Scaling up towards universal access to HIV/AIDS prevention, treatment, care and support

NEPAL COUNTRY REPORT

His Majesty's Government of Nepal
Ministry of Health

National Centre for AIDS and STI Control (NCASC)

Regional Consultation on Universal Access
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Acronyms and abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral
AusAID	Australian Agency for International Development
BSS	Behavioural Surveillance Surveys
CCA	Common Country Assessment
DACC	District AIDS Coordination Committee
DDC	District Development Committee
DFID	UK Department for International Development
DoC	Declaration of Commitment
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
IDU	Injecting Drug User
IEC	Information, Education and Communication
ILO	International Labour Organisation
INGO	International Non Governmental Organization
MoHP	Ministry of Health and Population
MSM	Men Who Have Sex with Men
MTCT	Mother to Child Transmission
NAC	National AIDS Council
NACC	National AIDS Coordination Committee
NCASC	National Centre for AIDS and STD Control
NGO	Non-Governmental Organization
OVC	Orphans and Vulnerable Children
PMTCT	Prevention of Mother to Child Transmission
STD	Sexually Transmitted Disease
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

COUNTRY COMMITMENT TO UNIVERSAL ACCESS

The Kingdom of Nepal has committed itself to moving towards universal access to HIV prevention, treatment, care and support for its people. The country is experiencing a **concentrated epidemic** which is spreading rapidly among its most-at-risk groups. It seems unlikely that the national response will achieve the Millennium Development Goal target of halting and beginning to reverse the spread of HIV/AIDS by 2015.

If Nepal's HIV response is to be scaled up, the country will need to continue its struggle to achieve the **three ones** and the recommendations of **the Global Task Team on Improving AIDS Coordination Among Multilateral Institutions and International Donors**.

The report that follows will describe the nature of the HIV epidemic in Nepal as well as the performance of the national response, its obstacles, goals, key targets and actions for a scaled-up effort towards universal access. This will be done in terms of the following areas of the national programme:

10 recommendations of the Global Task Team (July 2005):

1. National mechanisms that drive implementation and provide a basis for the alignment of external support.
2. Macroeconomic policies that support the response to AIDS.
3. Alignment of external support to national strategies, policies, systems, cycles, and plans.
4. Approaches to progressively shift from project to programme financing, and harmonisation of programming, financing and reporting.
5. Closer UN coordination on AIDS at country level.
6. UN system-Global Fund problem-solving mechanisms at global level.
7. Clarification of the division of labour among multilateral institutions
8. Increased financing for technical support.
9. Country assessments of the performance of multilateral institutions, international partners and national stakeholders.
10. Strengthening of country monitoring and evaluation mechanisms and structures that facilitate oversight.

II.1 – Advocacy, public policy and legal framework
II.2 – Strategic planning, alignment and harmonization
II.3 – Sustainable financing
II.4 – Human resources
II.5 – Organization and systems
II.6 – Infrastructure
II.7 – Partnerships
II.8 – Service coverage

These areas and their interrelationships will be discussed throughout this report.

NEPAL'S CONCENTRATED HIV EPIDEMIC

The HIV/AIDS situation in the Kingdom of Nepal has been categorised as a **concentrated epidemic**. This is because HIV prevalence estimates for the general population are around 0.7% while they may be as high as 52% amongst some of the groups identified as being most-at-risk. In this country context, most-at-risk groups include intravenous drug users, female sex workers and migrants.

The **country's vulnerability to HIV and AIDS** are further exacerbated by:

- Geographic and ethnic diversity
- Its landlocked location between India and China
- Poverty, inequality and underdevelopment
- Civil conflict and political instability
- Varied levels of knowledge about HIV transmission among most-at-risk groups and young people
- Insufficient risk reduction behaviours among most-at-risk groups and young people

These factors as well as the limited coverage and utilisation of HIV-related health services have also made **projecting the course and impact of epidemic** a challenging task.

The nature of Nepal's HIV epidemic

The first cases of AIDS were reported in Nepal in 1988. The epidemic that emerged has largely been transmitted through injecting drug use and unprotected sexual contact. The most recent prevalence estimates for Nepal indicate a **low-prevalence among the general population** – based on seroprevalence studies of ANC (0.7%, 2005) and blood donors (0.29%, Kathmandu, 2005). As of December 2005, the Ministry of Health (MoHP) has reported 959 cases of AIDS and 5,828 HIV infections. Given the existing medical and public health reporting system in Nepal and the limitations of the national HIV and AIDS surveillance system, it is very likely that the actual number of cases is many times higher. Nonetheless, Nepal's HIV epidemic is thought to be largely isolated to these groups identified as most-at-risk – consistent with a concentrated epidemic.

HIV transmission and prevalence in Nepal

- Predominant modes of transmission are injecting drug use and unprotected sexual contact, mainly heterosexual but increasing among men who have sex with men (MSM)
- Current prevalence of HIV/AIDS among urban-based MSM is 4%.
- Highest rates of HIV have been identified in injecting drug users (IDUs)
- Data indicates that risk behaviours are widespread among sex workers (FSWs), their clients, injecting drug users, labour migrants and youth/young people.
- Current estimated HIV infection rate is 0.3 % of the adult population between the ages of 15 - 49.
- There was evidence of an explosive increase in the number of infections from 1996, which now may have started to stabilize
- Increasing levels of Sexually Transmitted Diseases (STDs) reported

Prevalence rates in Kathmandu

Percentage of most-at-risk populations who are HIV infected:

Female Sex Workers	2%
Intravenous Drug Users	51.6%
Men who have Sex with Men	3.9%
Others (spouses of MAR)	12.4%

(Source: IBBS study- NCASC / New Era / SACTS / USAID/FHI 2004, 2005)

The low prevalence currently estimated among the general population is understood to be masking an **increasing prevalence among higher risk groups** including, FSWs (2% in Kathmandu, SACTS, 2005), IDUs (51.6% nationwide and 58% in the Kathmandu Valley, NCASC/USAID/FHI, New Era, 2005) and labour migrants returning from Mumbai (India) (7.7%, NCASC/USAID/FHI, New Era, 2002).

HIV infection has been noted among men and women and in rural and urban areas. There are however **more cases reported among men** (3 men for every woman, NCASC, 2006) and more cases reported in the **Central Region and in urbanized areas and districts where migrant labour is more common**. Accurate estimates of the rural-urban ratios are yet to be determined, but prevalence rates for rural districts are varied.

Table 1: Summary of the epidemiological situation in Nepal

	Data	Date
Estimated number of adults & children living with HIV/AIDS	68,600	2005
Estimated adult and child mortality due to HIV/AIDS	3,800	2005
Reported HIV cases	5828	Dec 2005
Reported AIDS Cases	959	Dec 2005

Source: NCASC, 2005

HIV knowledge and risk behaviour of young people in Nepal

The 2005 study conducted among 2401 young males and females aged 15-29 (56% under 19 years and 64% unmarried) reported that **youth in urban areas had high levels of knowledge about HIV and its prevention** - 95% had heard of HIV/AIDS and over 80% seem to know at least 3 correct ways to avoid HIV transmission. In general, knowledge on how HIV is transmitted found to be above 93 percent among all age groups. As shown in Table 2, the youths from 15-19 years seem to know more correct ways to avoid transmission (New Era/UNAIDS 2005).

Table 2: Knowledge of correct ways of HIV transmission by age group

Age group	No. of correct ways known					Total
	1	2	3	4	>=5	
15-19 Years	3.4%	12.0%	29.8%	29.6%	25.1%	100%
20-24	5.9%	11.4%	33.4%	28.7%	20.6%	100%
25-29	5.2%	16.8%	32.9%	26.6%	18.5%	100%
Total	4.7%	13.1%	31.9%	28.5%	21.8%	100%

According to the same study, the **mean age of first sex** is about 20 for males and 18 for females, predominantly in the context of marriage. Several studies have found that premarital sex is becoming more acceptable for both sexes, with 20 percent of teenagers considering it acceptable among young people[1]. In another study of 800 students, over 70 percent claimed to have had sex before the age of 19 years, with only eight percent of these students were married[2].

This profile is not applicable for one vulnerable group of young people – street children. A UNESCO/CREHPA (2005) study conducted among street children (age group 12-17) in two major locations Kathmandu (n=400) and Pokhara (n=113) revealed that **mean age of first sexual intercourse for street children was 13** while condom use at such sex was only 9 – 29%. Similarly, anal sex is reported among boys as high as 29%. While 75% of such street children have heard about HIV/AIDS, less than 20% of them have contact with an AIDS-related NGO.

Contextual factors increasing Nepal's vulnerability

The Kingdom of Nepal is a highly **heterogeneous country** in terms of geography, biodiversity, ethnicity, language and culture. Nepal is landlocked sharing borders with India and China and is made up of 75 districts divided into five development regions (Far-Western, Mid-Western, Western, Central and Eastern). The Himalayas cover the northern third of the country from east to west, bordering China. To their south lies a long east-west stretch of lower mountains (the hilly region) whose southern flanks flatten into the Terai, a fertile, sub-tropical plain spanning the border with India.

The increasing pressure of population growth on scarce resources such as land has **negated the impact of development initiatives**. For example, provision of better education or irrigation is of limited benefit to rural populations who depend on the land for their livelihood. In Nepal, the topography, environmental degradation, poverty and economic migration are all linked and they combine with other factors to increase vulnerability to HIV/AIDS.

Nepal's social indicators remain well below the average for the South Asia region: more than **31% of the Nepali population live below the national poverty line**, nearly half of all children below 5 years are underweight and nearly 60% of all adults are illiterate. Additionally, women have, traditionally, a lower status than men, and gender inequality is deeply rooted. **Less than 15% of women deliver their children under the care of skilled birth attendants**.

The **civil conflict** which started in 1996 has now entered into a protracted phase and thousands of people have lost their lives, have fled their homes and lost their livelihoods. Conflict-related displacement, migration and the breakdown of social structures and family ties further increases vulnerability to HIV (Nepal MDG Progress Report, 2005). This instability now calls for greater measures to ensure that the most vulnerable groups benefit from equitable access and protection from discrimination in HIV programming. Amidst this scenario, National Parliament was dissolved in May

[1] UNICEF (2001). *A Survey of Teenagers in Nepal for Life Skills Development and HIV/AIDS Prevention*. Kathmandu: UNICEF and UNAIDS.
[2] UNICEF ROSA. *A Force for Change: Young People and HIV/AIDS in South Asia*. Kathmandu: UNICEF Regional Office for South Asia.

2002 and by 2005 four interim governments had been appointed by His Majesty's the King before he assumed direct control in February 2005.

Poverty, gender inequality, low levels of education and literacy, denial, stigma and discrimination coupled with the current conflict are major contributing factors to HIV vulnerability. Female sex workers, mobile populations, injecting drug users and men having sex with men are most-at-risk populations largely due to their **marginalised status** in the society with little access to information and services related to HIV/AIDS. Young people and children are among the vulnerable groups who are exposed to various risk factors that potentially lead to infection.

Labour migrants make up 40% of the total known HIV/AIDS infections followed by clients of sex workers 18% and IDUs 14% (as cited in MDG report 2005). Prevalence of sexually transmitted infections was 19.4 percent for migrants, and 11 percent for their wives[3]. Migrants returning from areas with high rates of HIV/AIDS prevalence such as Mumbai in India, where 70–90 percent of female sex workers are estimated to be HIV positive[4], are also displaying increased prevalence rates. One study found that nearly nine percent of migrants returning from Mumbai to Achham District were HIV positive compared to 0.7 percent of non-migrants[5]. Internally Displaced People (IDPs) due to the conflict and the more than 100,000 Bhutanese refugees in Eastern Nepal have not been a major focus of the HIV programme.

Human trafficking
Trafficked girls to India (particularly Mumbai) are returned to Nepal when they are tested HIV+. In absence of other livelihood opportunity they are likely to continue sex trade in Nepal.

Migrant labour
Limited information available on sexual behaviour and HIV/AIDS incidence among the labour migrants going to countries other than India (Malaysia, South Korea, Gulf countries) where approximately 10 thousand people fly every month.

Likewise, the **estimated number of children orphaned by HIV/AIDS is over 13,000** (UNICEF, 2002 cited in MDG report 2005). Street children are without doubt one of the most vulnerable groups, widely exposed to various types of danger including sexual exploitation[6,7]. A recent study of street based children in Pokhara and Kathmandu revealed that only 20 % are reached by NGOs with HIV/AIDS education[8].

Projections of the spread and impact of the epidemic

The **potential for a rapid spread** of the epidemic was first recognized by J.Chin (1999/2000) who estimated that in the absence of effective interventions, HIV

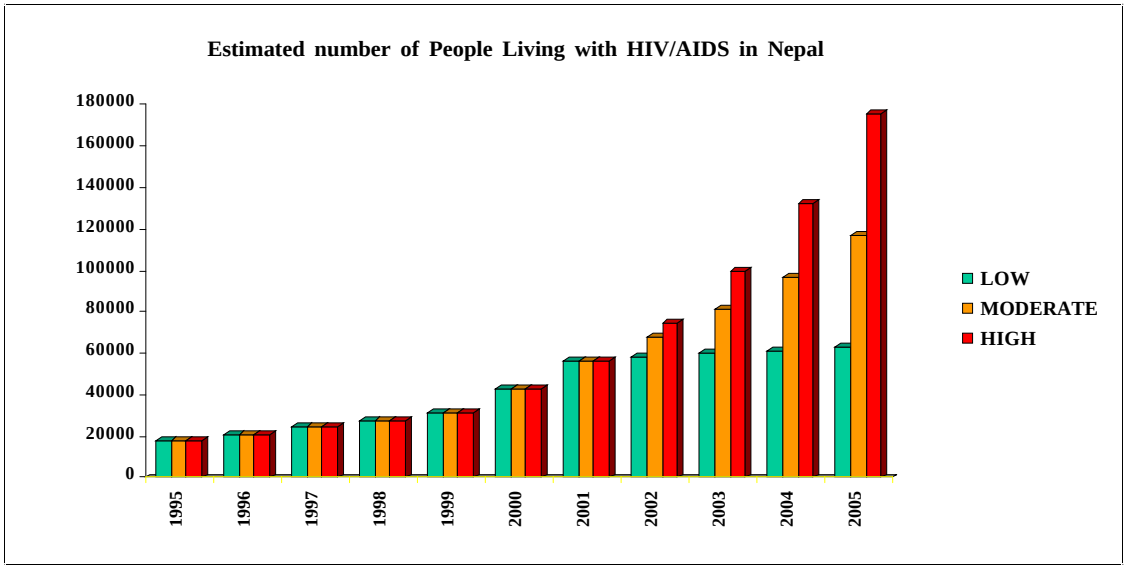
[3] GFTAM prop. P.23. 2001 New Era study
[4] Nepal/India Safe Migration Initiative (Reducing HIV risk among Nepali migrants to Mumbai, USAID Discussion paper, Draft Feb.2004.
[5] Nepal/India Safe Migration Initiative (Reducing HIV risk among Nepali migrants to Mumbai, USAID Discussion paper, Draft Feb.2004.
[6] *Peace and Governance Foundation South-Asia Partnership-Nepal*, Posted on 2004-10-20 ACR Weekly Newsletter Vol. 3, No. 42
[7] Norwegian Refugee Council (2004). Nepal: up to 200,000 people displaced by fighting remain largely unassisted. Geneva Switzerland
[8] A study on Knowledge, attitude practice and belief in the context of HIV/AIDS among out of school Street based children in Kathmandu and Pokhara (UNESCO/CREHPA November 2005)

prevalence in Nepal may, over the coming decade, increase to 1-2% of the 15-49 year old population. For Nepal this meant that 100,000-200,000 young adults would become infected and that by the end of the decade, 10,000-15,000 annual AIDS cases and deaths may be expected. This would make AIDS the leading cause of death in the 15-49 year old population.

UNAIDS/WHO estimated that the number of expected AIDS deaths in 2000 would double by 2005 to 6000. It is estimated that these AIDS deaths would increase total deaths in the 15-49 year-old age group by about 5% in 2000 and account for close to 20% of total deaths in this age group in 2005.

In 2001 a projection exercise based on available data (Sero-prevalence, BSS) was conducted by the Ministry of Health and Population and UNAIDS. Low, moderate and high infection rate scenarios were developed in order to estimate the number of people living with HIV/AIDS in Nepal (Figure 1).

Figure 1: Yearly estimates of the number of people living with HIV/AIDS in Nepal

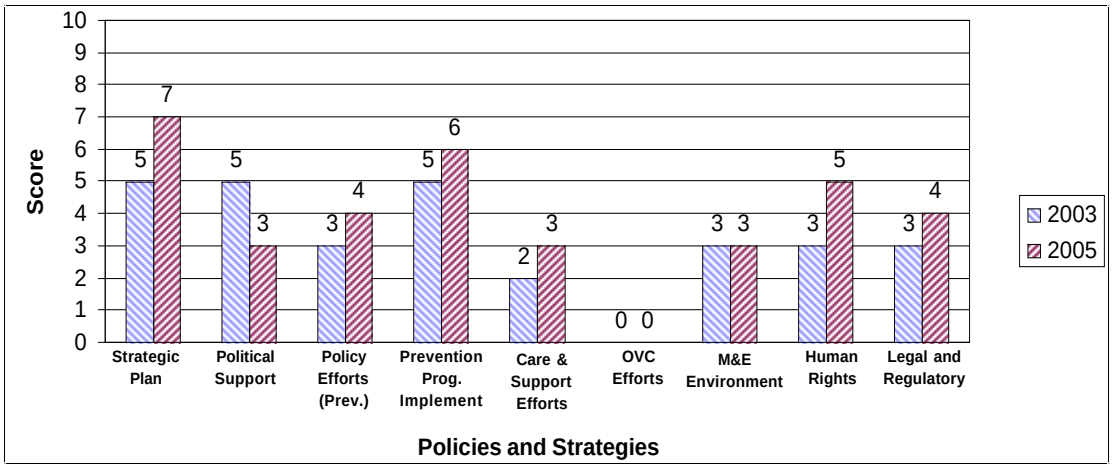


Antenatal clinic surveys, however, may not provide the best estimate of HIV prevalence in the general population as only about 28% of Nepali women receive antenatal care from a doctor, nurse or auxiliary nurse midwife at some point during their pregnancy (DHS, 2001). The relative advantages and disadvantages of using ANC attendees, blood donors and family planning attendees for estimates is currently being debated by epidemiologists in an effort to find the most accurate measure of prevalence in the general population.

KEY CHALLENGES AND ACTIONS FOR UNIVERSAL ACCESS

A recent study calculated Nepal's Programme Effort Index (Figure 2) to assess the **overall performance of the HIV/AIDS programme** in 2003 and 2005. This index refers to specific areas of the programme and shows the level of progress achieved and areas that require improvement. This type of study has enhanced the country's understanding of its programme and what needs to be done to work towards universal access.

Figure 2: A comparison of the 2003 and 2005 AIDS Programme Effort Index scores



Source: USAID /Futures Group, Policy Project, AIDS Programme Effort Index in Nepal, 2005

The areas covered by the Programme Effort Index relate closely to Universal Access areas covered in this report and its attached score charts (Annex 1).

Advocacy, public policy and legal framework (II.1)

Current context

Nepal's response to HIV and AIDS is led by the His Majesty's Government's **National Centre for AIDS and STD Control (NCASC)** which receives support from external development partners. Within the national health policy framework, NCASC has facilitated the development of the country's first national HIV/AIDS policies and strategies. The first of these was the Strategic Plan for HIV and AIDS in Nepal (1997-2001) followed by the comprehensive **National HIV/AIDS Strategy (2002-2006)** which was formulated after some external review. This current plan identifies 5 priority areas:

1. Prevention of STIs and HIV infection among vulnerable groups.
2. Prevention of new infections among young people.
3. Ensuring care and support services are available and accessible for all people infected and affected by HIV/AIDS

4. Expansion of a monitoring and evaluation frame through evidence based effective surveillance and research.
5. Establishment of an effective and efficient management system for an expanded response

A **legal audit** was collaboratively conducted in June 2004 by NCASC, USAID, POLICY Project and Forum for Women, Law and Development (FWLD) towards developing an improved legal framework that best contributes to control further spread of HIV and to protect the rights of people infected and affected with HIV and AIDS. Mapping was done of the Constitution of the Kingdom of Nepal, 1990. In total of 280 Acts, 210 Regulations, 3 Executive Orders, 7 Policies, 3 Guidelines and 2 Draft laws to compare its consistency with standards contained in International Guidelines. **Out of a possible maximum score of 100, the Nepalese legal system has scored 39.98**. The details of this study have guided subsequent action for legal reform and members of civil society have proposed and drafted an HIV and AIDS (Treatment, Prevention and Control) Bill and as well as amendment proposals to change existing laws.

Obstacles

As suggested by the legal audit above, Nepal's **current legal and policy framework does not provide sufficient support and protection** for a comprehensive and scaled up HIV/AIDS response. Although some laws address HIV/AIDS-related issues, PLWHAs and other vulnerable groups, such as MSM, IDUs and FSWs, are not well protected. Orphans and vulnerable children are also not central to current HIV/AIDS policy. The legal and policy framework relating to HIV/AIDS is not closely monitored although there is ongoing lobbying by civil society to achieve the required legal reforms. These **public advocacy activities are not consistent and continuous enough** ensure protection from discrimination and improved access to HIV/AIDS services.

Key actions

If advocacy, public policy and legal frameworks are to improve in the country a number of actions will be important. **Comprehensive laws** will need to be enacted to ensure the rights of PLWHAs and vulnerable groups are protected and respected, while policies will need to be improved to promote more **comprehensive HIV programming**, particularly for women, children, youth and the country's most-at-risk populations. **HIV/AIDS mainstreaming** into the development initiatives of non-health sectors of government and civil society will be key. If this is to be realised, the level of advocacy and action will need to be improved. Advocacy activities will need to **involve more stakeholders** (including the private sector) and create more linkages between the diverse participants to ensure strong advocacy and commitment building.

Goal(s)

These actions will contribute to achieving the following:

- Enforced legal framework on HIV/AIDS that promotes human rights and protection from discrimination, violence and subjugation
- Specific national policies in place to promote prevention, treatment and care and support with attention to barriers faced by women, children, youth and most-at-risk populations

- A functional M&E mechanism for the legal framework and national policies

Strategic planning, alignment and harmonization (II.2)

Current context

His Majesty's Government of Nepal has recognised HIV/AIDS as a cross-cutting issue it its 10th plan. The Ministry of Health launched the **National HIV/AIDS Strategy (2002-2006)** in January 2003. This recently formed the basis for an annual **National HIV/AIDS Action Plan and Budget (2005-2006)**, which was developed after an extensive consultation process with broad participation from civil society organisations and affected groups. This document reflects shared priorities, harmonized resource allocations and coordinated implementation mechanisms, including monitoring and evaluation. This was a milestone, resulting in the country achieving the first of the Three Ones.

The current National HIV/AIDS Strategy also makes provision for two mechanisms for the promotion of high-level political commitment and a multi-sectoral participation and coordination. The highest of these bodies is the **National AIDS Council**, chaired by the Rt. Honourable Prime Minister. This body was designed as a forum for advocacy and the development of national HIV/AIDS policy and strategy and is composed of representatives of various government ministries, the private sector and civil society. Under this Council is the **National AIDS Coordination Committee**, which is responsible for overseeing the operationalization and implementation of national policy and strategy, attending to the technical aspects of implementation and donor collaboration. This multi-sectoral committee consists of representatives of government, donors, NGOs and the private sector and advises the Council on technical aspects of policy and its implementation and supports district level implementation. **District AIDS Coordination Committees** are the bodies responsible for coordinating the HIV/AIDS response at a district level, under the District Development Committees.

Obstacles

Despite improved strategic planning, coordination mechanisms and multi-sectoral participation, some problems have emerged during implementation. The **functioning of coordination mechanisms has been poor**. Since its formation, the National AIDS Council has met twice by 2005. Due to frequent changes of Prime Minister and fluid political situation, subsequent meetings and policy direction as anticipated from the Council has not been possible. Moreover, the initial preparation and foundation work that was necessary before forming such a high level Council was lacking. The National AIDS Coordination Committee also has its challenges. Although Joint Secretary (Class I level government officer) level officials from different line ministries are represented on the Committee, their attendance or participation in the meeting is either minimal or they are represented by a junior officers. This committee is also not as functional as anticipated, but has been able to translate a number of policies and strategies into practical action plans. These national level experiences have been largely repeated at the district level where District AIDS Coordination Committees have been formed under the chairmanship of the District Development Committee. These mechanisms have also tended to be non-functional.

This poor functioning is understood to be a problem of capacity and mandate of partners. The participation and contribution of non-health ministries to the multi-secotral response was limited as they do not appear to have **clear opportunities and roles for their involvement**. The **capacity for strategic planning and coordinated and aligned programming** among government and civil society partners is not strong. In addition district level implementation is poor in areas where the regulations related to the Local Self Governance Act are not being implemented. This act allows for increased district level planning, budgeting and coordination between sectors.

Key actions

To overcome these barriers, key actions are needed to strengthen the multi-sectoral strategic planning, alignment and harmonization. This includes **reformulating the multi-sectoral aspects of the strategic framework** in the next planning cycle, with specific involvement from non-health ministries. The multi-sectoral guidelines that are developed should be **endorsed and enforced at the highest possible level of government** and implemented by each of the relevant government sectors. The sectoral government ministries' implementation has to be supported by appropriate resources and budgets. Partners will also need to be involved in defining their areas of need and a **capacity building package** should be implemented (supported by adequate resources). National **coordination and review meetings** will be held with multi-sectoral representation.

Goal(s)

The key actions will aim to achieve:

- A dynamic, functional, multi-sectoral National Strategic Plan (2007-2011) will scaled up annual planning to meet the prevention, treatment and care needs of at least 70% of most-at-risk populations
- A functional semi-autonomous multi-sectoral national authority to implement and monitor the National Strategic Plan with an appropriate level of authority and sufficient resources from public, private and external development partners' sources
- Greater participation and improved capacity of all sectors of government, the private sector and civil society (including PLWHAs, vulnerable groups and young people) to coordinate a scaled up response at national, district and village development committee levels

Sustainable financing (II.3)

Current context

Recent budgets for Nepal's HIV/AIDS response have increased dramatically as stakeholders have made more ambitious plans to address the country's epidemic (Table 3). The **yearly deficit in the HIV budget** has meant that activities could not be implemented at the scale planned. The majority of financial support for the current national HIV/AIDS response is provided largely by external development partners.

Table 3: Nepal's total national HIV/AIDS Budget

Total HIV/AIDS Budget (US $)			
	2003/04	2004/05	2005/06
Total budget (planned)	7,166,740	8,927,850	23,621,814
Pledged by EDPs	2,550,864	5,468,601	14,506,383

Source: NCASC

The government contribution increased in 2005 from 2003 levels (Table 4), but is a relatively small proportion of the current total HIV/AIDS budget (Table 5). The direct spending on HIV/AIDS is less than one percent of overall HIV/AIDS programme budget for 2005. The non-direct spending e.g. expenses for treatment of STIs and other opportunistic infections through regular health service delivery system, spending of Ministry of Education in preparing curriculum and delivering the lessons at the secondary school through out the country and similar costs have never been calculated.

Table 4: Government spending on HIV/AIDS

Government expenditure on HIV/AIDS (US $)			
	2003/04	2004/05	2005/06
Programme Cost	65,629	68,057	105,071
Management Cost	26,343	27,743	41,586
Total (HMG)	**91,971**	**95,800**	**146,657**
Utilized/Spent	80,293	82,000	
%	**87**	**86**	**0**

Source: NCASC

Table 5: Partners contributing to the national HIV/AIDS programme budget 2005/06

Funding Partners	Pledged ($)	%
DFID	4,797,456	33.07
USAID	4,739,924	32.67
GFATM	2,621,315	18.07
Nepal Red Cross	585,070	4.03
AusAid	406,238	2.80
FPAN	305,274	2.10
UNDP	186,000	1.28
UNICEF	182,500	1.26
UNAIDS	172,000	1.19
HMG	144,606*	1.00
UNFPA	120,000	0.83
WHO	100,000	0.69
ILO	85,000	0.59
World Bank	50,000	0.34
UNESCO	11,000	0.08

Total	**14,506,383**	**100.00**
(Source: NCASC Annual work plan 2005) ***original pledge in plan, final approval of 146,657**		

There is general perception among the policy makers within Ministry of Health and other ministries that HIV/AIDS programme components are adequately funded by donors, therefore scarce national resources should be allocated to other priority areas. However, **preliminary cost estimates for a scaled up HIV/AIDS response for the period 2003 to 2007 amount to a total of US$95.9 million**.

Obstacles

Linked to the shortage of funds, there are a number of other obstacles to a scaled up HIV/AIDS response in Nepal. These largely have to do with the country's ability to disburse, manage and utilise funds for up scaled activities. The first obstacle for programme implementation partners is the **lack of a clearly defined mechanism for accessing national funds**. This results in the underutilisation of available funds and the limited involvement of civil society organisations (particularly affected groups and grass roots organisations). Related to this challenge is the fact that there is **no national AIDS account or unified management or tracking system** for the public funds received from different sources (including government and external development partners), making the allocation, disbursement and utilisation of funds difficult to monitor or evaluate. The third obstacle is that there is **no national resource mobilisation plan** to ensure that sufficient finances are available. Finally, government and NGOs' **limited ability to manage resources** for a scaled up response has been a major obstacle.

Key actions

There will be a number of actions required to ensure sustainable financing for the country response. Firstly, a **functional mechanism and transparent procedures** should be established to ensure that financial resources are channelled appropriately from the national level to the district and village development committee level. This has to reach implementing partners from all sectors of government and civil society. This will be linked to the establishment of a **national AIDS account** with clear policies and guidelines for tracking the availability, disbursement and utilisation of funds among implementing partners. A **national HIV resource mobilization plan** should be developed and implemented to ensure that resources are generated, sustained and properly used in line with the National Strategic Plan and the criteria required by donors, government and other sources. Crucially, **capacity building** for government and NGOs (both international and local) for mobilising, disbursing, absorbing, managing and reporting on funds will need to be provided from a national level through to local levels.

Goal(s)

These actions will contribute towards ensuring:

- A well functioning national financial management system supporting a scaled up national HIV response
- A transparent system of monitoring the disbursement and absorption of the national HIV/AIDS budget

- Disbursement of financial resources in accordance with the National Strategic Plan (2007-2011) and that these resources reach local level implementation partners
- Optimal allocation of national funds for HIV/AIDS programming

Human resources (II.4)

Current context

There are a number of factors that influence the human resources for health in Nepal. These do not only affect government and the health sector, but discussing the government sector is a good illustration of the human resources context. The challenge in trying to deliver services in the areas that need them most is that these areas tend to be remote, geographically inaccessible and conflict-affected. In the case of government health services, this means that a number of posts are not filled or that the people who are meant to be filling those posts are not present performing the functions that are required of them. This is often the case for the more skilled positions in remote areas and there seem to be a number of reasons for this. The government tries to ensure that these posts are filled by blocking promotions for people who have not worked in more remote areas. There are however very few incentives for government staff to work in the areas where they are most needed. This includes difficulties with travel and insecurity, the loss of social networks and family ties and reduced secondary income-earning opportunities among others. Skilled women are particularly difficult to recruit to remote areas due to gender and sociocultural issues, including the expectation that they perform child care, household and family duties.

Obstacles

The human resource barriers to delivering a scaled up response to HIV/AIDS in Nepal are as follows. Firstly, the **number and distribution** of human resources are inadequate. Health workers, counsellors, community-based workers, clinical officers, managers, epidemiologists and data processors are amongst the types of human resources that are in short supply, particularly for the worst affected districts and most-at-risk groups. Secondly, the human resources that are available often **lack the skills they need** to provide quality services (such as VCT, ART, PMTCT, OI and STI treatment) and address the socio-cultural issues that relate to HIV/AIDS (such as stigma, discrimination, gender and poverty). As a result there is low access and utilisation of the available services and high treatment drop out rates. Lastly, **commodity supplies are inadequate or irregular** for universal precaution and prophylaxis for existing health facilities and prevention programmes.

Key actions

Crucial actions towards Nepal's approach to ensuring universal access will be efforts to strengthen human resources and logistics and supply management systems. The country will need to develop and implement a **comprehensive human resource development plan** as it relates to HIV/AIDS. This will spell out the number and type of staff that need to be employed for positions at each level of the programme, the skills they need and how these skills should be developed. To support this, the **logistics and supply management systems will need to be strengthened** to

ensure that commodities are supplied regularly, particularly for universal precaution and prophylaxis.

Goal(s)

Implementing these actions will achieve the following:

- Service providers will be able to provide quality prevention, treatment, care and support services with appropriate coverage in all districts
- A fully functional national human resource policy ensuring appropriate HIV programme-related management and human resources

Organization and systems (II.5)

Current context

His Majesty's Government has engaged in a decentralisation process where it is working to ensure that organisation and systems are functioning at district and local levels even in the remotest of areas. This process has been a struggle in a context of ongoing civil conflict, political instability and geographic inaccessibility. Despite some progress monitoring and evaluation systems, logistics and supply systems and decision-making bodies are largely weak regarding HIV/AIDS.

Obstacles

Several organisation and system challenges hamper Nepal's response to its HIV epidemic. Government **HIV and STI diagnostic systems are largely weak** without links to private sector providers. This includes the related supply and distribution chains required to perform these functions. These challenges extend to ARV treatment where **systems for providing, monitoring, care and support are inadequate** for the needs of PLWHAs. The supporting **HIV/AIDS-related monitoring and evaluation systems** are similarly weak in the government health system. At a national level, the **coordinating mechanisms** discussed earlier do not have the authority, mandate or support needed to improve linkages and systems between sectors and levels. At a district level, programming is hampered by the non-engagement of District Development Committees and District AIDS Coordination Committees and this can also be linked to the weak collaboration between local government bodies and community-based organisations.

Key actions

Advocacy, creating linkages and building capacity seem to be the most appropriate actions to meet these challenges. Advocacy is needed at all levels to ensure that a **new semi-autonomous multi-sectoral national authority** is established. At the district level, advocacy is needed to **ensure the functioning of the current district bodies** intended to lead the local AIDS response. Clinical systems and services should be upgraded by **improving linkages between public and private sector** services, including referral. In the public health sector, the capacity of **the laboratory systems** need to be enhanced to ensure that they are prepared to support scaled-up services including ARV treatment programmes.

Goal(s)

In Nepal, organisation and system improvements aim to achieve the following:

- Highly effective and coordinated management of the national response (including monitoring and evaluation systems) through an empowered semi-autonomous multi-sectoral national authority
- Reformed mandates of District AIDS Coordination Committees to include civil society representation and extend their work to the Village Development Committee level
- Adequate supply, monitoring and follow-up care services for PLWHAs on ARV treatment

Infrastructure (II.6)

Current context

On the whole, Nepal's health infrastructure is insufficient and not geographically well distributed. Much like its organisation and systems, geographic diversity and civil conflict influence the reach and quality of health services.

Obstacles

There are two main infrastructure barriers to providing universal access treatment, prevention, care and support for HIV/AIDS in the Nepalese context. Firstly, HIV/AIDS **services are not well integrated and lack continuity and referral systems**. This means that intended beneficiaries do not receive comprehensive and quality services. Secondly, the **geographic distribution of service points is insufficient and inappropriate**. The services have low coverage, particularly in remote areas, and crucial services like VCT, ART, PMTCT, OI, demand and harm reduction programmes are not located where they are most needed, reducing access by most-at-risk populations.

Key actions

These challenges are expected to be overcome by developing and implementing a **long-term service improvement plan**. This should cover a period of 5 to 10 years and include infrastructural and technological upgrading. In conjunction with this, the **locations of highest need for HIV/AIDS services should be mapped** to ensure that the expansion of service points are strategic.

Goal

These actions will work towards one goal:

- Improved coverage and quality of HIV/AIDS prevention, treatment, care and support

Partnerships (II.7)

Current context

Over the last two years, the momentum regarding HIV/AIDS has increased. The number of partners involved in the response to HIV/AIDS in Nepal has increased and in general, more focus is being put on this issue. This is partly due the increased funding from various international donors and due to the need for a scaled up HIV/AIDS response in the country.

National organisations both NGOs and private organisations have increased their involvement in HIV/AIDS activities. FHI reported having more than 53 partners implementing various programmes. Similarly, an inventory prepared by NCASC showed more than 120 organisations working in various aspects of HIV/AIDS (e.g. awareness, BCC, research, service delivery, VCT, ARV support and so on). The GFATM and DFID programmes have a partner network of some nineteen organisations. In addition, NAP+N, a network organisation of positive groups is coordinating implementation of special programme for 18 PLHWAs organisations through out the country for capacity development as part of DFID assistance called the Challenge Fund.

Crucially, networks of vulnerable groups like MSM, PLWHAs, IDUs, sex workers, returned migrants and women have become increasingly organised. These groups are becoming more involved in national forums, the development of annual programmes and in other consultation processes. With the involvement of these groups, it is expected that policy and programme would be specific to their needs while at the same time help government and other stakeholder to realise the principle of greater involvement of people living with AIDS.

Partnerships have been steadily expanding to other sectors – education, the media, the business community and religion have become involved in one way or another.

Obstacles

Key actions

Goal(s)

Service coverage (II.8)

Current context

Nepal's national HIV/AIDS programme incorporates prevention, treatment, care and support. These services are not of sufficient scale to be accessible for the majority of its most-at-risk populations. The quality of these services is also limited as they seldom provide comprehensive prevention, treatment, care and support. The **country response is strongest in areas related to prevention**, but progress is also being made to develop the treatment, care and support aspects. The country has been able to expand its prevention activities targeting its most-at-risk populations and there has been evidence of increased knowledge regarding risk reduction behaviours, particularly among young people and migrant groups.

HIV testing coverage

Percentage of most-at-risk populations who received HIV testing in the last month and who know the results:

FSWs	3.1%
IDUs	5.2 %
Migrants	0.03%
MSMs	0.04%
Others (FSWs clients)	0.21%

(Source: FHI VCT centres programme report)

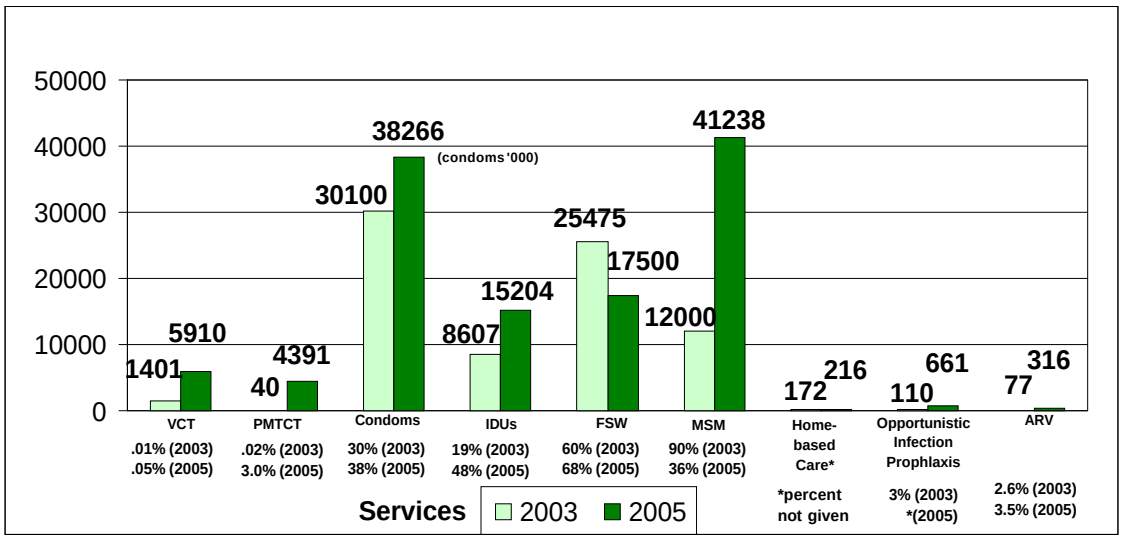
Prevention programme coverage

Percentage of most-at-risk populations reached by prevention programmes:

FSWs	35.2%
IDUs	8.6%
Migrants	0.04%
MSMs	5.4%

The figure below shows a comparison of the coverage of selected services in 2003-2005.

Figure 3: A comparison of 2003 and 2005 coverage for selected HIV/AIDS services



Source; USAID/Policy Project, Coverage of Essential HIV/AIDS Services in Nepal, 2005

Although the separation of prevention activities from treatment, care and support activities is artificial, activities that could largely be seen as prevention will be discussed separately for the sake of clarity.

Targeted prevention among most-at-risk groups

The dynamics of Nepal's epidemic seem to be following a predictable course – a rapid increase in the most vulnerable groups and then spread via bridge populations into the general population. The top priority of the national response has been to prevent a generalisation of the epidemic in Nepal and has targeted intervention to the most vulnerable group (most-at-risk groups). Targeted prevention occupies **75% share of total national budget for HIV/AIDS**. These prevention activities are **largely carried out by NGO implementation partners**. The national plan has classified 5 populations as most at risk and together with a sixth group, young people, they are the priority populations within the plan. The size estimates of the 5 most-at-risk populations are as follows in Table 4.

Table 4: National size estimate of most-at-risk populations (MARP) in Nepal

Most-at-Risk Population	Estimated numbers	
	Low	High
IDUs	16,500	23,200
MSMs	64,000	193,000
FSWs	25,400	34,100
Male clients of FSWs	564,000	754,000
Seasonal Labour Migrants	967,000	1,511,000

Source: NCASC/FHI 2005

The Policy Project's 2005 Services Coverage study found a total of **50 different VCT sites** are reported in some 30 districts where **5250 people reported to have received the service** during August 2004 – July 2005. These sites are largely operated by NGOs. NCASC has prepared VCT protocol 2004 which is being used by the VCT centres (Coverage survey 2005). The quality and types of services of those sites is not known and whether or not these sites offer comprehensive VCT services is not reported. Some VCT centres may be providing pre-test counselling and basic information only.

(a) Sex workers and their clients

Female Sex Workers (FSWs) who are traditionally highly marginalised and often criminalised have little access to information and services. Cultural, economic and social constraints further limit their access to legal protection and to medical services.

The emphasis of the national programme has continued for FSWs and their clients during 2003 to this reporting period with more than **12% of total budget** (2005/06) allocated for comprehensive package to FSWs. The Policy Project Services Coverage Study in 2005 indicated 60 – 77% coverage by outreach programmes in 22 major high-way districts, Kathmandu and Pokhara, largely undertaken by NGOs supported by FHI. Behaviour change information has been a key approach in these programmes, which includes local advocacy, behavioural change communications, community mobilisations and link to accessible, appropriate health services and commodities.

The total size of the FSW population varies enormously by location – a challenge for programme interventions attempting to reach the majority of FSWs. Nonetheless, the National Operational Plan (2005/06) aims to cover 70% of the total, including male sex workers.

The prevention programmes for sex workers have shown progressive results in terms of use of condoms which is reported to be 74% among the FSWs in Kathmandu and 53% in the Terai highway areas. This is further mirrored in the HIV prevalence among the FSW in Kathmandu where only 2% were found to be HIV positive. A study in 1993 had shown up to 17% prevalence among sex workers in Kathmandu. **Clearly the challenge is to maintain the low prevalence consistently in this group and expand the coverage in other areas.** An emerging concern is that many young girls and women who engage in sexual activity in exchange for money or goods do not identify themselves as sex workers, and may not, therefore, be among the clearly identifiable sex workers who are reached by HIV services. The composite data of prevention programmes (including mass media, peer education, VCT and STI treatment) shows that only 35% of sex workers are reached by prevention programme. (see annex 3, indicators 4 and 6)

(b) Injecting Drug Users (IDUs)

IDUs in Nepal are at risk not only by their injecting practices but also by a societal response, which ostracizes drug use and uses a predominantly punitive model coupled with limited drug treatment facilities (National HIV/AIDS Strategy 2002-6). The national efforts therefore remain focused on establishing a **conducive policy and social environment** while at the same time continued building capacities of national NGOs for **better service delivery** (including needle syringe exchange) with expanded coverage outside Kathmandu, made possible through Global Fund and DFID-supported activities.

Harm reduction has remained mainstay of the national programme for IDUs. However, the coverage and continuity of intervention followed by access to rehabilitation has remained a challenge. The composite programme reach index for IDUs is only about 8.6% - which clearly indicate that programmes are not reaching the larger population of IDUs scattered through the country (annex 3, indicator 4). Although a qualitative study reported to have reached 48% of IDUs, a thorough examination is required to ascertain the actual coverage. Nevertheless, those IDUs who are reached by the programme do have comprehensive knowledge on prevention of HIV. For example in Kathmandu 53% identified correct ways of prevention of HIV and also rejected major misconceptions about HIV transmission. Overall safe injecting practices were reported only from 34.5% of IDUs (IBSS, 2005). **The challenge is therefore is to reach more IDUs through increased and strategic programme coverage and promote safer injecting and sexual behaviour. At the same time, comprehensive rehabilitation and support services for IDUs must be stepped up.**

According to LALS, an organisation working on Harm Reduction in Kathmandu valley, there are over 2,000 IDUs who utilized their needle syringe exchange programme (estimate of IDUs in Kathmandu 5-6,500) and a total of 14,491 times in 11 districts, including Kathmandu, IDUs were part of needle syringe programme during September 2004-September 2005 implemented by some nine NGOs (POLICY Coverage Survey, 2005). In addition, risk reduction information was also provided. Rehabilitation services are also being offered by 26 organizations with government or

donor support. The total coverage for these services is on average 50 people per centre per year. Similarly, the size of the IDU population also varied by location and they are found to be highly mobile.

A challenge emerging from the National Action Plan's implementation strategy for IDUs is oral substitution therapy. **Oral substitution therapy was available only in Kathmandu through one centre** (Mental Hospital). Due to lack of financial and policy support, it has been discontinued for some time. In 2005/06 such facilities are expected to be available for 1000 IDUs from Teaching Hospital and BPK Memorial Hospital in Dharan and from some other major cities.

Despite the efforts to establish supportive HIV/AIDS policy, there is a further need to set in place a policy related to oral substitution, an effort now underway with the Ministry of Home Affairs. Furthermore, the comprehensive approach to deal with the needs of IDUs for HIV prevention and AIDS services – from demand to harm reduction to reintegration -- will require a collaborative strategy among the key Ministries of Health and Population, Home Affairs, and Labour and Development.

(c) Men having sex with Men

Currently, Blue Diamond Society is the only organisation representing this most-at-risk population group. MSM are **socially marginalized** and therefore their access to prevention services is believed to be low. **Condom use among the Male Sex Workers is 63% with non-commercial partners and about 36%** are reported to have reached by outreached programme within Kathmandu valley (POLICY Coverage Survey, 2005).

Most MSM are married due to social obligations, therefore they are exposed to sex with the spouse and multiple partners. A focused group discussion (FGD) conducted among the MSMs indicated that wives of MSM do not know the sexual orientation of their husbands, therefore they have **sex without the use of condom for fear of their status being discovered** in this way. The same FGD reported that MSM face harassment from police and security personnel for carrying condoms.

Programme reach for MSMs is only 5.4% (see Annex 3 indicator 7). Although size of MSM in the country is being estimated more vigorously to obtain actual information, the current estimation is somewhere between 64,000 – 193,000, which certainly indicates the need for careful programme intervention. A study reported 63% condom use among the MSM, whereas the Focus Group Discussion reported that condom use among TAs (more masculine MSMs) is very low they consisted of armed forces, security guards, rickshaw pullers and night taxi drivers despite the fact that they are reported to be aware about the risk of HIV/AIDS.

There are number of challenges facing the MSM component. **The primary challenge is social acceptance without which access to services and support mechanisms is difficult, if not impossible.** Secondly, ascertaining the actual size of the MSM population is difficult, especially as it is a hidden group and is forbidden by law. The outreach strategy to reach the community levels with information and services is promising but will require an extensive network and intensive inputs. Thirdly, other organisations committed to HIV prevention should find a role to play and support in MSM programme. This multi-pronged approach, while increasing coverage of services, will also help in creating a favourable social environment.

(d) Mobile populations

Due to **socio economic hardship** and lately **fuelled by conflict** labour migration to India and other countries have increased many folds over the period. It is estimated that **1-1.3 million people migrate every year** to India, Gulf countries and East Asian countries like Malaysia, South Korea and other location. The pre departure and post arrival services including counselling are lacking. Studies conducted in the far west indicate high vulnerability of migrants and their spouse to HIV/AIDS and other infections coupled with low access to health and preventative services.

In a UN/New Era study conducted in 6 districts outside Kathmandu among migrant labourers in 2005 under the support of GFATM, a high level of knowledge (mid to high 90s) on HIV, STIs, and AIDS was reported, especially among the 20-29 age group. However, less than half of the respondents would use condoms whether with their wives or sex workers. Only 6% of the respondents reported sexual intercourse with sex workers, and 8% reported having sex partners other than their wives and sex workers. A more revealing dimension is the perception among the respondents of HIV and AIDS are consequences of immoral sexual behaviour, indicating the need for the integration of stigma and discrimination messages in HIV prevention efforts.

The programme for mobile population varied with some focused interventions, such as VCT set up at Doti Hospital (CARE Nepal) to youth mobilisation programme (SoVAA programme Save the Children (SC) Norway) and safe migration programme (FHI/SC-US). Although a number of organisations have initiated training and supportive activities in care and support programmes in high migration districts, a concrete model and programme is lacking for care and support. The programme reach for migrants have been very low with only 0.04% covered.

There is general consensus the efforts addressing mobile populations need to be intensified. The GFATM-supported programme highlights this sector as a priority. As initiatives were only started in mid-2005, prevention education and HIV counselling and testing services are reaching only a fraction of this group (annex 3, indicator 4). In six districts, some 20,000 migrant labours have received HIV information and counselling through district-based centres. Scale-up of these programmes are being planned. **Mapping of high-migration districts, migration patterns and flows, and the precise needs of the diverse range of migrant groups is a basic need that is yet to be undertaken.**

(e) Uniformed services

Royal Nepal Army, Nepal Police and Armed Police constitute some **153, 000 cadres and officers posted in various locations** with varying levels of health and preventative services. STI treatment, VCT and supportive service are reported to be available within the system (Army Hospital and Police Hospital) the information and awareness message is believed to be inadequate. In addition, the sexual behaviour of these groups is not known. A systematically implemented peer-based HIV prevention programme by the Royal Nepal Army and the Nepal Police has been initiated under the GFATM-supported programme. At the end of 2005, 5000 members of these two arms of the uniformed services have received HIV prevention education. Recently, PSI has conducted a behavioural study with technical input from FHI, results of which are due in 2006.

(f) Young people

Young people constitute **38% of total population** who are regularly exposed to vagaries of conflict, socio economic deprivations whose vulnerability is further compounded by peer pressure, ambitions and poor access to information and services related to health and reproductive information.

In the 2005 UNAIDS/New Era Behaviour, Information, and Services (BIS) Survey, broadcast media (TV and radio) was recorded as the primary source of information on HIV/AIDS. A surprising but positive finding was that, among young people who would have sexual intercourse with sex workers, **86% would use condoms**. It closely correlates with consistent condom use of those who had sexual intercourse with sex workers in the last 12 months (71%).

A study conducted among 2748 youths has indicated that only 57% of youth said that it is easy for them to obtain information about HIV/AIDS (RHIYA/UNFPA 2005). Nonetheless, 91 % of respondent in the same study reported being aware of the ways of avoiding HIV/AIDS. Premarital sex among the boys (13%) was quite high compared to girls (2%) and condom use in their first sexual contact was found to be only 14%.

The **current school curriculum provides basic information** about HIV/AIDS and reproductive health but the adequacy of the information and delivery of it has often been concern. There are major interventions targeting youth, which are expected to provide access to information, enhance their skills for reducing their vulnerability to HIV/AIDS and encourage the use of health services. Some of the most notable activities include youth friendly services centres, a life skills based media programme called Saathi Sanga Mann Ka Kura (meaning 'chatting with my best friend'), life skills based education programme through the education system and sexual and reproductive health activities.

UNICEF have a **cross-cutting approach to the HIV response children and young people in and out of school**. Over the last four years they have been working with the Ministry of Education and Sports to integrate life skills based education for HIV and drug prevention into the national health curriculum of school grades 1 to 10. The programme is currently being piloted in 13 districts of Nepal. Similarly, UNICEF and the UNFPA/Reproductive Health Initiative for Youth in Asia have a peer-based life skills programme aimed at reaching out-of-school children in more than 32 districts. This is taking place through their numerous support and implementation partners at international, national and district levels. These peer education programmes were been scaled up in 2005 under the GFATM programme. By the end of 2005, the programme reported reaching close to 50,500 in and out-of-school young people.

With injecting drug use as the primary mode of transmission, the young population will continue to be a priority.

(g) Emerging priority groups

Workplaces

There is strong evidence that private sector is attracting a larger workforce then ever before, clearly indicating clear shift from agriculture to production sector where 44% increase in labour force recorded in 2001 compared to 1991 (private sector 47,100; Public sector 376,000)[9]. Following a partnership programme of FNCCI with UNAIDS

[9] HIV/AIDS vulnerability assessment among Trade Unions, GEFONT/SARDI (2005) Kathmandu (Unpublished)

and the ILO, on education and awareness programmes for employers and workers in the Nepalese formal private sector initiated in 2002. A more comprehensive pilot programme has been initiated in 10 major private enterprises with assistance from ILO. Out of ten enterprises, seven have already developed their own internal workplace policy based on ILO code of practice.

In 2003 a 13 - member National Steering Committee for Workplace was constituted with representatives drawn from government (chair), NGOs, PLWHAs, Private sectors and UNAIDS and ILO.

A workplace policy has been developed by jointly FNCCI, Trade Unions and Government with support from ILO and UNAIDS which is awaiting government endorsement. National Steering Committee has already endorsed it and has forwarded to government for final endorsement. The policy is expected to guide the private enterprises to develop workplace programme for the employees and workers. Operation Plan 2005/06 envisage further support in terms of expanding services like awareness raising, peer education and VCT referral in the private sectors.

Marginalized groups

Experiences of NGOs and UNESCO with trafficked girls & women and street children, respectively, have indicated the need to address the HIV prevention and care needs of these two groups. Maiti Nepal, the leading NGO in the trafficking area, has reported growing levels of HIV infection among young girls it has rescued. UNESCO completed a study in November 2005 that reported that only 20% of street children in Kathmandu had been exposed to an HIV prevention activity.

Treatment, care and support

(a) Antiretroviral therapy

There are **very few organizations currently providing community care and support services** in Nepal. PLWHAs who have some resources often run community care centres. Service offered at these centres are nutrition, referral to district hospitals or private facilities for medical care, HIV testing, counselling and psychosocial support for PLWHAs and their families. According to one study, HIV positive injecting drug users receive more support than any other group affected/infected by HIV/AIDS.

Initiation of care and support programme for infected and affected groups has been rather late, having only started in a systematic manner in 2003. Although national guideline for ARV treatment was developed and finalised in 2004, ARV treatment was started in 2003 (for 77 PLWHAs). Currently there are about 160 (30% women) people receiving ARV treatment from seven locations in which two sites being outside the Kathmandu (Dharan and Nepalgunj). About 450 patients will be provided with ART through currently available funding from the government. With the Global Fund and other sources, a total target of 1,000 patients to be provided with ART has been set under the National Operational Plan for 2005/2006.

(b) PMTCT, paediatric AIDS and orphans & vulnerable children (OVC)

The NCASC conducted a situation assessment in July 2004 in order to initiate the **PMTCT pilot programme** in Nepal[10]. A PMTCT Working Group was established and the government introduced National Guidelines for the PMTCT 2004 and is in the process of updating. Currently there are three pilot sites and expected to **expanded into 6 more sites**. It was reported that some 2306 women received PMTCT services during July 2005 – November 2005. This service could be just counselling only and not comprehensive (Coverage survey 2005)

According to estimates used in the National Action Plan 2005-6, there are just over 900 children (under 15 years) with HIV and 10% of these are in need of ARVs. A paediatric AIDS diagnosis and treatment guidelines draft was developed in September 2005 and in the process of being finalized. A plan of action to initiate paediatric AIDS programme from 2006 is in place.

Through an initiative in Accham district, an INGO with local partners have started to provide psychosocial support including play-skill tools to all children orphaned by HIV (now over 50) and educational support including books, stationery, etc. to all orphans. Another INGO in Rupandehi district is supporting 50 children of sex workers.

Obstacles

Key actions

Key actions for improved service coverage will be identified through the next 5-year planning cycle that will result in the new **National Strategic Plan (2007-2011)**.

Goal(s)

A new National Strategic Plan (2007-2011) will include the goal of meeting the prevention, treatment, care and support needs of at least **70% of most-at-risk populations**.

[10] PMTCT in Nepal, Situation Assessment and Recommendations, 2004 July, Elisabeth A. Preble, MPH, Consultant, UNICEF/Nepal

KEY TARGETS AND ESTIMATED RESOURCE REQUIREMENTS

External Development Partners (EDPs) have played a vital role in country's development initiatives including in the area of HIV/AIDS. Some of the critical areas where EDPs support required are as follows.

In order to have an effective expanded, multisectoral and coordinated response to the epidemics, the **institutional mechanism** needs to be seriously considered. The scope and capacity of current institutional set up within the purview of Ministry of Health is structurally limited to move beyond the health sector. Therefore an appropriate institutional mechanism needs to be developed where sectors outside the health would have a role to play. The EDPs can assist government of Nepal, both technically and financially in developing an appropriate institutional mechanism.

Similarly, NCASC being a nodal agency for HIV/AIDS programme and policy development should focus on **capacity development in the areas of monitoring and surveillance** for which EDPs needs to join hand in building the capacity of NCASC with proper system, facility and staffing.

Donor coordination and harmonisation is important aspect not only to build national system but also for coordinated response for HIV/AIDS. While current coordinating mechanisms such as UN Theme Group; Association of International NGOs; regular Donors Meetings (MOH) have been useful, but due to lack of **a single framework or mechanism for donor coordination** and resource harmonisation, multisectoral response has not been fully achieved. EDPs therefore should explore the possibility of mechanism for coordination and harmonisation.

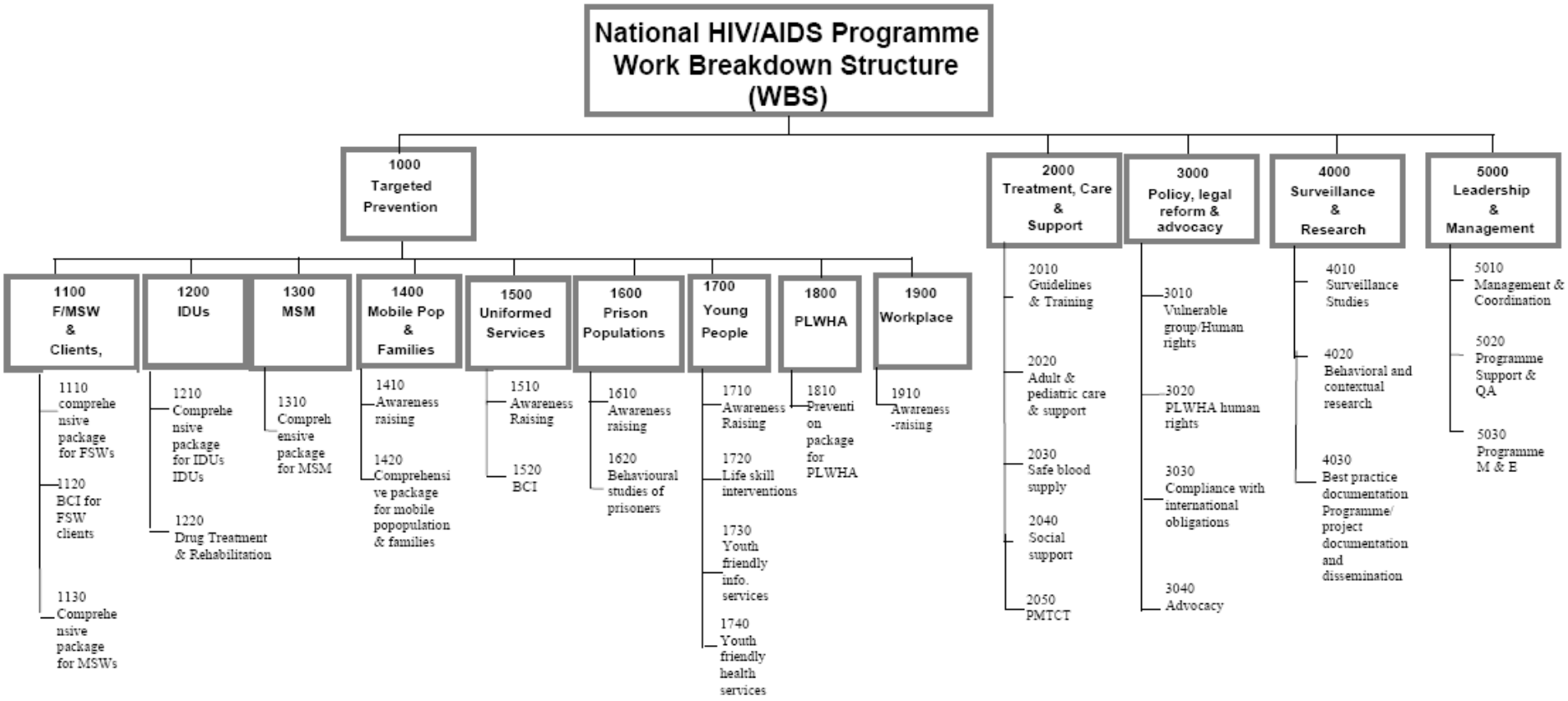
A national monitoring framework and mechanism is long overdue. In absence of an **effective monitoring and evaluation framework and mechanism**, tracking the achievements, resource flow and input to policy development has often been rather ad hoc scattered. EDPs should assist the government to set up a national HIV/AIDS monitoring and evaluation mechanism urgently.

The commitment to scale up **ART coverage** has several important implications: i) the health care system, in terms of personnel at national and district levels, must receive intensive and up-do-date ART training, especially for monitoring compliance and detecting drug resistance; ii) the current system for logistics and supply management needs technology and infrastructure augmentation; iii) laboratory facilities must be likewise upgraded. These extensive needs are areas where external technical and financial support is clearly needed.

Annexes

Annex 1: Universal access score charts

Annex 2: Programme framework



Annex 3: