCT programme data have been used as proxies for males and females who are not part of key affected populations.

DISCUSSION

Regular production and updates of HIV estimates are central to Nepal’s efforts to provide much needed strategic information to guide the HIV national response. Specific information on the projection of HIV over the years is not only essential but key for designing high quality HIV interventions including projection of future investments. However, the quality and accuracy of the estimates depends largely on the quality and accuracy of the data used in the projection model. Over the years, Nepal has generated a fair amount of new data, focusing on the drivers of the epidemic - particularly the key affected populations that must be central for current and future investments, to achieve the most significant successes towards “Getting to Zero” in Nepal.

Although the overall HIV prevalence is showing a declining trend, based on a proven reduction in the number of new HIV infections, attention will be given to the rising trend of HIV, particularly among street-based female sex workers, in addition to gay men and other men who have sex with men, for whom the HIV prevalence has not changed much.

It should be also noted that most of the data are used in the projection model are from capital city, Kathmandu. Strategic data collection, generation and analysis will increasingly be undertaken from the other regions of Nepal. This will require geographical expansion of future IBBS. In addition to migrants, more proxy data to explain the contribution of clients of sex workers to the HIV epidemic in Nepal is required, in order to improve the estimates.

Estimations, using the EPP/Spectrum Model generate strategic information in measuring the country’s progress on ART coverage for adults and children and mothers needing PMTCT services. The new estimations suggest that there is a considerable gap in the coverage of ART and PMTCT, which requires rapid scaling up. Although the number of people who are in need of ART has gone up, due to the recent adjustment of WHO CD4 criteria, treatment coverage is far below the global and regional averages.

CONCLUSION

Nepal will continue its efforts, not only to regularly produce national HIV estimates; the country is also committed to improve the quality and accuracy of these estimations. Data collection will be expanded to cover wider geographical areas besides the capital city, and collaboration with civil society will be intensified to get the right information on the HIV epidemic, and to get this information right. Only with good quality and trusted strategic information can well-planned actions and investments be undertaken to get to “Zero New Infections, Zero Discrimination and Zero AIDS-Related Deaths”: Major contributions to reaching and sustaining the Millennium Development Goals, as a shared responsibility.

REFERENCES


2 Antiretroviral therapy for HIV infection in Adults And Adolescents: Recommendations for a public health approach: 2010, WHO
### TABLE 1: HIV Infections by age and sex, 2011

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
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<tbody>
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<td>0-4</td>
<td>742</td>
<td>705</td>
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<tr>
<td>5-9</td>
<td>833</td>
<td>790</td>
<td>1,622</td>
</tr>
<tr>
<td>10-14</td>
<td>378</td>
<td>358</td>
<td>736</td>
</tr>
<tr>
<td>15-19</td>
<td>456</td>
<td>335</td>
<td>791</td>
</tr>
<tr>
<td>20-24</td>
<td>2,567</td>
<td>1,760</td>
<td>4,328</td>
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<tr>
<td>25-29</td>
<td>5,874</td>
<td>3,684</td>
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<td>30-34</td>
<td>6,563</td>
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</tr>
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<td>45-49</td>
<td>3,055</td>
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</tr>
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<td>1,535</td>
<td>524</td>
<td>2,058</td>
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<tr>
<td>55-59</td>
<td>631</td>
<td>214</td>
<td>844</td>
</tr>
<tr>
<td>60-64</td>
<td>214</td>
<td>57</td>
<td>271</td>
</tr>
<tr>
<td>65-69</td>
<td>54</td>
<td>7</td>
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<td>75-79</td>
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</tr>
<tr>
<td>80+</td>
<td>2</td>
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<td>2</td>
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<tr>
<td><strong>Total</strong></td>
<td>33,447</td>
<td>16,841</td>
<td>50,288</td>
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### TABLE 2: Estimated HIV incidence among young population (15-24yrs), 2000-2015

<table>
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<th>Female</th>
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<td>2000</td>
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<td>2003</td>
<td>0.39</td>
<td>0.26</td>
<td>0.07</td>
</tr>
<tr>
<td>2004</td>
<td>0.38</td>
<td>0.26</td>
<td>0.06</td>
</tr>
<tr>
<td>2005</td>
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<tr>
<td>2009</td>
<td>0.18</td>
<td>0.13</td>
<td>0.01</td>
</tr>
<tr>
<td>2010</td>
<td>0.14</td>
<td>0.10</td>
<td>0.01</td>
</tr>
<tr>
<td>2011</td>
<td><strong>0.11</strong></td>
<td><strong>0.08</strong></td>
<td><strong>0.01</strong></td>
</tr>
<tr>
<td>2012</td>
<td>0.08</td>
<td>0.06</td>
<td>0.01</td>
</tr>
<tr>
<td>2013</td>
<td>0.06</td>
<td>0.05</td>
<td>0.00</td>
</tr>
<tr>
<td>2014</td>
<td>0.05</td>
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<tr>
<td>2015</td>
<td>0.04</td>
<td>0.03</td>
<td>0.00</td>
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### TABLE 3: HIV population among adults and children, 2000-2015

<table>
<thead>
<tr>
<th>Year</th>
<th>Total HIV Population</th>
<th>HIV population: Adults (15+)</th>
<th>HIV population: Children (0-14)</th>
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<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>Total</td>
</tr>
<tr>
<td>2000</td>
<td>24,181</td>
<td>10,225</td>
<td>34,406</td>
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<td>2001</td>
<td>30,146</td>
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<td>2002</td>
<td>35,530</td>
<td>15,506</td>
<td>51,036</td>
</tr>
<tr>
<td>2003</td>
<td>39,792</td>
<td>17,633</td>
<td>57,425</td>
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<tr>
<td>2004</td>
<td>42,594</td>
<td>19,165</td>
<td>61,759</td>
</tr>
<tr>
<td>2005</td>
<td>43,869</td>
<td>20,047</td>
<td>63,916</td>
</tr>
<tr>
<td>2006</td>
<td>43,777</td>
<td>20,321</td>
<td>64,098</td>
</tr>
<tr>
<td>2007</td>
<td>42,663</td>
<td>20,124</td>
<td>62,787</td>
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<tr>
<td>2008</td>
<td>40,807</td>
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<tr>
<td>2009</td>
<td>38,466</td>
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<tr>
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<td>2011</td>
<td><strong>33,447</strong></td>
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<td><strong>50,288</strong></td>
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<td>2012</td>
<td>31,543</td>
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<tr>
<td>2013</td>
<td>30,131</td>
<td>15,511</td>
<td>45,641</td>
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<tr>
<td>2014</td>
<td>28,964</td>
<td>15,040</td>
<td>44,004</td>
</tr>
<tr>
<td>2015</td>
<td>28,063</td>
<td>14,687</td>
<td>42,750</td>
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</table>
### TABLE 4: Estimated HIV infection by key population groups, 2011

<table>
<thead>
<tr>
<th>Key Affected Populations</th>
<th>Total Population (age 15+ years)</th>
<th>Estimated HIV infections (15—49 years)</th>
<th>% of total infections</th>
</tr>
</thead>
<tbody>
<tr>
<td>People who inject drugs (PWIDs)</td>
<td>31,103</td>
<td>939</td>
<td>2.2%</td>
</tr>
<tr>
<td>Male Sex Workers, Transgender and their Clients (MTCs)</td>
<td>73,894</td>
<td>3,099</td>
<td>7.2%</td>
</tr>
<tr>
<td>Other men who have sex with men (MSM)</td>
<td>172,525</td>
<td>6,245</td>
<td>14.4%</td>
</tr>
<tr>
<td>Female Sex Workers (FSWs)</td>
<td>26,574</td>
<td>647</td>
<td>1.5%</td>
</tr>
<tr>
<td>Clients of FSWs</td>
<td>727,854</td>
<td>1,915</td>
<td>4.4%</td>
</tr>
<tr>
<td>Male Labour Migrants</td>
<td>1,281,125</td>
<td>11,672</td>
<td>27.0%</td>
</tr>
<tr>
<td>Remaining Male Population</td>
<td>4,663,778</td>
<td>6,914</td>
<td>16.0%</td>
</tr>
<tr>
<td>Remaining Female Population</td>
<td>7,276,167</td>
<td>11,808</td>
<td>27.3%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>14,253,020</strong></td>
<td><strong>43,239</strong></td>
<td><strong>100.0%</strong></td>
</tr>
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</table>

### TABLE 5: Estimated number of new HIV infections, 2000-2015

<table>
<thead>
<tr>
<th>Year</th>
<th>Total HIV Population</th>
<th>HIV population: Adults (15+)</th>
<th>HIV population: Children (0-14)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>Total</td>
</tr>
<tr>
<td>2000</td>
<td>6,748</td>
<td>2,914</td>
<td>9,661</td>
</tr>
<tr>
<td>2001</td>
<td>7,175</td>
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<td>10,328</td>
</tr>
<tr>
<td>2002</td>
<td>6,983</td>
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<tr>
<td>2003</td>
<td>6,304</td>
<td>2,864</td>
<td>9,168</td>
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<tr>
<td>2004</td>
<td>5,306</td>
<td>2,460</td>
<td>7,766</td>
</tr>
<tr>
<td>2005</td>
<td>4,223</td>
<td>2,004</td>
<td>6,227</td>
</tr>
<tr>
<td>2006</td>
<td>3,235</td>
<td>1,570</td>
<td>4,805</td>
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<tr>
<td>2007</td>
<td>2,481</td>
<td>1,237</td>
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<td>2008</td>
<td>1,856</td>
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<td>1,134</td>
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<td>2011</td>
<td><strong>932</strong></td>
<td><strong>505</strong></td>
<td><strong>1,437</strong></td>
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<td>2012</td>
<td>714</td>
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<td>2013</td>
<td>541</td>
<td>283</td>
<td>825</td>
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<tr>
<td>2014</td>
<td>437</td>
<td>225</td>
<td>662</td>
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<tr>
<td>2015</td>
<td>356</td>
<td>178</td>
<td>534</td>
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### TABLE 6: Estimated number of annual AIDS deaths, 2000-2015

<table>
<thead>
<tr>
<th>Year</th>
<th>Total HIV Population</th>
<th>HIV population: Adults (15+)</th>
<th>HIV population: Children (0-14)</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
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<td>Total</td>
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<tr>
<td>2000</td>
<td>706</td>
<td>284</td>
<td>991</td>
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<tr>
<td>2001</td>
<td>989</td>
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<tr>
<td>2002</td>
<td>1,340</td>
<td>547</td>
<td>1,887</td>
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<td>2003</td>
<td>1,749</td>
<td>718</td>
<td>2,467</td>
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<tr>
<td>2004</td>
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<td>3,101</td>
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<td>2005</td>
<td>2,635</td>
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<tr>
<td>2015</td>
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<td>499</td>
<td>1,576</td>
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### TABLE 7: Estimated ART needs (Adult and Children) and Mothers needing PMTCT

<table>
<thead>
<tr>
<th>Year</th>
<th>Need of ART 15+</th>
<th>Need for ART Children (0-14)</th>
<th>Total ART Need</th>
<th>Mother Needing PMTCT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td>Female</td>
<td>Total</td>
<td>Male</td>
</tr>
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For further information:

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National Centre for AIDS and STD Control
Teku, Kathmandu
Ph: 977-1-4261653, 4262753, 4258219
Email: info@ncasc.gov.np, web: www.ncasc.gov.np

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