Country Progress Report
NEPAL

To Contribute to Global AIDS Monitoring Report 2017

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

March 2018

Acronym

AEM	AIDS Epidemic Model
AHF	AIDS Health Foundation
AIDS	Acquired immunodeficiency syndrome
ANC	Ante-natal care
ARV	Anti-Retro Viral
ART	Antiretroviral therapy
CBS	Central Bureau of Statistics
CBT	Community-based testing
CD4	Cluster of Differentiation 4
CIWH	Children infected with HIV
CM	Community mobilizer
DFID	Department for International Development
DBS	Dried Blood Sample
eCS	Elimination of congenital syphilis
EID	Early Infant Diagnosis
eVT	Elimination of vertical transmission (of HIV)
FCHV	Female community health volunteer
FSW	Female sex worker
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GBV	Gender-Based Violence
HCV	Hepatitis C Virus
HIV	Human immunodeficiency virus
HMIS	Health management information system
HTC	HIV testing and counseling
HTS	HIV testing service
IBBS	Integrated biological and behavioral survey
IRRTTR	Identify, Reach, Recommend, Test, Treat and Retain
IRW	In-reach worker
KP	Key Population
MCH	Maternal and Child Health
MLM	Male Labour Migrants
MOH	Ministry of Health
MOHA	Ministry of Home Affairs
MSM	Men who have sex with men
MSW	Male sex worker
NCASC	National Centre for AIDS and STD Control
NGO	Non-governmental organization
NHSP	National HIV Strategic Plan
NTP	National Tuberculosis Program
OST	Opioid Substitution Therapy
OW	Outreach worker
PE	Peer educator
PrEP	Pre-exposure prophylaxis
PSM	Procurement and supply chain management
PLHIV	People living with HIV and AIDS
PWID	People who inject drugs
PWID-Female	People who inject drugs-female
PWID-Male	People who inject drugs-male
RDT	Rapid Diagnostic Test
SRH	Sexual and Reproductive Health
SW	Sex worker
STI	Sexually transmitted infection
TB	Tuberculosis
TG	Transgender
TGSW	Transgender sex workers
UN	United Nations
UNAIDS	Joint United Nations Programme on AIDS
USD	United States Dollar
WHO	World Health Organization

Table of Contents

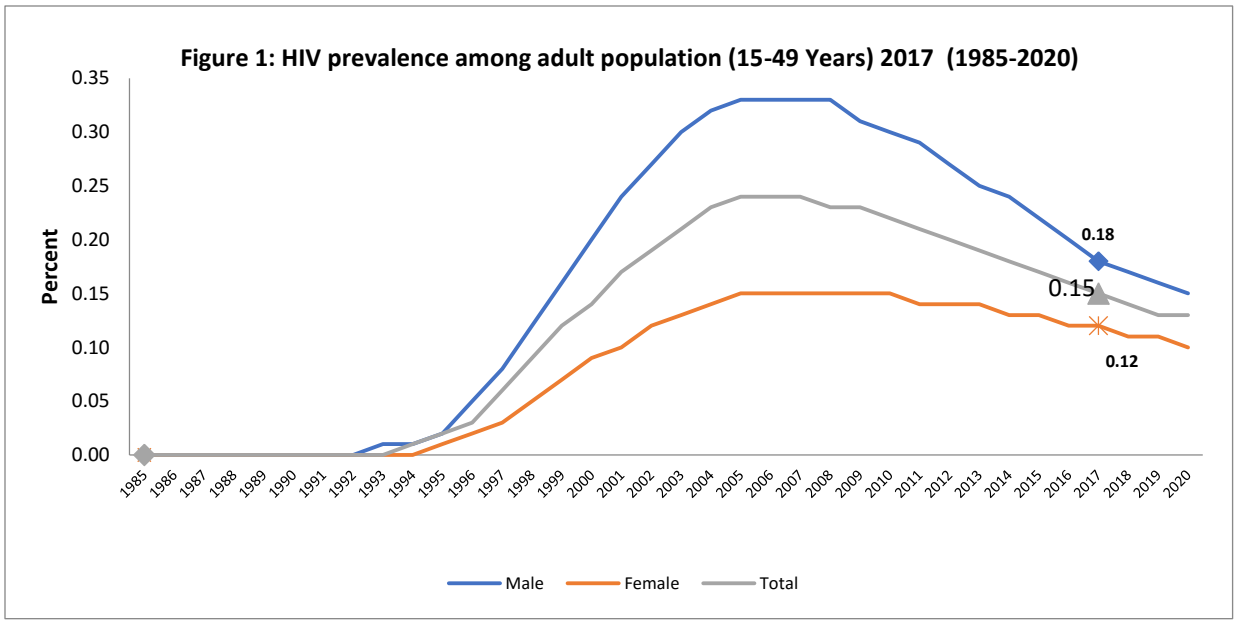
List of Figures

OVERVIEW

The HIV epidemic has evolved from a 'low prevalence' to 'concentrated epidemic', i.e. a low prevalence of HIV infection in the general population but a higher prevalence in specific sub-populations; people who inject drugs (PWID), men who have sex with men (MSM), transgender people (TG), male sex workers (MSW), female sex workers (FSW) and male labor migrants (MLM), as well as their spouses. The national estimate of FSW is minimum 43,829 and maximum 54,207. Similarly, estimates of MSM/MSW/TG are minimum 88,009, and maximum 112,150 and PWIDs are minimum 27,248 and maximum 34,487 (NCASC Mapping Report, 2016).

Nepal's HIV epidemic remains concentrated among key populations, with HIV prevalence at 5% among MSM and 8.5% among TG people in certain parts of the country; 8.8% among males who inject drugs and 8.8% among women who inject as well; 2.2% among FSW; and 0.4% among MLM. The majority of new infections are occurring among 'low risk' women infected by from their spouses, male labour migrants and MSM.

The estimated national HIV prevalence among the 15 to 49 years age group was 0.15% with an estimated number of 31,020, people living with HIV at the end of 2017. Out of these, 62% were males, 38% were females with 4% being children aged 0-14 years. The 2017 national HIV infection estimation shows that the prevalence among adult aged 15-49 years has dropped from a peak (0.24%) in 2005 and is likely to remain around 0.13 percent in 2020. HIV prevalence among the age group of 15-24 years was 0.02 percent in 2017. New infection of HIV was peaked in 2003 with almost 5,000 new cases in a calendar year, and this has declined to 835 in 2017. The 2017 national HIV infection estimation shows that AIDS-related deaths are also in declining trend with 1,306 deaths in 2017, compared to 1,687 deaths in 2010. The AIDS-related mortality rate was 4.49 per 100,000 cases in 2017.



Source: National HIV infection Estimates 2017

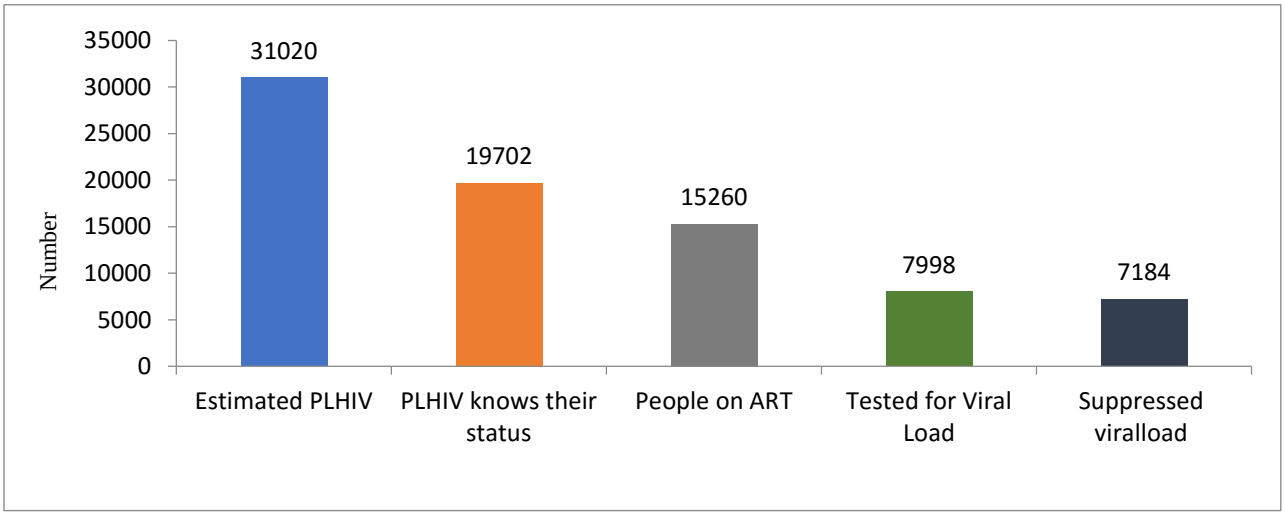
Table 1: Key Indicators of HIV Estimates in Nepal, 2017

Indicators		2017
Estimated number of people living with HIV:		31020
	Children (0-14 years)	1,192
	Adult (15-49 years)	22812
	Adults (50+ years)	7016
Estimated number of male living with HIV:		19020
Estimated number of female living with HIV:		12000
Adult HIV prevalence (15-49)		0.15%
HIV Incidence per 1000		0.03%
Percentage of women 15-49 years living with HIV (of estimated adult PLHIV)		31.0%
Annual number of new infection (Male to Female ratio)		835 (2:1)
	Annual number of new HIV infections - Male	556
	Annual number of new HIV infections - Female	279
Annual number of new HIV positive pregnant women		304
Average number of new infections per day		2
Annual number of new infections amongst children (0-14 years)		66
Annual number of AIDS-related deaths		1,306
Annual number of AIDS-related death among children (0-14 years)		33

Source: National HIV infections Estimation 2017

The number of people accessing ART is increasing, particularly with Nepal's recent adoption of the Test and Treat strategy. As of December 2017, 19,702 (64%) of the estimated 31,020 people living with HIV in Nepal had been diagnosed and linked with HIV care, and 49% (15,260) were receiving ART as of December 2017. In 2017, 87.6% of people on ART were still on treatment after 12 months. Although data on viral suppression is scarce due to the limited availability of viral load testing, in 2017, 7,184 (90%) out of 7,998 people on ART who were tested were found to have suppressed viral loads. In 2017, around 63% of all estimated HIV-positive pregnant women received ART to reduce risk of HIV transmission to HIV serodiscordant partners and improve maternal health.

Figure 2: Treatment Cascade 2017



Given the above, Nepal is lagging behind in achieving the ambitious 90-90-90 treatment target in the next two years; by 2020, as set out in 'Nepal HIVision 2020,' the National HIV Strategic Plan 2016-2020 - including:

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

Overall challenges on the response

Test and Treat Strategy has recently started in all over the country and there is need for orientation to health workers including ART counsellors about it. ,Domestic resource mobilisation in National, provincial and local level, and its proper utilization is still a challenge. Procurement of drugs and commodities through health system to ensure the availability of the drugs is another key challenge. For fast-tracking the response to achieve 90-90-90 by 2020, the public sector health services and NGOs working with and for KP and their partners need to find solutions that increase demand for services: a) Identify, Recommend and Reach KP for HIV prevention b) Increase HIV testing among KP and c) Retain in HIV care.

This Country Progress Report serves as a guide to gauge the overall performances of the national response for the achievement of 10 international commitments. The data were validated with the key stakeholders.

COMMITMENT 1

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

On first December 2016, Nepal launched new National HIV Strategic Plan (NHSP) 2016-2021 which is fully aligned with the global commitment of 90-90-90. Subsequently in line with national commitment and NHSP, Nepal's amended relevant guidelines on HIV testing and treatment as well, which plan catalytic role to scale up the test and treat services in the country. Likewise, HIV testing services through community-led approach are being implemented as an innovative approach to enhance the HIV testing coverage in the country.

Currently, DHS 2016 data shows that thirty-four percent of women and 58 percent of men know where to get an HIV test, and 10 percent of women and 20 percent of men have ever been tested and received the results (MoH et al., 2017). Likewise, around two-thirds of people living with HIV (64%) know their status (Source: NCASC, Routine program data).

As of December 2017, HIV treatment services are provided through 69 ART centers. The ART coverage is estimated at 49% (15,260/31,020). Out of them; 7,292 are males (40% among male), 7,000 are females (61% among female), and 968 are children (81% among children).

Treatment retention among people living with HIV who initiated treatment in last 12 months was 87.6 percent in 2017, which is at decent however country has envisioned to increase it to 90 percent by 2020.The retention in ART is defined as the percentage of PLHIV who are alive and on ART for at least 12 months.

During 2017, 7998 people living with HIV were tested for viral load, out of which 7,184 people on ART (90%) were found to have their viral loads suppression (≤1000 copies/mL). However, if calculated against the total estimated number of PLHIV (31,020), only 23.2 percent had suppressed viral load.

Twenty-two percent (601) of 2,779 PLHIV who initiated ART in between July 16, 2016 and 15 July 2017 presented late for HIV care (initial CD4 cell count less than 200 cells/mm3). Furthermore, 36.5 percent of them (996) had initial CD4 cell count less than 350 cells/mm3.

It is encouraging to note that all ART centers (69) reported zero stock out of antiretroviral medicine. An annual number of AIDS-related deaths has been decreased after it peaked in 2007. An annual number of AIDS-related death was 4.49 (7.21 for male and 1.93 for female) per 100000 population in 2017.
Though a gradual increase has been observed on the treatment cascade (64% tested, 49% on treatment and 23% virally suppressed), the current pace needs to be significantly increased to achieve the fast track target of 90-90-90.

As a foundation for the implementation of the NHSP, the National HIV Testing and Treatment Guidelines, National Community Led HIV Testing Guidelines were developed, including Community-Led HIV testing, based on 'Test-for-Triage'. Furthermore, the country's Strategic Information Guidelines on HIV was also updated to track the targets set on NHSP 2016-2021.

Challenges

The low ART coverage implies that we are missing to link in care a large proportion of undiagnosed PLHIVs or those who diagnosed but not initiated ART. Thus, identifying undiagnosed PLHIV or timely linking diagnosed PLHIV to will act as a catalyst to achieve 90-90-90 by 2020.

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

Way Forward

The following activities may help to address the existing challenges:

a) Improve HIV testing among KP through innovative approach such as community-led testing. The community-led testing should incorporate accompanied positively identified clients to a health facility for confirmatory testing and avoid loss of such clients.

b) PLHIV who are identified positive but not on ART should be linked to HIV care. The implementation of test and treat strategy may help to address this issue in coming days.

c) The information of individual client on ART should be kept and routinely updated in electronic database system since such information is more helpful to analyze the barriers and facilitators of retention in HIV care rather than aggregated level routine program report (disaggregated by age, risk groups and gender).

d) The viral load testing facility should be available in each province. There are only three viral load testing sites (of which two are in the capital city).

COMMITMENT 2

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

Early Infant Diagnosis (EID)

Early Infant Diagnosis (EID) service has been started since September 2014. Currently, Dried Blood Samples (DBS) are collected from 28 sites across the country. Only 44.7 percent (136) of total estimated 304 infants born to HIV-positive mothers received an HIV test within two months of birth (Routine Program Report, NCASC 2017).

Elimination of Vertical Transmission

Nepal has scaled up elimination of Vertical Transmission (eVT) services in recent years covering all birthing centres across the country. After the implementation of elimination of vertical transmission strategy, HIV testing among pregnant women has increased almost by 10% in 2017 (52.3%; 396258/758652) as compared with 43% in 2016.

Estimated percentage of children newly infected with HIV from mother-to-child transmission among women living with HIV delivering in the past 12 months was 22% (66/304).The eVT coverage in 2017 has reached 63 percent (192/304) in 2017 which was 35 percent in 2015. Out of these 192 pregnant women who received ARV, 86 (45%) were newly initiated on antiretroviral therapy during the current pregnancy, remaining 106 (55%) were already receiving antiretroviral therapy before the current pregnancy.

Though the national program focuses on elimination of congenital syphilis, the prevalence of syphilis and congenital syphilis is under-reported in the national reporting system. According to the report from Health Management Information System (HMIS); as of July 2017, only 0.000832 % of women accessing antenatal care services were tested for syphilis, tested positive and treated. Similarly, Health Management Information System (HMIS) reported none of the reported congenital syphilis cases for the year 2017. It could be the national program does not supply test kits for syphilis screening among pregnant women, and most of the pregnant women visit private laboratories/hospitals for the test so the reported data might be underreported.

Challenges

Low EID coverage is an obstacle in the national response particularly for improving mortality and morbidity among children living HIV. HIV testing in pregnant women is low in the country. Thus, testing all pregnant women for HIV as well as syphilis and to ensure the reporting of the tests in the national system is the biggest challenge.The program did not capture those pregnant women who do not access antenatal services/delivery at home.

Way-forward

The scaling up of the eVT service (that needs to be scaled up to 90 percent by the end of 2020 from the present coverage of 63 percent) through intensified case finding among pregnant women who do not visit for ANC checkup and who visit private health facility for antenatal services is crucial. For this, the private sector

contribution to eVT has to be enhanced, including through in-reach by women in the communities, such as Female Community Health Volunteers, in particular, reaching those pregnant mothers who do not access antenatal services and visit health institutions for deliveries. Moreover, pregnant women, who are members of the key populations, need to be unfailingly tested and, if HIV positive, should be enrolled in the ART to keep them alive and well.

COMMITMENT 3

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

Incidence

The incidence rate of HIV has decreased from 0.05 per 1000 population in 2015 to 0.03 per 1000 population in 2017. (Source: National HIV Infections Estimates, 2017, NCASC).

Estimates of the size of key populations

The latest mapping and size estimation exercise among KPs, MSM, MSW, TG, PWID and FSW was carried in 2016. The national estimate of FSW, MSW and MSM was 49013, 18287 and 60,333 respectively. Similarly, the national estimates of TG was 21, 460. Furthermore, the estimated numbers of male and female PWID were 27,567 and 3,301 respectively (NCASC, 2017).

Female sex workers

Overall HIV prevalence among FSW in Kathmandu valley is almost stable, i.e. 1.7 percent in 2011 to 2.2 percent in 2017 (IBBS, NCASC, 2017). However, the HIV prevalence widely differs among FSW working in different settings, i.e., 3.8 percent among street-based sex workers in 2017 Vs 1.9 percent in the establishment and home-based sex workers (IBBS-Kathmandu Valley, 2017).

Recent IBBS surveys conducted in Kathmandu valley in 2017 has shown that prevalence of Active Syphilis among FSW was 2.2 (Street based=2.5 and Establishment and home based=2.1).

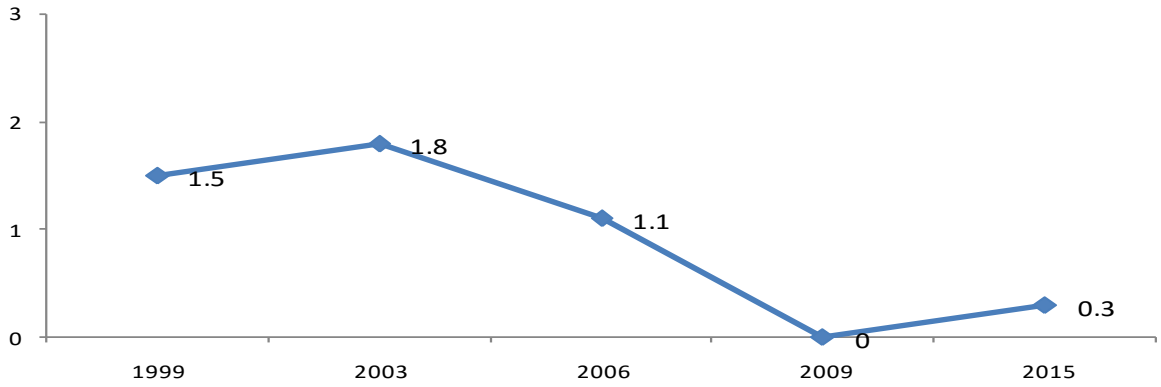
Consistent condom use of FSW with a regular client in the past year was 61.7 percent. Consistent condom use with a non-paying regular partner in the past one year was only 17.8 percent. Condom use with other than clients, husband and a male friend was 82.7 percent in the past one year. FSW who used a condom with their most recent client was 84.8 percent.

Percent of Female sex workers who knew their HIV status was 98.3 percent in Kathmandu Valley (IBBS, NCASC 2017).

Clients of Sex workers

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

Figure 3: Trend of prevalence in clients of FSW

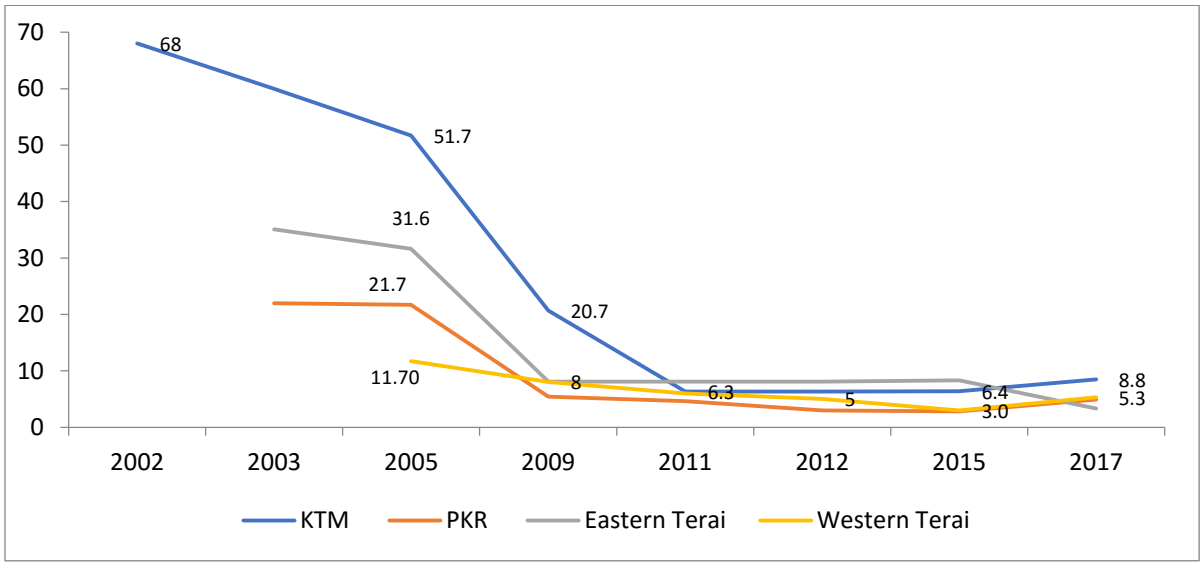


(Source: IBBS, NCASC, 1999- 2015)

People Who Inject Drugs (PWID)

Due to its early interventions, Nepal is successful to reduce HIV infection among the PWID. The recent IBBS survey suggested that, the HIV prevalence among PWID in Kathmandu has slightly increased to 8.8 in 2017 from 6.3 in 2011 and 6.4 percent in 2015 and a similar trend has been observed among PWID in Pokhara valley with the prevalence of 4.9 percent in 2017 from 2.8 percent in 2015. In addition, HIV prevalence among PWID in Western to Far Western region was 5.3 and 3.3 percent in the Eastern Terai in 2017 (IBBS NCASC 2017).

Figure 4: Trend of prevalence among PWID in Nepal (2002-2017)



(Source; IBBS, NCASC 2000-2017)

Percentage of PWID in Kathmandu who used condom at the last sex had been almost stable since 2010 (50.8% in 2010 and 48.9% in 2017). However, consistent condom use with FSW among PWID in Kathmandu was 59.6 percent. Similarly, consistent condom use with non-regular female partner was 38.4 percent. Likewise, consistent condom use during anal sex with male partner was 37.5 percent (IBBS, 2017). Among PWID in Pokhara, consistent condom use with female regular partner in the past 12 months was only 2.8 percent. Likewise, consistent condom use with FSW was 52.2 percent, and consistent condom use with non-regular female partner was 32.6% (IBBS, 2017).

Ninty one percent of PWID in Kathmandu, 87.5 percent of PWID in Pokhara did not use non-sterile syringe/needle at any time in the last month. Similarly, 87.5 percent PWID in Pokhara did not use non-sterile syringes in the last month. On the other hand, 80.7 percent PWID in Eastern region and 88 percent of PWID in Western region avoided the use of the non-sterile syringe in the last month (IBBS, 2017).

Safe injecting practice is high among PWID in recent years despite number of needles and syringes distributed per person among PWID per year remaining low over the years. Around 61 needles and syringes were distributed per person per year in 2017.

HIV testing among PWID is still low. One third (34.4%) of PWID in Kathmandu valley had tested HIV in the past 12 months, and among them, 98.3 percent know their HIV status (IBBS, NCASC 2017). Similarly, 29 percent of PWID in Pokhara had tested HIV in the last 12 months, and all of them know their HIV status.

Besides Needle syringe program, Nepal is also providing Opioid Substitution Therapy (OST) program for PWID. National HIV strategic Plan envisioned to have an OST coverage of 10 of 10% by 2020, however, due to coordination issues and lack of geographical coverage OST coverage among PWID is still unacceptably low. Currently, only 930 PWID (Male: 907 Female: 23) were on Opioid Substitution Therapy (OST). Among them, 769 (82.7%) were on methadone, and 161 (17.3%) were on buprenorphine.

HIV prevalence among female injecting drugs users in Kathmandu valley was 8.8 percent in 2016. Around 68 percent of those females, reported having an HIV test. The same study also highlighted that 67.6 percent of them know their HIV status. Likewise, 81 percent female injecting drugs user reported using sterile injecting equipment the last time they injected (IBBS, NCASC 2016). Likewise, the prevalence of HIV among female injecting drugs users in Pokhara was 1.9 (95% CI=0.5, 5.9) and prevalence of syphilis was 3.9 (95% CI=1.5, 8.6) in 2016. Almost one-sixth of female injecting drugs users (16%) had shared needle/syringe with one or more people in the last injection. Nearly a tenth of them (7%) had used the syringe given by their friend or relative after their use in their last injection (IBBS, NCASC, 2016). The number of PWID-Female enrolled in OST was 23 in the period of 2017 (NCASC, Routine Program data, 2017).

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

The overall prevalence of HIV among MSM in Kathmandu Valley was recorded 5 percent in 2017 which has increased by a more than twice proportion in comparison to 2.4 percent in 2015 (IBBS, NCASC 2017). HIV prevalence in Kathmandu Valley was higher among MSW group (7.4%) than among Non-MSW groups (1.3%).

HIV prevalence among TG has slightly increased in 2017 (8.5%) than 2015 (6.2%). All TG while 89.6 percent MSM were aware of their HIV status. Ever had an HIV test was higher among SW (87%) than Non-SW (65.1%). The majority of the MSM-TG who had an HIV test (91.2%) conducted the most recent HIV test within the past 12 months (IBBS, 2017).

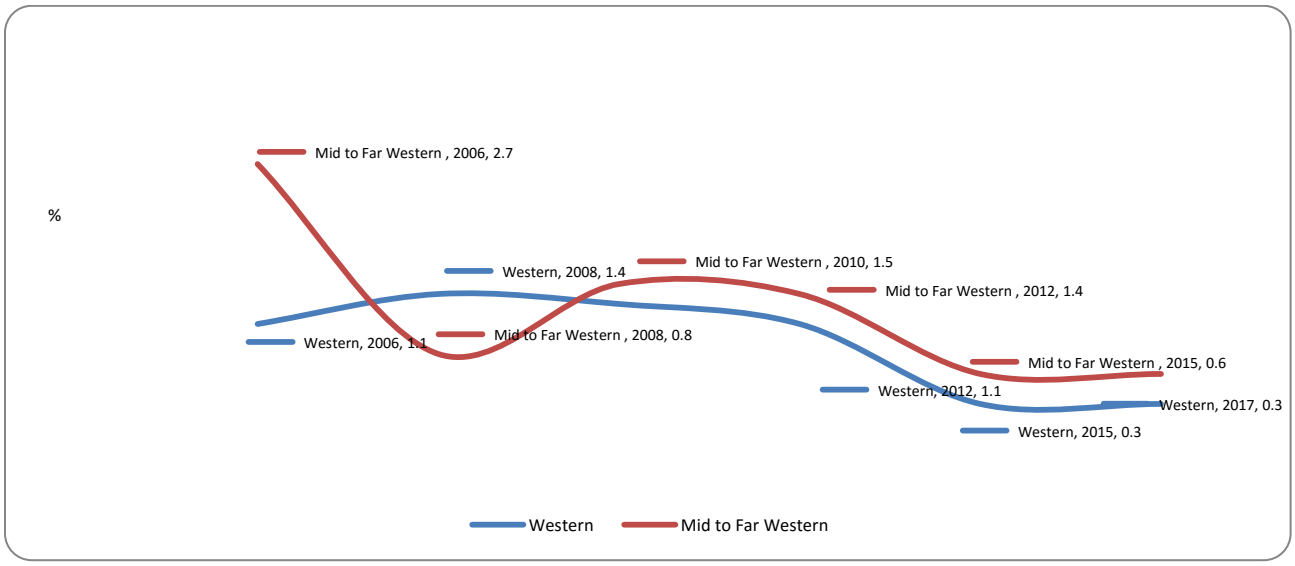
Condom use with the most recent client was slightly higher among TGSW (99%) than MSW (96.7%) and MSM (94.6%). Consistent condom use with non-paying male sex partner in the last month among TG was 77.2 percent. Similarly, consistent condom use with non-paying sex partner was 71.6 percent, and non-paying female sex partner was 60.9 percent in the last month among MSM. Consistent condom use while having anal sex with regular male/TG women in the last month among TG was 86.5 percent and among MSM was 72.2 percent. All TG (100%) and 64.2 percent MSM used condom while having anal sex with paying male sex partners in the last month (IBBS, 2017).

Male Labour Migrants (MLM) going to India

National HIV Strategic plan 2016-2021 considered male labor migrants are going to India as one of the key population for HIV. Indo-Nepal treaty of 1950, allowed Nepali to go and work in India and vice-versa. Every year people from western to far western region of Nepal goes to India to work mostly in the informal and non-skilled sector as seasonal labors. The destination cities of Nepali migrants in India are mostly those cities with a higher risk of HIV and being away from their partners for a long period of time keeps them at risk of HIV as they are likely to practice unsafe sexual behaviors. Many studies including the IBBS show that sexual intercourse with female sex workers is not uncommon among migrants. A fifth of the MLMs (20%) had ever had sex with FSWs in India. More than a third of the MLMs (35%) reported that they visited 2-3 FSWs during their lifetime in India. About 83 percent of the MLMs had used condom consistently in all the episodes of sex with FSWs in the past year (IBBS, 2017). For minimizing the additional HIV risk in Nepal, GoN is implementing HIV programme among migrants since early 2000, and still country is getting significant number of new infections from returnee migrants from Nepal.

Currently, HIV prevalence among Male Labor Migrant (MLM) is showing a decreasing trend in Western region (1.1 in 2006 to 0.3 in 2017) and Mid to Far Western region (2.7 in 2006 to 0.6 in 2017) as a result of continuous and prioritized program in the migration prone districts (IBBS, NCASC 2017).

Figure 5 Trend of HIV prevalence among MLM (2006-2017)



Source: (IBBS, NCASC 2006-2017)

More than two-thirds MLM (66.5%) were aware of the place where HIV testing can be done. 18.6% of MLM ever had an HIV tested. Only 7.1 percent of MLM had tested for HIV within the last 12 months. 89.6% of those who had HIV tested within the 12 months had obtained the test result (IBBS, 2017).

Viral Hepatitis among Key Populations

Prevalence of Hepatitis especially HCV is high among PWID. IBBS surveys show that prevalence of HCV is 38.1 percent among PWID Eastern Terai, 18.8 percent among PWID Kathmandu, 21.2 percent among PWID Pokhara and 23 percent among PWID Western region. Prevalence of HBV was 1.3 percent among PWID-Kathmandu,, 3.1 percent among PWID-Pokhara, 2.7 percent among PWID-Western region and 0.8 percent among PWID-Eastern region. Similarly, co-infection of HIV and HCV was alarmingly high among the PWID-Kathmandu (7.35%) (IBBS, 2017).

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

The prevalence of HBV and HCV among PWID-Female in Pokhara was 2.6 percent (95% CI=0.8, 6.9) and 1.3 percent (95% CI= 0.2, 5.1) respectively (IBBS, NCASC, 2017).

Challenges

HIV Testing practice among key populations is still low among all Key population. In addition to the low testing levels, the coverage of needle and syringe exchange program is only 49 percent, whereas OST coverage is 3 percent. The needles and syringes provided per PWID per year are far below the recommendation of 200 needles and syringes per person per year. Only 61 needles and syringes were distributed per PWID per year. Key challenges with the current OST programme are: a) limited coverage of services; b) unavailability of HCV prevention and treatment services and c) poor retention rate among enrolled OST clients.

Way -forward

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

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

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

COMMITMENT 4

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

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

Prevalence of Stigma and Discrimination

The reduction of stigma and discrimination has been one of key elements of Nepal's National HIV Strategic Plan 2016-2021. The Positive Protection Toolkit was launched with and for women leaders from key populations, followed by training on Positive Protection to empower Women Affected by HIV to protect their rights in health care settings. Under the guidance and monitoring support of Right to Health Women's Group (RTHWG) at the national level, several 'Right to Health' action-groups are now actively engaged in documenting rights' violation as well as in joint advocacy at the district level. Gender Assessment of National Responses to HIV and TB was conducted in early 2016 and recommendations were incorporated in National HIV Strategic Plan 2016-2021.

The government of Nepal and UN jointly facilitated a baseline study and five-year work-plan and budget for cost-shared 'Catalytic Funding' to scale-up programs for removing human rights barriers, for key populations to access health services.

Prevalence of discriminatory attitudes towards HIV is still high. The DHS 2016 shows that forty percent of women and 33 percent of men expressed discriminatory attitudes towards people living with HIV (MoH et al., 2017).

Prevalence of recent Intimate Partner Violence

Intimate Partner Violence (IPV) which often is considered as a potential barrier to women's access to health services was included in the Demographic Health Survey (DHS) 2016. The DHS 2016 shows that twenty-two percent of women age 15-49 have experienced physical violence since age 15, and 7 percent have ever experienced sexual violence. Twenty-six percent of ever-married women have ever experienced spousal physical, sexual, or emotional violence. The most common type of spousal violence is physical violence (23%), followed by emotional violence (12%). Furthermore, seven percent of ever-married women have experienced spousal sexual violence (MoH et al., 2017).

Violence in all three forms (psychological, physical and sexual) has repeatedly been observed among key populations over the years. 23.6 percent of the FSWs in Kathmandu valley (street based=26.3%; establishment and home based=23.1%) in 2017 have experienced verbal abuse, discriminated or threatened in the past 12 months. About 10 percent of FSWs faced physical attack in the past 12 months. Similarly, 29.2

percent of the FSWs reported that they had encountered clients who refused to pay money after having sex (IBBS 2017).

Among MSM and TG in Kathmandu, almost a fifth of the SW (19%) reported facing discrimination in jobs and daily life. The level of discrimination among SW has not changed in 2004 and 2017. However, the percent of SWs facing discrimination in jobs and daily life has decreased during 2015 and 2017 (42% vs 19%). More than a tenth (11%) MSM-TG (16% TG and 8% MSM) had experience of physical violence. Similarly, 6 percent of MSM-TG had experience of sexual violence (IBBS 2017).

According to IBBS conducted among FSW in the Pokhara Valley in 2016, around 15 percent of FSW had experienced verbal abuse (psychological violence), and 6 percent of them had experience of physical violence. Moreover, 6.1 percent of FSW in Pokhara Valley had experience of sexual violence (IBBS NCASC 2016).

More than a tenth (11%) MSM-TG (16% TG and 8% MSM) in Kathmandu valley had experience of physical violence. Similarly, 6 percent of MSM-TG had experience of sexual violence. Almost a fifth of the male sex workers (19%) reported facing discrimination in jobs and daily life (IBBS, 2017).

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

Challenges

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

Way -forward

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

The upcoming program through cost-shared Catalytic finding for programs to remove human rights barriers, for key populations to access health services will also play a pivotal role to minimize these challenges.

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

COMMITMENT 5

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

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

The DHS 2016 data showed that twenty-one percent of young women and 27 percent of young men age 15-24 have comprehensive knowledge of HIV. Fifty-six percent of the total demand for family planning is satisfied by modern methods. (MoH et al., 2017).

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

The youth-led social media movement 'Live2LUV in Nepal' was launched in Kathmandu on November 30, 2017. This movement contributes to achieving the goal of 90% of young people having the knowledge, skills and competencies to protect themselves from HIV and other STI, and having access to good quality youth competent sexual and reproductive health services.

Challenges

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

Way –forward

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

COMMITMENT 6

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

The national social protection framework of Nepal includes cash beneficiaries including elderly people, single women, people of deprived communities, those living in remote areas and school children of deprived communities. In the HIV context, Nepal has recognized social protection as a critical enabler of the HIV response in its current and previous National HIV Strategic Plans.

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

Aligning with the National HIV Strategic Plan, Nepal has been implementing a social protection scheme for Children Infected by AIDS (CIBA). More than 1,300 of these children aged between 0-18 years, across 60 districts, are receiving the monthly financial support of Nepali Rs 1,000, (approximately USD 10) on their bank accounts. Apart from this, civil societies are also advocating for incorporating this social protection program into the broader social protection framework of the Government of Nepal with the aim of ensuring the financial sustainability of social protection program for CIBA. Moreover, Nepal has been providing nutritional supports to PLHIV especially to female and children living with HIV.

Challenges

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

Way –forward

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

COMMITMENT 7

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

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

With the prevention-treatment continuum of IRRTTR at the center, the 2016-2021 NHSP emphasizes a pivotal role for communities in the country's national HIV response through in reach Critical participation of communities include relevant public-private partnerships between government and civil society, and 'task sharing' between health workers and trained laypersons of the key population, such community-led testing thereby expanding HTS among key population by key populations.

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

Challenges

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

Way-forward

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

COMMITMENT 8

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

The government of Nepal increased spending in health regarding total volume over the last decade. As a percentage of GDP, it has remained around the 5-6% level over the last 5 years. According to Nepal's most recent national health accounts (2011/12), out-of-pocket household payments account for more than 50% of all health expenditure, while almost half is spent on medicines and curative care.

During this period, reliance on external funding has declined significantly, with GoN funding increasing from around 50% during the first health sector plan (NHSP-1) from 2005-2009, to some 75% at the start of NHSP-3 (2016).

In contrast, the HIV program in Nepal remains heavily dependent on external assistance. GoN financing for the program comes both through direct sectoral budgets and through the Pooled Fund, a basket of funds which comprises, from external partners, including the World Bank, DFID, and KfW. The Pooled Fund accounted for around 10% of overall HIV spending in 2014, and was used primarily to support comprehensive HIV prevention program for key populations (including migrants).

The largest single contributor is the Global Fund, which supported just under half of HIV expenditure in 2014, while bilateral funding—principally from USAID and GIZ—accounted for just over one-fourth of spending in 2014. Several other partners, including UN agencies and INGOs, also continue to support the response.

However, this funding landscape is now in a period of transition, with external resources on a rapid downward trend since 2014—the reduced Global Fund envelope for 2018-2021 will result in a decrease of around 35% in 2018 —while the government has taken important steps towards securing the sustainability of the response by stepping up its contribution. For 2017-18, the government has, for the first time, committed significant resources (USD 1.4 million) for the procurement of ARV and has pledged to fund 100% of ARV procurement in 2018-19 and 2020-21. As of 2018-19, the GoN will also assume full financial responsibility for the eVT program, TB-HIV interventions, and prevention programs for migrants and in prisons and other closed settings. In addition, it is increasingly taking over support for human resources, commodities and services that have hitherto been supported by the Global Fund.

Ministry of Health, in particular, has implemented a budget and expenditure tracking system called Transaction Accounting and Budget Control System (TABUCS) which requires all the spending units all over the country within Ministry of Health to upload their expenditure reports in every trimester. This allows expenditure tracking more efficiently and timely. Besides, periodic exercise (NASA) will further provide information on HIV spending tracking in the country.

Challenges

As discussed above, Nepal's HIV program is heavily dependent on foreign aid. Development aid, especially for HIV, is reducing over time from donor countries and the international financing mechanisms, such as the Global Fund, as priorities are shifting to support countries with the highest HIV burden. GoN is committed for significant resource increment for the HIV program, however failing to allocate adequate resource as

committed will hamper the program specifically in the procurement of drugs, and interventions among migrants and prison population. The 2016 United Nations High Level Meeting on ending the AIDS epidemic by 2030 Political Declaration that was also endorsed by Nepal, as Member State of the UN General Assembly, recommends that countries substantially increase their domestic contribution to a comprehensive HIV prevention, treatment and care response.

Way-forward

A further increase in domestic investment in HIV is required to ensure the sustainability of the HIV response in Nepal. Apart from this, HIV-related services that relied on this pooled funding need to be assessed and reshaped to fit the new prevention-treatment paradigm and public-private partnerships, through task-sharing. Formal engagements with recipients and sub-recipients of the pool fund need to be streamlined in light of more effectiveness and efficiency. Moreover, multi-year contracts needs be issued, where feasible, to avoid implementation gaps. The government of Nepal has been contributing to Targeted Interventions in particularly for key populations.

Apart from this, the Government is contemplating financing particularly for ART from its sources. This initiative will leverage sustainable financing especially for ART as well as increase the share of domestic contribution to the national response.

COMMITMENT 9

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

The September 2015 Constitution of Nepal guarantees that every person regardless of situation or condition has the following fundamental rights: Right to live with dignity, Right to freedom, Right to equality, Right to justice, Rights of a victim of crime, Right against torture, Right against preventive detention, Right against untouchability and discrimination. Article 18 (2) under Right to Equality also states that no discrimination shall be made in the application of general laws on the grounds of origin, religion, race, caste, tribe, sex, physical condition, condition of health, marital status, pregnancy, economic condition, language or region, ideology or on similar other grounds. The Constitution also contains a specific right to healthcare, including information on one's health condition, access to emergency health care and equal access to healthcare. Women, are specifically included as having the right to safe motherhood and reproductive health and protection against any violence. The present NHSP has recognized that human rights, gender, justice, equity and inclusion are pivotal for an effective HIV response. Apart from that, Nepal has put in place accountability mechanisms in relation to discrimination and violations of human rights in healthcare settings.

National Human Rights Commission takes care of complaints of cases of HIV-related discrimination as well as other forms of discrimination. Similarly, existing legal system also takes care of any plea related to discrimination lodged at it. Envisaging particular attention to human rights and gender issues, the present NHSP has underpinned the monitoring for zero tolerance.

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

Challenges

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

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

Way-forward

Human rights, gender justice, equity and inclusion should be clearly recognized as critical enablers as well as important areas of the investment for the success of national HIV response. Recognizing the law enforcement agencies and other uniformed services have an important role in protecting the disadvantaged key

populations, they should be well trained in order to provide support and protection services to key populations. To address the funding barrier, in addition to regular funding for HIV, the global fund is allocating additional 1.3 million USD as a catalytic investment to address human rights-related barriers to access health services among key populations.

COMMITMENT 10

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

Co-managing TB and HIV treatment

The National Tuberculosis Program (NTP) is implementing TB/HIV activities in all districts. Currently, Isoniazid prevention therapy (IPT) services are being provided through all ART Centers.

In 2017, 214 (males 154 and female 60) HIV positive new and relapse TB patients started on TB treatment who were already on antiretroviral therapy or started on antiretroviral therapy during TB treatment. Similarly, 14 percent of People living with HIV were newly enrolled in HIV care with active TB disease. (NCASC, Routine program data 2017).

Management of Viral Hepatitis

By incorporating HCV and HBV in IBBS survey, from 2015, Nepal has started to monitor the prevalence of these viral diseases among PWID male and female. The country is also planning to treat all PWIDs through its study to validate treatment protocol of HCV.
From 2017 NCASC is acting as a member secretary of steering committee formulated for Hepatitis B and C related response in the county.

Challenges

Co-infection of HIV and HCV was alarmingly high among the PWID-male (7.35%) in 2017 and 5.62 percent among female PWID (IBBS, 2016) in Kathmandu valley.

The high rate of HIV/Hepatitis C co-infections, ranging from 13.1 percent to 47.5 percent, has been diagnosed among PWID in recent IBBS studies.

Comprehensive surveillance systems for Hepatitis B and Hepatitis C are yet to be developed in the country. The treatment service is not freely available among the PWID.

Way-forward

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

References

NCASC, 2017. Mapping and size estimation of FSW, MSM, MSW, TG and PWID in Nepal. Government of Nepal Ministry of Health. National Centre for AIDS and STD control Teku, Kathmandu

Ministry of Health, Nepal; New ERA; and ICF. 2017. Nepal Demographic and Health Survey 2016. Kathmandu, Nepal: Ministry of Health, Nepal.

DoHS (2017). Annual Report. Department of Health Services 2072/73 (2015/2016), Government of Nepal, Ministry of Health, Department of Health Services, Kathmandu, Nepal

Sharma M and Paudel P (2016). Nepal National AIDS Spending Assessment (NASA) for the year 2013 and 2014. Goverment of Nepal, Ministry of Health, National Centre for AIDS and Control. Kathmandu

NCASC (2017). Integrated Biological and Behavioral Surveillance (IBBS) Survey among People Who Inject Drugs (PWID) in Kathmandu Valley-Round VII. National Centre for AIDS and STD Control Teku, Kathmandu 2017

NCASC (2017). Integrated Biological and Behavioral Surveillance (IBBS) Survey among People Who Inject Drugs (PWID-Male) in Pokhara Valley. Round VII. National Centre for AIDS and STD Control Teku, Kathmandu 2017.

NCASC (2017). Integrated Biological and Behavioural Surveillance (IBBS) Surveys among People Who Inject Drugs (PWID) in Eastern Terai Highway Districts. Round VII . National Centre for AIDS and STD Control Teku, Kathmandu 2017

NCASC (2017). Integrated Biological and Behavioural Surveillance (IBBS) Surveys among People Who Inject Drugs (PWID) in West to Far West Terai Districts. Round VI . National Centre for AIDS and STD Control Teku, Kathmandu 2017