FOLLOW-UP TO THE DECLARATION OF COMMITMENT ON HIV/AIDS (UNGASS)

COUNTRY REPORT FOR NEPAL

Reporting period: January-December 2002

15th April 2003

LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ARV	Anti Retro Viral
AusAID	Australian Agency for International Development
BSS	Behavioural Surveillance Surveys
CCA	Common Country Assessment
DFID	Department for International Development
DHS	Department of Health Services
FHI	Family Health International
FNCCI	Federation of Nepalese Chambers of Commerce & Industry
FSW	Female Sex Worker
HIV	Human Immunodeficiency Virus
HMG	His Majesty's Government
IDU	Injecting Drug User
IEC	Information, Education and Communication
ILO	International Labour Organisation
INGO	Non Governmental Organization
KAP	Knowledge, Attitude and Practice
MoH	Ministry of Health
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
PMTCT	Prevention of Mother to Child Transmission
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
SW	Sex Worker
UMN	United Mission to Nepal
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
UoH	University of Heidelberg
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
WHO	World Health Organization

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I. STATUS AT A GLANCE

NATIONAL COMMITMENT & ACTION

1. National Composite Policy Index: **See Annex 2**
2. Government funds spent on HIV/AIDS: **USD 710,325**

NATIONAL PROGRAMME & BEHAVIOUR

Prevention

3. % of schools with teachers who have been trained in life-skills-based education and who taught it during the last academic year: **Not known**
4. % Large enterprises/companies that have HIV/AIDS workplace policies and programmes: **Not known**
5. % of HIV+ pregnant women receiving a complete course of ARV prophylaxis to reduce the risk of MTCT: **Not known**

Care/Treatment

6. % of patients with sexually transmitted infections at health care facilities who are appropriately diagnosed, treated and counselled: **Not known**
7. % of people with advanced HIV infection receiving ARV combination therapy: **Not known**

Knowledge/Behaviour

8. % of respondents 15-24 years of age who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission or prevention: **(Target: 90% by 2005; 95% by 2010): Partially known, refer to Annex 3, NPBI-7**
9. % of people aged 15-24 reporting the use of a condom during sexual intercourse with a non-regular sexual partner: **Partially known, refer to Annex 3, NPBI-8**
10. %of injecting drug users who are reached with HIV/AIDS prevention services: **Known, refer to Annex 3, NPBI-6**

Impact alleviation

11. Ratio of orphaned to non-orphaned children 10-14 years of age who are currently attending school: **Not known**

IMPACT

12. HIV prevalence among sex workers and their clients, injecting drug users, men having sex with men: **Partially known, refer to Annex 3, II-1B**

13. % of infants born to HIV infected mothers who are infected **(Target: 20% reduction by 2005; 50% reduction by 2010): Not known**

II. Overview of the HIV/AIDS epidemic

The first cases of AIDS were reported in Nepal in 1988. Available epidemiological data in Nepal indicate a low-prevalence among the general population - ANC: 0.2% (1999), FP attendees 0.3% (1999), blood donors 0.48% (Kathmandu, 2001). As of March 2003, the Ministry of Health (MoH) has reported 635 cases of AIDS and 2,755 HIV infections. Given the existing medical and public health infrastructure in Nepal and the limitations of the national HIV/AIDS surveillance system, it is very likely that the actual number of cases is many times higher.

Summary of epidemiological situation

	Data	Date
Reported HIV cases	2755	March 2003
Reported AIDS cases	635	March 2003
Estimated number of adults & children living with HIV/AIDS	60,018	End 2002
Estimated adult and child mortality due to HIV/AIDS	2,958	2002
HIV prevalence		
IDUs (Kathmandu)	68%	2002
FSWs (Kathmandu)	15,61%	2002
STI patients	0.7-6.6	2000
Blood donors	0.28-0.48	2001
ANC	0.2%	1999

Sources: reported cases: MoH data; Estimates: UNAIDS/WHO Working Group on Global HIV/AIDS and STI Surveillance; Estimated HIV prevalence IDU: New Era Study 2002, Estimated HIV prevalence FSW: SACTS/FHI study, 2001; STI patients: MoH/University of Heidelberg 2000; Blood donors: Red Cross Nepal, 2001, ANC: MoH/University of Heidelberg, 1999.

Sentinel surveillance data among STI patients, 2001

	Sample Size		HIV	
Site Name, Location	**Number**	**%**	**Number**	**%**
AMDA Hospital, Jhapa	300	16.4	1	0.3
Bheri Zonal Hospital, Nepalgunj	300	16.4	16	5.3
Bir Hospital, Kathmandu	48	2.6	0	0.0
Birgunj Hospital, Birgunj	301	16.5	1	0.3
Kathmandu Hospital, Kathmandu	52	2.9	0	0.0
Mahakali Zonal Hospital, Mahendranagar	300	16.4	25	8.3
Maternity Hospital, Thapathali	300	16.4	0	0.0
Western Regional Hospital, Pokhara	223	12.2	7	3.1
TOTAL	**1824**	**100.0**	**50**	**2.7**

The currently seen low prevalence among the general population masks an increasing prevalence in several groups: FSW in Kathmandu 15,61% (SACTS, 2002), injecting drug users (IDUs) 40.4% nationwide, and 68% in the Kathmandu Valley (NCASC, 2000; New Era, 2002) and labour migrants returning from Mumbai (India) 7.7% (New Era, 2002). In fact it is apparent that Nepal has entered the stage of a "**concentrated epidemic",** i.e. the HIV/AIDS prevalence consistently exceeds 5% in one or more sub-groups.

Prevalence data among FSWs, IDUs and migrant laborers

- Among all IDUs in Nepal (estimated number 20,000), approximately 40% are HIV positive, and among IDUs in Kathmandu (estimated 10-15,000) the rate has increased to around 68%. In addition, a survey of 300 female sex workers in Kathmandu (FHI, 2000) revealed that 15 self-reported ever having injected drugs, representing 5% of the total sample. Of these 15 women, 11 were found to be HIV positive.

  A 2002 study completed by FHI, New Era, and SACTS, indicates that of those IDUs surveyed, one third of men and 74% of women had not shared a syringe in the week prior to the survey. The report also showed a high level of sexual activity with high condom use in sex work and low condom use with regular partners. The study also showed that nearly one third of men and 17% of women had injected drugs outside of Kathmandu and outside of Nepal. This mobility will have epidemiological implications.

- In this same seroprevalence survey in Kathmandu, 52 out of 300 FSWs (17%) were HIV positive. A mere six years ago, in 1996, HIV prevalence among Kathmandu FSWs was 2.7%. These data also suggest a strong link between HIV and STDs. Among the 300 FSWs in this study, 58 women (over 19%) had untreated syphilis. Of these 58 women with untreated syphilis, 15 (25.8%) were HIV positive. Of the 242 women negative for untreated syphilis, only 37 (8.9%) were HIV positive. The total estimated number of FSWs in the Kathmandu valley is between 7,500 and 10,000.

- Among a sample of 400 FSWs in the Terai, 16 (3.9%) were HIV positive and 77 (18.8%) had untreated syphilis (FHI, 1999). Two statistically significant correlates for HIV infection were having worked in India, especially Mumbai, and having untreated syphilis. Of 16 women who reported working in Mumbai, half or 8, were HIV positive. Among the 400 FSWs in this study, 9 of the 77 (11.7%) women with untreated syphilis were HIV positive. Only 1.3%, or 4 out of 333 women without untreated syphilis were HIV positive.

- One of the most threatening prospects of an expansive HIV epidemic in Nepal lies with the country's large male migrant population. An estimated 600,000-1.3 million Nepali men migrate to India for seasonal and long-term work, and an estimated 400,000 of these go to Mumbai, often without their families.

In the beginning of 2001 a study was conducted in Doti District (Poudel, 2001) in the far-western region, which found that 10% of male migrants returning from Mumbai (India) were HIV positive. Since then results from three other studies from the same region have been published (New Era, 2002). As the sample size of the studies done in Achham and Kailali is approximately six times larger than the Doti study, they are statistically more representative. These two studies clearly indicate the important relation between the migration destination and HIV status of returning labour migrants.

40% of the respondents in Achham study migrated internationally and of these 38% migrated to Mumbai only, the rest migrated to other states in India. Among the international migrants from Achham going to Mumbai 7.7% were found HIV+. This is due to the fact that the HIV prevalence in particular among the FSWs in Mumbai is very high.

Behavioural Data among Young People

A study among young factory workers (M. Puri, 2002) among 550 girls and 500 boys in carpet and garment factories in the Kathmandu Valley points to vulnerabilities among young people. Over four-fifths (83%) of the sampled boys and two-thirds of the girls (66%) fell in the age group of 17-19 years. In the whole sample the proportion who have experienced sexual intercourse rises from about 15% among 14 year olds to 50% among 19 year olds. Among the sexually active, the mean age at first sexual intercourse was 15.8 years for boys and 15.4 years for girls. Over half the girls (51%) and over one-thirds of the boys (34%) had first sexual intercourse before the age of 16 years. The study has shown that substantial proportions of young factory workers indulge in risky sexual behaviour. Substance abuse, early sexual experimentation, multiple partners, irregular use of condoms, low use of other contraceptives, unwanted pregnancies, frequent occurrence of unsafe abortions and instances of rape or sexual harassment are common. Despite high-risk behaviour, relatively few young people considered themselves to be at risk of getting STIs or HIV/AIDS or unwanted pregnancy (18%). Knowledge of contraceptive methods seems to be superficial and information regarding the risk of unsafe sex and its consequences is inadequate.

UNICEF conducted a KAP survey of teenagers (1,400 boys and girls, age group 12-18 years) in Nepal (UNICEF, 2001). Main findings included that the majority (94%) have heard about HIV/AIDS, 74% knew that they should use condoms when having sex, and 69% could say that they should not have sex with commercial sex workers. 65% of the boys had used a condom during sexual intercourse and 74% of the girls. The study also shows that 20% of teenagers considered premarital sex as proper, and unprotected sex led to a 14% pregnancy rate and a 22% STD rate in boys and 13% rate in girls.

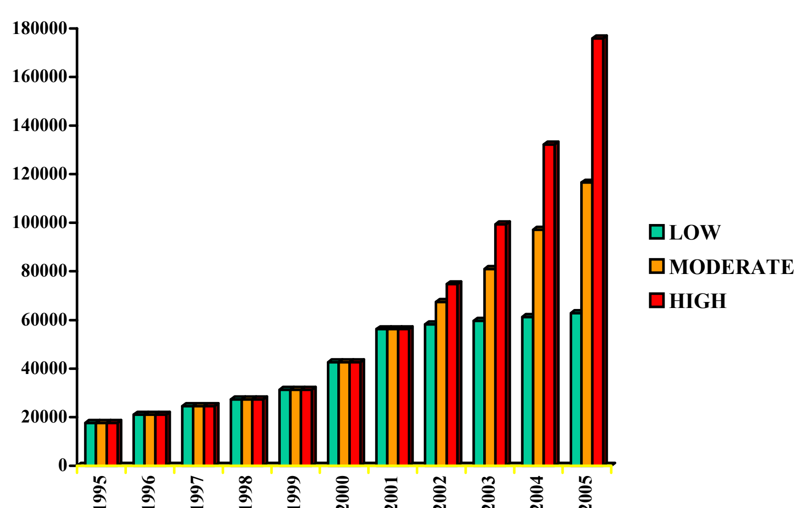
Potential for a rapid spread of HIV/AIDS in Nepal

The potential for a fast spread was first recognized by J.Chin (1999/2000) who estimated that in the absence of effective interventions, HIV prevalence in Nepal may, over the coming decade, increase to 1-2% of the 15-49 year old population. For Nepal this would mean that 100,000-200,000 young adults will 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.**

WHO estimates that the number of expected AIDS death in 2000 will double by 2005 (6000). It is estimated that these AIDS deaths will 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 (seroprevalence, BSS) was done by the MoH and UNAIDS, and based on this the following three scenarios were developed:



As previously described, some initial general population prevalence information does exist for HIV/AIDS in Nepal. However, at this time, data is **not** completely collected for the two **Indicators of Impact** identified in the UNGASS *Monitoring the Declaration of Commitment on HIV/AIDS*.

UNGASS Core Indicators - HIV Prevalence at a Glance

1. HIV prevalence among sex workers and their clients, injecting drug users, men having sex with men.

   Sex Workers - **15.7% (SACTS, 2001)**
   Clients of sex Workers - **Not Known**
   Injecting Drug Users – **68% (New Era, 2003)**
   Men Having Sex With Men - **Not Known**

2. Infants born to HIV infected mothers who are HIV infected – **Not Known**.
   Target: 20% reduction by 2005; 50% reduction by 2010

Given the current reality that only approximately 10% of Nepali women visit antenatal clinics, the assessment of general population HIV prevalence through this

method is not feasible. There is currently a discussion among epidemiologists on the relative merits of ANC attendees, blood donors and family planning attendees as the most appropriate indicator to develop as the measure for general population prevalence.

In the development of the monitoring and evaluation plan for the operationalization of the *National HIV/AIDS Strategy*, a prevalence baseline will be developed and/or strengthened, and data collected on a biennial basis.

III. National response to the HIV/AIDS epidemic

1. National commitment and action

Policy

In 1988, HMG/Nepal launched the first National AIDS Prevention and Control Programme. This programme, known as the Short-Term Plan for AIDS Prevention and control, formed the basis for the First Medium Term Plan 1990-92. This programme was externally reviewed in December 1992 and on the basis of the recommendations made during the review, the Second Medium Term Plan for AIDS Prevention and Control in Nepal was formulated covering the years 1993-97.

In 1993, HMG/Nepal accepted the need for multi-sectoral involvement for AIDS and STD control and different focal points were appointed in various sectoral ministries. HMG/Nepal adopted a national policy for AIDS prevention, with 12 key policy statements, in 1995. However, due to frequent political changes neither the National AIDS Coordination Committee, nor the multisectoral coordination and cooperation was fully functional.

The National Policy on AIDS and STD Control

1. HMG will give high priority to HIV/AIDS and STD prevention programme.
2. HIV/AIDS and STD Prevention activities will be conducted as multisectoral programmes.
3. HIV/AIDS and STD prevention activities will be implemented on the basis of decentralization at village, district and regional level.
4. HIV/AIDS and STD prevention activities will be implemented through both governmental and non- governmental sectors.
5. HIV/AIDS and STD prevention activities will be integrated with other programs both in governmental and non-governmental sectors.
6. HIV/AIDS and STD prevention activities will be coordinated, followed up and evaluated incessantly in both governmental and non-governmental sectors.
7. Safer sexual behaviour will be promoted.
8. Counseling and other services will be provided to people with HIV/AIDS.
9. Discrimination on the basis of HIV status will not be done to people with HIV/AIDS.
10. Results of the blood test carried out for AIDS and STD prevention programme will be treated with confidentiality.
11. The reports of the blood tests will be made available to National Centre for AIDS and STD control by fastest means.
12. All the donated blood will be screened before transfusion.

In an effort to strengthen the implementation of the national HIV/AIDS prevention and control strategies, Nepal has established a National AIDS Council (NAC) under the chairmanship of the Rt. Honorable Prime Minister. The structure of the NCASC divides responsibility for dealing with the disease into three main sections. The Technical Section is responsible for surveillance, technical assistance, research, planning supervision and evaluation of health workers.

The STD Section concentrates on control of STDs including infection with HIV and has responsibility for condom promotion. The Preventive Section has subsections to address IEC, training, counseling and NGO coordination. However, this will change as the newly endorsed National HIV/AIDS strategic plan envisages a restructuring of the NCASC. As the Ministry of Health is leading the response, HIV/AIDS is still perceived as a "medical" issue with limited involvement of other ministries. Moreover, the NCASC traditionally had more of an implementing role and its limited capacity is absorbed in various activities, leaving less time and energy for management (coordination) functions. The NCASC cooperates closely with a number of individual, externally funded projects and INGOs.

Strategic Framework

Based on the National Policy, a "Strategic Plan for HIV and AIDS in Nepal", covering 1997 to 2001 was developed and adopted. It aimed at operationalizing the national policy and to define key activities for each policy objective. Although the strategic plan contained a number of activities aimed at the prevention of a rapid spread of the epidemic, only a limited number of them were actually implemented. The strategic plan sought to broaden the response to other sectors beyond health and integrate HIV/AIDS concerns within them. Factors relating to mobility of populations, urbanization, heavy labour migration to areas where large infrastructure projects are being undertaken, the open border between Nepal and India and widespread poverty have been recognized as opportunities for the spread of the infection in the country.

On the 3 October 2002 the National HIV/AIDS Strategy 2002 – 2006 was endorsed by the National AIDS Council chaired by the Rt. Honorable Prime Minister. The overall objective of Nepal's strategy for HIV/AIDS is to contain the HIV/AIDS epidemic in Nepal. The vision of the National Strategy is to expand the number of partners involved in the national response and to increase the effectiveness of the response. It will do this by focusing on activities within priority areas thereby optimizing prevention and reducing the social impact of HIV/AIDS in the most cost-effective manner.

The strategy emphasizes prevention as the mainstay for an effective response. It also highlights the need for care and support for people infected and affected by HIV/AIDS. This is not only important in it's own right, but it is also an important contribution to effective prevention. Considering the dynamic nature of the HIV/AIDS epidemic, the strategy acknowledges the importance of accurately tracking the epidemic and monitoring the effectiveness of interventions. In the strategy five priority areas are clearly identified:

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

In August 2002 a costing exercise was completed to estimate the resource requirements of the national HIV/AIDS strategy. It was estimated that for the period 2003-2006 USD 51 million is required, naturally depending on how the strategy is operationalized.

Since November 2002 a team of consultants in close collaboration with the NCASC have been working on translating the national strategy into an HIV/AIDS programme, initially for the period June 2003 – December 2004. This operational plan defines the key activities, responsible partners as well as the targets, which need to be reached for the various activities.

National stakeholders in the field of HIV/AIDS

During the last couple of 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 evident due to the increased political commitment from the side of HMG/Nepal but can also be seen from the increased funding from various international donors present in Nepal.

In 2002 HMG/Nepal established a National AIDS Council chaired by the Rt. Honourable Prime Minister. Nepal was the first country in the South Asian Region to have such a Council. The aim of the council is that it will lead the future multisectoral response and will advocate for active participation in the fight against this epidemic among all strata of society.

The Rt. Honourable Prime Minister also announced that the year 2002 was dedicated as a multifaceted campaign year against the spread of HIV/AIDS. The objective of the campaign was to increase the awareness among the general population, with specific focus on young people, about HIV/AIDS and prevention methods. A national campaign logo was developed and various activities were undertaken including a national essay contest among young people.

Other stakeholders have also become increasingly involved in the response to HIV/AIDS in Nepal. In March 2002, FNCCI signed a declaration of commitment on HIV/AIDS as well as signed an MOU with the Asian Business Coalition on AIDS. This has accelerated the business response to HIV/AIDS in Nepal and a full time HIV/AIDS focal point was appointed in December 2002 to carry out various HIV/AIDS activities within FNCCI.

The ‘Nepal Initiative’ is an example of the recent increased commitment from the bi- and multilateral donors. The Nepal Initiative is a consortium of multi-and bilateral

donors (UNAIDS, UNDP, USAID, DFID, AusAid). These donors joined forces to collaborate with the NCASC to address the urgent risk and harm reduction needs of FSWs, their clients and IDUs in a phased approach. The Nepal Initiative will seek to expand the HIV harm and risk reduction services for FSW, their clients and IDUs. The Nepal Initiative was initiated in April 2001 and will come to an end by April 2003. The total budget was approximately USD 2.5 mill.

Government funding on HIV/AIDS

According to the report of the 'Survey on Financial Resource Flows for Population from the National Government and Non-Governmental Organizations in Nepal' from August 2002 USD HMG/Nepal had allocated USD 710,325 for the financial year 2002, which was derived from the 2059/2060 fiscal year budget. It is important to note that much of this amount is salary given to staff based in various HMG/Nepal institutions.

National Commitment at a glance

1. National Composite Policy Index: **See Annex 2**
2. Government funds spent on HIV/AIDS: **USD 710,325**

2. National programmes and behaviour

As previously discussed, the response to HIV/AIDS is currently being developed through the operationalization of the new *National AIDS Strategy*. This *Strategy* and operational plan recognizes both the lack of sound sero-surveillance and behavioural-surveillance data, as well as the need to build national capacity in HIV/AIDS surveillance, research and monitoring and evaluation. As such, only three of the nine programme and behaviour indicators of the UNGASS *Monitoring the Declaration of Commitment on HIV/AIDS* can be partially reported upon in the 2003 *UNGASS Nepal Country Report*.

UNGASS Core Indicators – National Prevention Programmes at a Glance

1. Schools with teachers who have been trained in the life-skills-based education and who have taught it during the last academic year – **Not Known**.
2. Large enterprises/companies that have HIV/AIDS workplace policies and programmes – **Not Known**.
3. HIV+ pregnant women receiving a complete course of ARV prophylaxis to reduce the risk of MTCT – **Not Known**.

Education Programmes (Formal and Non-Formal)

While HIV/AIDS life-skills-based education does **not** currently exist in the national curriculum, the *National HIV/AIDS Strategy* has identified the development of such education as a priority for the prevention of the HIV infection among young people.

It is expected that through the operationalization of the *Strategy*, Nepal will be able to report progress against this UNGASS indicator by 2005.

Workplace Programmes

In the context of a new epidemic with a low prevalence rate in the general population and extremely limited resources, the operationalization of the new Strategy will not place an emphasis on workplace programmes beyond general HIV/AIDS awareness, general stigma and discrimination elimination, and condom promotion. No VCT, STI diagnosis and treatment, and provision of HIV/AIDS-related drugs are planned for at the workplace.

Currently, the FNCCI working in partnership with UNAIDS and the ILO, has initiated small education and awareness programmes for employers and workers in the Nepalese formal private sector. However, it should be recognized that the formal Nepalese private sector represents only a small proportion of Nepalese businesses and workers. Given the limited size of this sector in Nepal, the priority for future workplace programmes will probably focus on the public and parastatal sectors, the non-formal sector, and migrant workers.

As such, Nepal will **not** be conducting significant specific programming in this area, and consequentially will not be measuring this indicator for 2005. However, Nepal does hope to report on the expansion of workplace programming in the public and parastatal sectors, the non-formal sector, and migrant workers by 2005.

Mother-to-Child-Transmission (MTCT)

There is currently no provision for the prevention of MTCT in Nepal through Anti Retro Viral (ARV) prophylaxis. The *National HIV/AIDS Strategy* has identified MTCT for the development of protocols and IEC materials only. At the same time, while the *Strategy* recognizes that the epidemic is not currently at a stage requiring the provision of ARV therapy to the general population, it has identified HIV+ pregnant women as a priority group for any ARV therapy that should be made available, particularly female IDUs and the female partners of IDUs.

In a proposal submitted by Nepal to the *Global Fund to Fight AIDS, Tuberculosis and Malaria* the provision of prevention of MTCT to 1000 HIV+ pregnant women at the Maternity and UMN Hospitals by 2006 has been planned.

Given the lack of information on the general prevalence of HIV/AIDS in the population, work will be required to develop a plausible estimate of the total number of pregnant women in Nepal who are HIV+. It is expected that Nepal will be able to report only limited progress against this UNGASS indicator by 2005.

UNGASS Core Indicators – National Care and Treatment Programmes at a Glance

4. Patients with sexually-transmitted infections at health care facilities who are appropriately diagnosed, treated and counselled – **Not Known**.
5. People with advanced HIV infection receiving ARV combination therapy – **Not Known**.

Sexually-Transmitted Infections (STI) Care

While there are no current qualitative health facility surveys on the treatment of STIs in Nepal, the operationalization of the *Strategy*, will allow Nepal to undertake the facility surveys required to report progress against this UNGASS indicator by 2005. This requirement is driven by the HIV prevalence rate amongst STI patients, which ranges from 0.7% to 6.6% (MoH and University of Heidelberg, 2000).

ARV Therapy

There is currently no provision for ARV combination therapy in Nepal. The *National AIDS Strategy* has also not identified ARVs as a priority intervention. However, a proposal submitted by Nepal to the *Global Fund to Fight AIDS, Tuberculosis and Malaria* has planned for the provision of ARVs to a 2500 HIV+ people through 12 treatment centres by 2006.

Given the lack of information on the general prevalence of HIV/AIDS in the population, work will be required to develop a plausible estimate of the total number of people in Nepal with advanced HIV infections. As such, it is expected that Nepal will be able to report only limited progress against this UNGASS indicator by 2005.

UNGASS Core Indicators – National Behaviours at a Glance

6. Respondents 15-24 years of age who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission or prevention **(Target: 90% by 2005; 95% by 2010): Partially known, refer to Annex 3, NPBI-7**

7. People aged 15-24 reporting the use of a condom during sexual intercourse with a non-regular sexual partner: **Partially known, refer to NPBI-8**

8. Percent of injecting drug users who are reached with HIV/AIDS prevention services: **Known, refer to Annex 3, NPBI-6**

Correct Knowledge and Condom Use Among Young People

In the last couple of years several behavioural studies have been done regarding young people in Nepal (please see section II regarding behavioural data among young people). However, the data gathered does not exactly match the measurement methodologies of the UNGASS core indicators.

The development of correct knowledge on HIV and its prevention among young people is a priority for the *National HIV/AIDS* Strategy. However, as the next DHS is not scheduled until 2006, Nepal will not be able to provide data from a population-based survey until then. In the interim, this indicator will be measured on a 6-12 month basis through BSS. This BSS data will be used to report progress against this UNGASS indicator and its target in 2005. The DHS data will be made available in 2006.

Increased condom use by young people is also a priority for the *National HIV/AIDS* Strategy. Likewise, BSS data will be used to report progress against this UNGASS indicator. The DHS data will be made available in 2006.

Injecting Drug Use

Considerable work has been done with Injecting Drug Users (IDUs) in Nepal, particularly in the Kathmandu area. In recent years there has been considerable capacity development in IDU HIV/AIDS prevention services and a corresponding growth in coverage of IDUs.

Increased harm reduction practices and reduced drug use are priorities for the *National HIVAIDS Strategy*. It is expected that through the operationalization of the *Strategy*, Nepal will be able to report progress against this UNGASS indicator by 2005.

UNGASS Core Indicators – Impact Alleviation at a Glance

9. Ratio of orphaned to non-orphaned children 10-14 years of age who are currently attending school – **Not Known**.

School Attendance of Orphaned Children

A study was conducted in November 2002 by UNICEF in which, it is stated that the estimate for children who have been orphaned by AIDS is 13,000. However, work is required to develop a plausible estimate of the total number of orphans in Nepal, disaggregated by urban and rural settings, cause of parents' death and by who are attending/not attending school.

Given the state of the epidemic, impact alleviation and mitigation work is not yet a priority. However, this indicator will be included in the next DHS scheduled for 2006 or the next appropriate population-based survey covering either education or family status.

IV. Major Challenges Faced and Actions Needed to Achieve the Goals/ Targets

Data collection plan (2005 reporting)	2003	2004	2005
Household surveys			
Health facility surveys		1. STI Comprehensive Case Management	
School-based surveys			
Workplace surveys			
Sentinel Surveillance		1. HIV Prevalence Among SWs and Their Clients, IDU, and MSM	1. HIV Prevalence Among SWs and Their Clients, IDU, and MSM
Desk review	1. Government Funding for HIV/AIDS 2. Government HIV/AIDS Policies	1. Government Funding for HIV/AIDS 2. Life-skills Based HIV/AIDS Education in Schools 3. IDU: Coverage with HIV Prevention Services	1. Government Funding for HIV/AIDS 2. Prevention of MTCT: ARV Prophylaxis 3. HIV Treatment: ARV Combination Therapy 4. Reduction in MTCT

UNGASS Core Indicators that will not be measured by 2005:

1. **Workplace HIV/AIDS Control:** Given the low prevalence in the general population and the small size of the formal sector in Nepal, this indicator will not be measured within this three-year period. The National HIV/AIDS Program will however, report on the mainstreaming of HIV/AIDS into the public sector and work with labour migrants.
2. **Young People's Knowledge of HIV Prevention:** A DHS and a UNAIDS/UNICEF survey of Nepali teenagers were completed in 2001, proving partial answers to these questions. The next DHS is scheduled for 2006. In the interim period, Behavioural Surveillance Surveys (BSS) will be conducted among high-risk behaviour groups on six-month basis.
3. **Young People's Condom Use with Non-Regular Partners:** A DHS and a UNAIDS/UNICEF survey of Nepali teenagers were completed in 2001, proving partial answers to these questions. The next DHS is scheduled for 2006. In the interim period, Behavioural Surveillance Surveys (BSS) will be conducted on a six-month basis.
4. **Orphan's School Attendance:** A UNICEF study on "children at risk" in Nepal was completed in 2002, providing partial information. This indicator will be included in the 2006 DHS or the next appropriate population-based survey covering either education or family status.

The *National HIV/AIDS Strategy* is currently being converted into an operational plan. This will permit a full costing and the creation of a detailed implementation plan during the first half of 2003. The current proposed implementation modality is for an external executing agency, reporting to the National AIDS Coordination Committee (NACC), to develop an implementation plan(s) and to provide program management services. This external executing agency would receive technical direction and oversight from the NCASC. This modality has not yet been confirmed.

There are currently several major challenges, which must be addressed in order to achieve the goals of the *Strategy.* The progress report of 2002 stated that the supportive environment for combating HIV/AIDS was "weak but improving". The operationalization of the *Strategy* addresses three of the most significant challenges: (1) institutional capacity, (2) the development of a supportive environment and governance structure, and (3) the development of an improved understanding of the epidemic and the response to it.

The first major challenge to the implementation of the *Strategy* is the need to build institutional capacity within Nepal in general, and within the *National HIV/AIDS Program's* governance structures in particular. This challenge will be addressed both through the use of implementation partners, experienced in delivering a range of required HIV/AIDS services, and through the building of capacity within HMG/Nepal and local bodies (governmental, non-governmental, and community) during the initial years of the *Strategy's* implementation.

To build the institutional capacity required to understand and respond to the epidemic will (1) require External Development Partners technical support and (2) the acceptance by all stakeholders that this capacity is a prerequisite for the achievement of the *National HIV/AIDS Program's* expected results.

The requirement for capacity building within the NCASC will entail the engagement of professional and administrative staff with appropriate competencies, and their support through technical working groups, technical assistance consultancies, and professional development planning during the initial years of program implementation.

The second major challenge is the need to develop an effective governance structure to support the national response to HIV/AIDS. This includes the development and confirmation of the accountabilities, roles and responsibilities of the NAC, NACC, and NCASC, including a mechanism for execution. The resolution of these issues will allow HMG/NEPAL to lead and manage the response to HIV/AIDS, create effective policies and legislation, build capacity and partnerships for implementation, and advocate for social mobilization.

The third major challenge is the need to develop a solid understanding of the serological, behavioural and contextual realities and influencing factors behind the spread of HIV/AIDS in Nepal. The resolution of this challenge lies in the development of the NCASCs surveillance and research, and monitoring and evaluation capacities.

The *National HIV/AIDS Strategy* identifies priorities for Nepal's response to the epidemic, which are mainly focussed on prevention. Thus, not all issues addressed in the UNGASS Commitments are addressed in the *Strategy* (i.e. antiretroviral therapy).

V. Support Required from Nepal's Development Partners

In order to implement the *National HIV/AIDS Strategy*, Nepal's External Development Partners will need to provide substantial input to the programming and technical support required to implement the national programme and build Nepal's capacity to respond to the epidemic.

Two important components of this support are:

- The coordination and rationalization of donor performance measurement requirements; and
- The sharing of best practices from other developing countries on how governments can most effectively lead and manage a national response to HIV/AIDS.

It should be noted that there is a current donor understanding to coordinate their HIV/AIDS prevention efforts in support of the *National HIV/AIDS Strategy*.

VI. Monitoring and Evaluation Environment

The NCASC does not currently have an M&E Unit or the capacity for one, though both an M&E Unit and a Research and Surveillance Unit are planned for within the current draft Operational Plan. As reported in the *Millennium Development Goals: 2002 Progress Report*, the HMG/NEPAL's current HIV/AIDS M&E capacity, will require considerable development:

- *Data-gathering capacities* - *weak*
- *Quality of recent survey information* - *fair*
- *Statistical tracking capacities* - *weak*
- *Statistical analysis capacities* - *weak*
- *Capacity to incorporate statistical analysis into policy, planning & resource allocation mechanisms* - *weak*
- *Monitoring & evaluation mechanisms* - *weak*

In general, M&E units require funding, human resources (epidemiology, statistics, social science, data management), and external technical support. The development of the NCASC M&E Unit and the Surveillance and Research Unit will require these components, if they are to support the implementation of the National HIV/AIDS Programme's Performance Measurement Framework.

In addition, while the health and education information systems required for complete reporting on UNGASS core indicators do exist, the quality of data is low and generation and collection systems need to be strengthened.

It is recommended that all UNGASS Core Indicators be included in the existing *South Asia HIV Database Management System*.

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ANNEX 1
Preparation/Consultation Process for the National Report on Monitoring the Follow-Up to the Declaration of Commitment on HIV/AIDS

1) Which institutions/entities were responsible in filling out the indicators forms?

a) NAC or equivalent	Yes	No√
b) NAP	Yes √	No
c) Others	Yes √	No
(please specify): UNAIDS; FHI		

2) With inputs from:

Ministries:

Education	Yes	No√
Health	Yes √	No
Labour	Yes	No
Foreign Affairs	Yes	No
Others (please specify)	Yes	No

Civil society organizations	Yes √	No
People living with HIV/AIDS	Yes	No
Private sector	Yes	No
UN organizations	Yes	No
Bilaterals	Yes	No
International NGOs	Yes	No
Others (please specify)	Yes	No

3) Was the report discussed in a large forum?	Yes	No√
4) Are the survey results stored centrally?	Yes √	No
5) Is data available for public consultation?	Yes√	No

Name/Title: Dr. B. B. Karki, Chief,
Planning and Foreign Aid Division, Ministry of Health

Date: 15th. April 2003

Signature: ________________________________

ANNEX 2
National Composite Policy Index Questionnaire

Strategic plan

1. Has your country developed multisectoral strategies to combat HIV/AIDS? (Multisectoral strategies should include, but not be limited to, the health, education, labour, and agriculture sectors)

Yes X	No	N/A
Comments: 'The National HIV/AIDS Strategy (2002-2006)' is a multisectoral strategy document, formally endorsed in October 2002, which includes strategies as well as key activities with defined key-partners. The key-partners defined, among others, include various line ministries, the civil society and multi/bilateral donors. The document strongly emphasises the need for a multisectoral response in order to ensure that the HIV/AIDS epidemic is effectively combated.		

2. Has your country integrated HIV/AIDS into its general development plans (such as its National Development Plans, United Nations Development Assistance Framework, Poverty Reduction Strategy Papers and Common Country Assessments)?

Yes X	No	N/A
Comments: HIV/AIDS figures in the PRSP/10th Development Plan for Nepal (2002-2007) as one of the main priority issues as well as in the CCA and UNDAF for Nepal.		

3. Does your country have a functional national multisectoral HIV/AIDS management/coordination body? (Such a body must have terms of reference or equivalent, defined membership, action plans and staffing support, and should have met at least once in the last 12 months.)

Yes X	No	N/A
Comments: The TOR of National AIDS Council (NAC) clearly states that NAC is a high-level coordinating body for HIV/AIDS prevention. The council has a defined membership and the ministry of health (MOH) serves as the secretariat of the council. The last meeting was held in October 2002, which endorsed the National HIV Strategy 2002-2006.		

4. Does your country have a functional national HIV/AIDS body that promotes interaction among government, the private sector and civil society? (Such a body must have terms of reference