

Country Progress Report NEPAL

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

June 2015



Government of Nepal

Ministry of Health & Population

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Ramshahpath, Kathmandu
Nepal

Date : June 16, 2015

Message

I am delighted to share you Nepal Country Progress Report on AIDS Response 2014 with Nepal's amplified voice calling to "Ending AIDS, by 2030". When "Nepal ending AIDS by 2030, was put forwarded" in January of this year during the United Nations Economic and Social Commission for Asia and the Pacific (ESCAP), Intergovernmental meeting on HIV, I was looking forward to the evidence to assist us in measuring our progress towards the HIV targets of 90-90-90, as well as the challenges faced by the programme to achieve these 'fast-track' targets by 2020. This Country Progress Report over 2014 shows that Nepal is indeed successful to halt and reverse HIV. To maintain these achievements and further reduce new infections, the Government of Nepal is committed to be ambitious and focused, while stopping what does not work and scale up proven programmes. This will include broadening options for service delivery to reduce the burden on our already strained health system and extend the reach of services, including greater use of community-based approaches and partnerships.

The Country Progress Report 2014 highlights that a number of efforts are being taken for the integration of key components of HIV into relevant sectors within the Ministry of Health and Population, including the health information management system; logistics management. Also, capacity enhancing through relevant departments within the Ministry of Health and Population. Furthermore, the programme related to the elimination of vertical transmission of HIV is being shifted to the Family Health Division to integrate with Maternal and Neonatal Care services. As we move forward, I am confident all these integrated efforts will lead to the integration of HIV services into public health services and through innovative public private partnerships to meet the specific needs of key populations.

This report is a result of a joint and collaborative process, and the support and active involvement of all stakeholders including government agencies, key populations and their networks, UN Agencies, bilateral and multilateral organisations, national and international NGOs.

This report is an evidence-informed document that will inform policy makers and programme managers in guiding a national HIV response that will ultimately lead us to ending AIDS. Achieving 90-90-90 is my vision for 2020, as Secretary in the Ministry of Health and Population, as I reiterate my confidence to Nepal ending AIDS by 2030. My special appreciation goes out to Dr. Dipendra Raman Singh, Director NCASC and his team and all those who were involved in the preparation of this report, and who are now taking us on this trajectory, by quickening the pace and accelerating the scale-up of effective and efficient services, with an intensity and quality needed to reach the targets, while ensuring that all of this is done with people at the centre.

.....
Mr. Shanta Bahadur Shrestha
Secretary



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Message

It is our pleasure to present the Nepal Country Progress Report on Nepal's 2014 AIDS Response, with a satisfactory note that the HIV epidemic in Nepal is either stabilizing or decreasing in most of the key populations. HIV can be further reduced if more prioritized and focused activities are considered in key geographical areas and among key populations. These achievements are evidence that our efforts on preventing HIV, as well as treatment, care and support have started yielding tangible results. I acknowledge these results have been possible as a result of relentless efforts from all the stakeholders in our national response, including key populations' communities, grass-roots workers, health care workers, leaders from various walks of life, and external development partners.

In the face of the dynamic nature of HIV, all the gains so far achieved can be easily lost, if we fail to address the major challenges; notably: bridging the gap between the estimated HIV infected population and the total reported cases, and scaling up of ART coverage as well as the elimination of vertical transmission to prevent babies from being born with HIV, in our country and keeping mothers alive and well. To address this gap, the country is considering different initiatives such as increasing HIV testing through community-led approaches; applying Option B+ for scaling up of coverage of PMTCT services, so that no child is born with HIV and also the revised criteria for the initiating ART. However, we need to ensure a scope, scale, intensity, quality, innovation and speed of implementation of these initiatives to achieve our targets. For this, the pivotal role of people living with HIV and other key populations is indispensable.

I am confident that this Nepal Country Progress Report, 2014 will serve as an enriched documented source of data and a valuable body of knowledge and inspiration for informing our national HIV response. Taken together with the Nepal HIV Investment Plan 2014 -2016, this report will help re-calibrate the investments that need to be made – informed by evidence, such as made available in this report. I laud the commendable efforts of Dr. Dipendra Raman Singh, Director NCASC and wish to thank all those who were involved in preparation this report.

Dr. Senendra Raj Upreti
Director General

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FOREWORD



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Foreword

We are pleased to put forward the Nepal Country Progress Report on our AIDS Response 2014. This report focuses on tracking Nepal's progress with respect to national commitments in the areas of HIV prevention; treatment, care and support of infected people; human right issues; engagement of civil society organizations, and the development of critical programme and social enablers.

During 2014, Nepal has gathered momentum to reinforce its national response to HIV and ensure that no one is left behind. The new narrative envisions stepping up HIV treatment to reach the 90-90-90 targets where, by 2020: 90% of the people living with HIV will know their HIV status, 90% of people living with HIV who know their status will be on antiretroviral treatment, and 90% of people on treatment will have suppressed viral loads. If these ambitious targets are to be achieved by 2020, urgent efforts to scale up prevention strategies are needed grounded in principles of human rights, mutual respect, and inclusion. Focused prevention programming for key populations, such as community-based HIV testing and counseling; harm reduction services for people who inject drugs, and tailored approaches to male labor migrants and their spouses, are required to complement HIV treatment and to eliminate discrimination and social exclusion.

The review of the data indicates that the epidemic transmission of HIV has stabilized in Nepal. In the other hand, it also urges for further collaborative efforts, political commitment and action, system preparedness and timely adoption and implementation of new, simpler, and more affordable technologies in order to successfully end AIDS by 2030.

We would like to express our sincere thanks to all individuals, national government entities, external development partners, civil society organizations, vulnerable groups, including people living with HIV, for their contribution and active role played in preparation of this report.

.....
Dr. Dipendra Raman Singh
Director

Stop AIDS, Keep the promise

TABLE OF CONTENTS

FOREWORDS	ii
TABLE OF CONTENTS.....	iv
LIST OF ABBREVIATIONS.....	vi
I. STATUS AT A GLANCE	1
A .The inclusiveness of the stakeholders in the report writing process.....	1
B. Status of the epidemic	1
C .The Policy and Programmatic Response	1
D. Indicator data in an overview table	3
II. OVERVIEW OF THE AIDS EPIDEMIC	8
III. NATIONAL RESPONSE TO THE AIDS EPIDEMIC.....	15
1. Prevention, treatment, care and support	15
A. Prevention	15
B. Test, Treat and Retain	18
2. National Programme and Achievements.....	24
V. MAJOR CHALLENGES AND REMEDIAL ACTIONS	31
VI. SUPPORT FROM THE COUNTRY'S DEVELOPMENT PARTNERS	32
VIII. REFERENCES	37

LIST OF FIGURE

Figure 1: Estimated HIV infections among adult aged 15-49 years, 1985-2020	8
Figure 2: Trends of new infections 1985-2020	9
Figure 3: Estimated HIV infections by age group for the year 2014	9
Figure 4: Distribution of HIV infection among key populations in 2014.....	10
Figure 5: HIV prevalence among Female Sex Workers	11
Figure 6: HIV prevalence among People Who Inject Drugs.....	12
Figure 7: HIV prevalence among MSM and MSW and TGSW in Kathmandu Valley.....	12
Figure 8: HIV prevalence among Male Labour Migrants	13
Figure 9: eVT Coverage for the period of 2006 to 2014 in Nepal.....	20
Figure 10: People on ART for the period of 2004 to 2014.....	20
Figure 11: HIV Treatment Cascade-2014.....	21

LIST OF TABLE

Table 1: Status of Nepal's Progress on HIV/AIDS Response 2010-2014.....	3
Table 2: Service for FSWs and their clients for the period of July 2011 to July 2014	16
Table 3: Services for PWID for the period of July 2011 to July 2014.....	17
Table 4: Services for Men who have sex with men for the period of July 2011 to July 2014	17
Table 5: Services for labor migrants and spouses for the period of July 2011 to July 2014.....	18
Table 6: Service Statistics HIV Testing and Counseling for the period of 2008 -2014 by year	19
Table 7: Diagnosis of HIV for the period of 2012 -2013 by year.....	19
Table 8: ART Profile for the period of 2011 to 2014	21

LIST OF ABBREVIATIONS

AHF	AIDS Healthcare Foundation
AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral (drugs)
AusAID	Australian Agency for International Development
BCC	Behaviour Change Communication
BDS	Blue Diamond Society
BSS	Behaviour Sentinel Surveillance
CABA	Children Affected By AIDS
CBO	Community-Based Organization
CCC	Community Care Centre
CD4	Cluster of Differentiation 4
CHBC	Community and Home-Based Care
CTTC	Community Test and Treat Competence
DACC	District AIDS Coordination Committee
DBS	Dried Blood Spot
DDC	District Development Committee
DFID	Department for International Development (UK)
DoHS	Department of Health Services
DOTS	Directly Observed Treatment, Short-Course
DNA	Deoxyribonucleic Acid
DQA	Data Quality Assessment
EDP	External Development Partner
EID	Early Infant Diagnosis
EQAS	External Quality Assurance System
eVT	Elimination of Vertical Transmission
EWI	Early Warning Indicators
FHD	Family Health Division
FP	Family Planning
FSW	Female Sex Worker
GARPR	Global AIDS Response Progress Reporting
GBV	Gender-Based Violence
GFATM	The Global Fund to Fight AIDS, Tuberculosis and Malaria
GIZ	Germany's Agency for International Development
GoN	Government of Nepal
GV	Gender Violence
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HLM	United Nations High Level Meeting
HMIS	Health Management Information System
HSCB	HIV and STI Control Board
HSS	Health Systems Strengthening
HTC	HIV testing and counselling
IBBS	Integrated Biological and Behavioural Surveillance
IPT	Isoniazid Preventive Therapy
KfW	Kreditanstalt für Wiederaufbau
KP	Key Population
LMD	Logistics Management Division
M&E	Monitoring and Evaluation

MLM	Male Labour Migrants
MoHA	Ministry of Home Affairs
MoHP	Ministry of Health and Population
MSM	Men who have Sex with Men
MSW	Male Sex Workers
NASA	National AIDS Spending Assessment
NCASC	National Centre for AIDS and STD Control
NCPI	National Commitments and Policy Instrument
NDHS	Nepal Demographic Health Survey
NGO	Non-Governmental Organization
NHIP	Nepal HIV Investment Plan (2014-2016)
NHSP	Nepal Health Sector Programme
NHSP-IP	Nepal Health Sector Programme Implementation Plan
NPHL	National Public Health Laboratory
NSP	National Strategic Plan (2011-2016)
NTC	National Tuberculosis Center
OI	Opportunistic Infection
OST	Opioid Substitution Therapy
PMTCT	Prevention of mother to child transmission of HIV (also see: eVT)
PWID	People who Inject Drugs
SI	Strategic Information
SRH	Sexual and Reproductive Health
SSP	Saath-Saath Project
STI	Sexually Transmitted Infection
SW	Sex Worker
SWAp	Sector-Wide Approach
TB	Tuberculosis
TG	Transgendered person/people
TGSW	Transgendered Sex Worker
TTR	Test, Treat and Retain
TWT	Technical Working Team
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNODC	United Nations Office on Drugs and Crime
USAID	United States Agency for International Development
USD	United States Dollar
WHO	World Health Organization

I. STATUS AT A GLANCE

A. The inclusiveness of the stakeholders in the report writing process

The Ministry of Health and Population (MoHP) assigned its National Centre for AIDS and STD Control (NCASC) with the responsibility of leading the preparation and submission of the Nepal Country Progress Report 2014 in collaboration with technical partners and stakeholders for the Global AIDS Response Progress Reporting (GARPR). In March 2015, the NCASC nominated the Strategic Information Technical Working Group as an Advisory Group (AG) for the preparation of the country progress report. At the same time, a Technical Working Team (TWT) was also formed with the responsibility of the actual preparation of the report. The road map for the Country AIDS Response Progress for the GARPR reporting was developed in consensus with the AG and TWT. A series of consultations and group discussions were conducted for the data collection process for the reporting of the core indicators. The draft report was shared with the stakeholders involved in HIV programmes for inputs. Furthermore, reported data were verified internally by NCASC and later on further validated with a wider group of people including representatives from multilateral, bilateral, I/NGOs, key population networks and government officials. Finally, the relevant comments from these stakeholders were incorporated into the final report.

B. Status of the epidemic

With the HIV prevalence among the adult population (15-49) estimated at 0.20%, the HIV prevalence among the adults has not changed much over the last five years and has remained within the range of 0.2 - 0.3% in Nepal. It is estimated that currently there are around 39,249 people living with HIV in 2014, decreasing from 40,723 in 2013. An estimated number of 2,576 deaths were due to AIDS in 2014 declining from 3,362 deaths in 2013. The number of estimated deaths is projected to decline to 1,266 in 2020, due to an expected increase in the numbers of people on Antiretroviral Therapy (ART). The estimated number of new cases in 2014 is 1,493 as compared to 1,408 in 2013. The HIV epidemic remains concentrated among people who inject drugs (PWID), men who have sex with men (MSM), transgender people (TG), sex workers (male and female) and male labor migrants (MLM) including their spouses.

C. The Policy and Programmatic Response

The National Policy on HIV and STI 2011 serves as the foundation upon which the national response to HIV is built upon. The National Strategy Plan 2011-2016 (NSP) - with the inclusion of stipulated targets to be achieved by the end of 2016 on a number of outcome indicators - provides a guiding framework for implementation of the national response, whilst the Nepal HIV Investment Plan 2014-2016 (NHIP) provides yearly action plan for the period of 2014 -2016.

During the reporting period, the various national guidelines related to HIV testing and treatment have been revised and compiled into the “National Consolidated Guidelines for Treating and Preventing HIV in Nepal” (NCASC, 2014). The National Consolidated Guidelines has been put in practice on 15 March 2015. The new comprehensive guideline encompasses clinical recommendations to provide treatment care, elimination of Vertical Transmission (eVT), as well as HIV testing and counselling (HTC) services in the alignment of “Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection” published by the World Health Organization (WHO) in June 2013. Based on the NHIP, a concept note was elaborated in May 2014 for the national roll-out of Community Test and Treat Competence (CTTC) through Save the Children, under a Global Fund programme. The concept note envisions community-based HIV testing and counselling (HTC) in Nepal as an effective policy to reach out the most affected key populations with community-led initiatives to support the “Test, Treat and Retain” strategy for Nepal.

Apart from National Consolidated Guidelines for Treating and Preventing HIV in Nepal, The Ministry of Home Affairs (MoHA) has endorsed the National Guidelines on Opioid Substitution Therapy 2014 (OST 2014), which envisages to support the scaling up of OST programmes, and maintain the quality and retention of OST (that includes Methadone and Buprenorphine) users in the programmes.

Nepal in this reporting period also has endorsed “National Strategy on HIV Drug Resistance Monitoring and Surveillance (2014-2020)”. This National Strategy on HIV Drug Resistance Monitoring and Surveillance provides a strategic framework for the monitoring of and maintaining surveillance on the emergence and transmission of HIV drug resistance (HIVDR). Likewise, HIV Viral Load testing scale-up plan (2014-2018) has been prepared in 2014 with the joint efforts of National Public Health Laboratory (NPHL) and NCASC.

Finally, the NCASC, during November 2014, led on an Assessment of the Legal and Policy Environment in Response to HIV in Nepal which provides recommendations for creating an enabling environment especially for people living with HIV (PLHIV). The recommendations of this assessment are expected to work as a body of evidence-based knowledge to inform: a) the draft HIV bill, and b) the upcoming constitution in advancing the rights of PLHIV. Acting on one of the recommendations of this assessment, an amendment to the existing criminal code has been proposed in the parliament through the active participation of community leaders and parliamentarians. The proposed amendments seek to end the criminalization of and prejudice especially against sexual minority groups and PLHIV.

D. Indicator data in an overview table

Table 1: Status of Nepal's Progress on HIV/AIDS Response 2010-2014

Indicat or #	Indicators Titles	Indicators		2014	2013	2012	2010	Data Source	Remarks	
		GARPR	UA							
	Target 1. Reduce sexual transmission of HIV by 50% by 2015									
	General population									
1.1	Young People: Knowledge about HIV Prevention	✓		No new data	Total: 27.81% Male=33.9% Female=25.8%	Total: 27.810% Male=33.9% Female=25.8%	NA Male=43.6%, Female=27.6 %	DHS 2011		
1.2	Sex Before the Age of 15	✓			Total: 6.0% Male=3.1% Female=7.0%	Total: 6.0% Male=3.1% Female=7.0%	NA	DHS 2011		
1.3	Multiple sexual partners	✓			Male=3.8% Male=3.8%	Male=3.8% Male=3.8%	NA	DHS 2011		
1.4	Condom Use During Higher Risk-Sex	✓			Male=26.5% Male=26.5%	Male=26.5% Male=26.5%	NA	DHS 2011		
1.5	HIV Testing in the General Population	✓			Total: 4.0% Male=7.5% Female=2.9%	Total: 4.0% Male=7.5% Female=2.9%	NA	DHS 2011		
1.6	Reduction in HIV Prevalence	✓			NA	NA	NA	NA		
	Sex Workers									
1.7	Sex Workers: Prevention programmes	✓			No new data	MSW=79.3% FSW=60%	MSW=93.3% FSW=60%	MSW=93.3% FSW=40.8%	MSW: IBBS among MSM in Ktm Valley, 2009, 2012 FSW: IBBS among FSW in Ktm Valley , 2009, 2011	
1.8	Sex Workers: Condom Use	✓	✓			MSW=90.4% FSW=82.6%	MSW=37.8% FSW=82.6%	MSW=37.8% FSW=75.0%	MSW: IBBS among MSM in Ktm Valley, 2009, 2012 FSW: IBBS among FSW in Ktm Valley , 2009, 2011	
1.9	Sex Workers: HIV Testing	✓	✓			MSW=58.5% FSW=54.6%	MSW=65.2% FSW=54.6%	MSW=65.2% FSW=32.4%	MSW: IBBS among MSM in Ktm Valley, 2009, 2012 FSW: IBBS among FSW in Ktm Valley , 2009, 2011	
1.10	Sex Workers: HIV Prevalence	✓	✓	MSW=6.8% MSW=5.2%		MSW=5.19%	MSW=5.19%	MSW: IBBS among MSM in Ktm Valley, 2009, 2012 FSW: IBBS among FSW in Ktm Valley , 2009,		

Indicat or #	Indicators Titles	Indicators		2014	2013	2012	2010	Data Source	Remarks
		GARPR	UA						
								2011	
					FSW=1.7%	FSW=1.7%	FSW=2.2%	MSW: IBBS among MSM in Ktm Valley, 2009, 2012 FSW: IBBS among FSW in Ktm Valley , 2009, 2011	
1.11	Men who have sex with men: Prevention programmes	✓		No new data	64.00%	77.25%	77.25%	IBBS among MSM in Ktm Valley, 2009, 2012	
1.12	Men who have sex with men: Condom Use	✓	✓		91.40%	75.25%	75.25%	IBBS among MSM in Ktm Valley, 2009, 2012	
1.13	Men who have sex with men: HIV Testing	✓	✓		42%	42%	42%	IBBS among MSM in Ktm Valley, 2009, 2012	
1.14	Men who have sex with men: HIV Prevalence	✓	✓		3.80%	3.80%	3.80%	IBBS among MSM in Ktm Valley, 2009, 2012	
	Testing and Counseling								
1.15	Number of health facilities that provide HIV testing and counselling services		✓	Total: 405 Public sector: 272 Private Sector: 133				NCASC Programme Data	New Indicator
1.16	HIV Testing and counselling in women and men		✓	Total: 270,003	Total: 277,046	213,312	198 ,045	NCASC Programme data	
				HTC: 109,380	HTC: 135,043				
				PMTCT: 158,146	PMTCT: 142,043				
				Child tested: 2,477					
1.17	Sexually Transmitted Infections								
1.17.1	Percentage of women accessing antenatal care (ANC) services who were tested for syphilis		✓	NA	NA	NA	NA		
1.17.2	Percentage of antenatal care attendees who were positive for syphilis		✓	NA	NA	NA	NA		
1.17.3	Percentage of antennal care attendees positive for syphilis who received treatment		✓	NA	NA	NA	NA		
1.17.4	Percentage of sex workers with active syphilis		✓	No new data	MSW=2.2%	MSW=3%	MSW=3%	IBBS among MSM in Ktm valley, 2009, 2012	
1.17.5					FSW=0.7%	FSW=0.7%	FSW=1%	IBBS among FSW in Ktm valley, 2008, 2011	
1.17.6	Percentage of men who have sex with men (MSM) with active syphilis		✓	No new data	MSM=0.8%	MSM=1.5%	MSM=1.5%	IBBS among MSM in Ktm valley, 2009, 2012	
1.17.7	Number of adults reported with syphilis (primary/secondary and latent/unknown) in the past 12 months		✓	NA	NA	NA	NA		
1.17.8	Number of reported congenital syphilis cases (live births and stillbirths) in the past 12 months		✓	NA	NA	NA	NA		
1.17.9	Number of men reported with gonorrhea in the past 12 months		✓	NA	NA	NA	NA		
1.17.10	Number of men reported with urethral discharge in the past 12 months		✓	NA	NA	NA	NA		
1.17.11	Number of adults reported with genital ulcer disease in the past 12 months		✓	NA	NA	NA	NA		
1.19	Diagnosis of HIV and AIDS cases		✓	1,861	2426	2433	2015	NCASC Programme Data	

Indicat or #	Indicators Titles	Indicators		2014	2013	2012	2010	Data Source	Remarks
		GARPR	UA						
	Target 2. Reduce transmission of HIV among people who inject drugs by 50 per cent by 2015								
2.1	People who inject drugs: Prevention Programmes	✓	✓	36	34.9	71.38	NA	Programme Data (SCN, UNODC and NCASC)	# Needle syringe distributed in 2014 1,877,187
	(Number of Syringes distributed per IDU per year by Needle and Syringe Programmes)								
2.2	People who inject drugs: Condom Use	✓	✓	No new data	46.50%	46.50%	50.80%	IBBS among male IDUs in Ktm valley, 2011, 2009	
2.3	People who inject drugs: Safe Injecting Practices	✓	✓	No new data	95.30%	95.30%	99.10%	IBBS among male IDUs in Ktm valley, 2011, 2009	
2.4	People who inject drugs: HIV Testing	✓	✓	No new data	21.40%	21.40%	21.50%	IBBS among male IDUs in Ktm valley, 2011, 2009	
2.5	People who inject drugs: HIV Prevalence	✓	✓	No new data	6.30%	6.30%	20.70%	IBBS among male IDUs in Ktm valley, 2011, 2009	
2.6a	Estimated number of opiate users (injectors and non-injectors)		✓	NA	NA	NA	NA	NA	Size estimation of opiate users (injectors and non-injectors) has not been conducted yet
2.6b	Number of people on opioid substitution therapy (OST)		✓	640 Methadone: 519 Buprenorphine: 121	346	538	349	Programme Data	
2.7 a	Number of needle and syringe programme sites		✓	60	29	44	46	Programme Data	Including 3 female OST sites
2.7 b	Number of opioid substitution therapy (OST) sites		✓	15	6	3	3	Programme Data	
	Target 3. Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths								
3.1	Prevention of Mother-to-Child Transmission	✓	✓	162 (32.53%)	142 (20.9%)	134 (12.2%)	3.29%	NCASC monthly PMTCT report	
3.1a	Prevention of mother-to-child transmission during breastfeeding	✓	✓	22.43%	23.6%	11.6%	NA	NCASC monthly PMTCT report and HIV Infection Estimates	Previously 3.8
3.2	Early Infant Diagnosis	✓	✓	32 (6.4%)	21(3.1%)		NA	FHI360 SSP/USAID (5 sites)	
3.3	Mother-to-Child transmission rate (modeled)	✓		35.7% (178/498)	35.6%	39.70%	NA	HIV Infection Estimates	
3.3a	Mother-to-child transmission of HIV (based on programme data)	✓	✓	0.8%	NA	NA	NA		New Indicator
3.4	Percentage of pregnant women who know their HIV status (tested for HIV and received their results-during pregnancy, during labour and delivery, and during the post-partum period (<72 hours), including those with previously known HIV status		✓	21.8% (158,146)	18.5%	16.9%		NCASC monthly PMTCT report	
3.5	Percentage of pregnant women attending antenatal care whose male partner was tested for HIV in the last 12 months		✓	119 (0.02%)	58 (0.01%)	69 (0.01%)	91 (0.01%)	NCASC monthly PMTCT report and DoHS Annual Report	
3.6	Percentage of HIV-infected pregnant women assessed for ART eligibility through either clinical staging or CD4 testing		✓	16.1%	16.1%			NCASC monthly PMTCT report and HIV Infection Estimates	
3.7	Percentage of infants born to HIV-infected women provided with antiretroviral prophylaxis to reduce the risk of early mother-to-child transmission in the first 6 weeks		✓	25.5%	20%	13.90%	8.40%	NCASC monthly PMTCT report and HIV Infection Estimates	

Indicator #	Indicators Titles	Indicators		2014	2013	2012	2010	Data Source	Remarks
		GARPR	UA						
3.9	Percentage of infants born to HIV-infected women started on cotrimoxazole (CTX) prophylaxis within two months of birth		✓	15.7%	11.9%	6.10%	5.50%	NCASC monthly PMTCT report and HIV Infection Estimates	
3.10	Distribution of Outcomes of HIV-Exposed Infants		✓	# of infants born to HIV +ve mothers: 139 diagnosed positive for HIV: 9 diagnosed negative for HIV: 67				NCASC monthly PMTCT report	New Indicator Data of 2013
3.11	Number of pregnant women attending ANC at least once during the reporting period		✓	622,202	769,694	653,485	666,425	DoHS Annual Report	
3.12	ANC and EID Facilities		✓	ANC with HTC: 238 EID sites: 5					New Indicator
Target 4. Reach 15 million people living with HIV with lifesaving antiretroviral treatment by 2015									
4.1	HIV Treatment: Antiretroviral Therapy	✓	✓	26.5%	21.8%	23.70%	19.03%	ART Programme Data and HIV Infection Estimates	
4.2a	HIV Treatment: 12 months retention	✓	✓	83.90%	85.70%		90.56%	ART Cohort Data	
4.2b	HIV Treatment: 24 months retention		✓	83.50%	78.10%		NA	ART Cohort Data	
4.2c	HIV Treatment: 60 months retention		✓	NA	NA	NA	NA	ART Programme Data	
4.3a	Health facilities that offer antiretroviral therapy		✓	53	39	36	35	ART Programme Data	
4.3b	Health facilities that offer pediatric antiretroviral therapy		✓	52	43	38		NCASC	
4.4	ART stock outs		✓	0%	0%	0%	0%	Logistic bi-monthly consumption report, NCASC	
4.5	Percentage of HIV positive persons with first CD4 cell count < 200 cells/μL in 2014		✓	37.2% (748/2010)				ART Programme Data	New Indicator
4.6	HIV Care: Number of adults and children enrolled in HIV care		✓	Total: 25,421 in 2014: 2,034				ART Programme Data	New Indicator
4.7a	Percentage of people on ART tested for viral load (VL) who were virally suppressed in the reporting period		✓	83.8% (1004/1198)				National Routine Programme Data 2014(NPHL)	New Indicator
4.7b	Percentage of people on ART tested for viral load (VL) with VL level ≤ 1000 copies/ml after 12 months of therapy		✓	NA					New Indicator
4.7c	Percentage of people on ART tested for viral load (VL) with undetectable viral load in the reporting period		✓	NA					New Indicator
Target 5. Reduce tuberculosis deaths in people living with HIV by 50 per cent by 2015									
5.1	Co-Management of Tuberculosis and HIV Treatment	✓	✓	290	551			ART Programme Data	
5.2	Percentage of adults and children living with HIV newly enrolled in care who are detected having active TB disease		✓		46.80%			HMIS reporting system	
5.3	Percentage of adults and children newly enrolled in HIV care (starting isoniazid preventive therapy (IPT)		✓	2.10%	32.50%			Programme Data (from 6 sites only)	

Indicat or #	Indicators Titles	Indicators		2014	2013	2012	2010	Data Source	Remarks
		GARPR	UA						
5.4	Percentage of adults and children enrolled in HIV care who had TB status assessed and recorded during their last visit		✓	51.40%	74.90%	47.60%		ART Programme Data	
	Target 6. Close the global AIDS resource gap by 2015								
6.1	AIDS Spending	✓		No new data	No new data	20.45 mil	17.6 mil	National AIDS Spending Analysis	Expenditure Analysis has not been conducted after 2010
	Target 7. Eliminating gender inequalities								
7.1	Prevalence of Recent Intimate Partner Violence (IPV)	✓		No new data	No new data	14.40%		DHS 2011	New Indicator from 2012
	Target 8. Eliminating stigma and discrimination								
8.1	Discriminatory attitudes towards people living with HIV	✓		No new data	M: 24.7% F: 29.7%			DHS 2011	New Indicator from 2013
	Target 9. Eliminate travel restriction								
	There is no travel restriction								
	Target 10. Strengthening HIV integration								
10.1	Current school attendance among orphans and non- orphans aged 10–14	✓		NA	NA	NA	NA		
10.2	Proportion of the poorest households who received external economic support in the last 3 months	✓		NA	NA	NA	NA		New Indicator from 2012

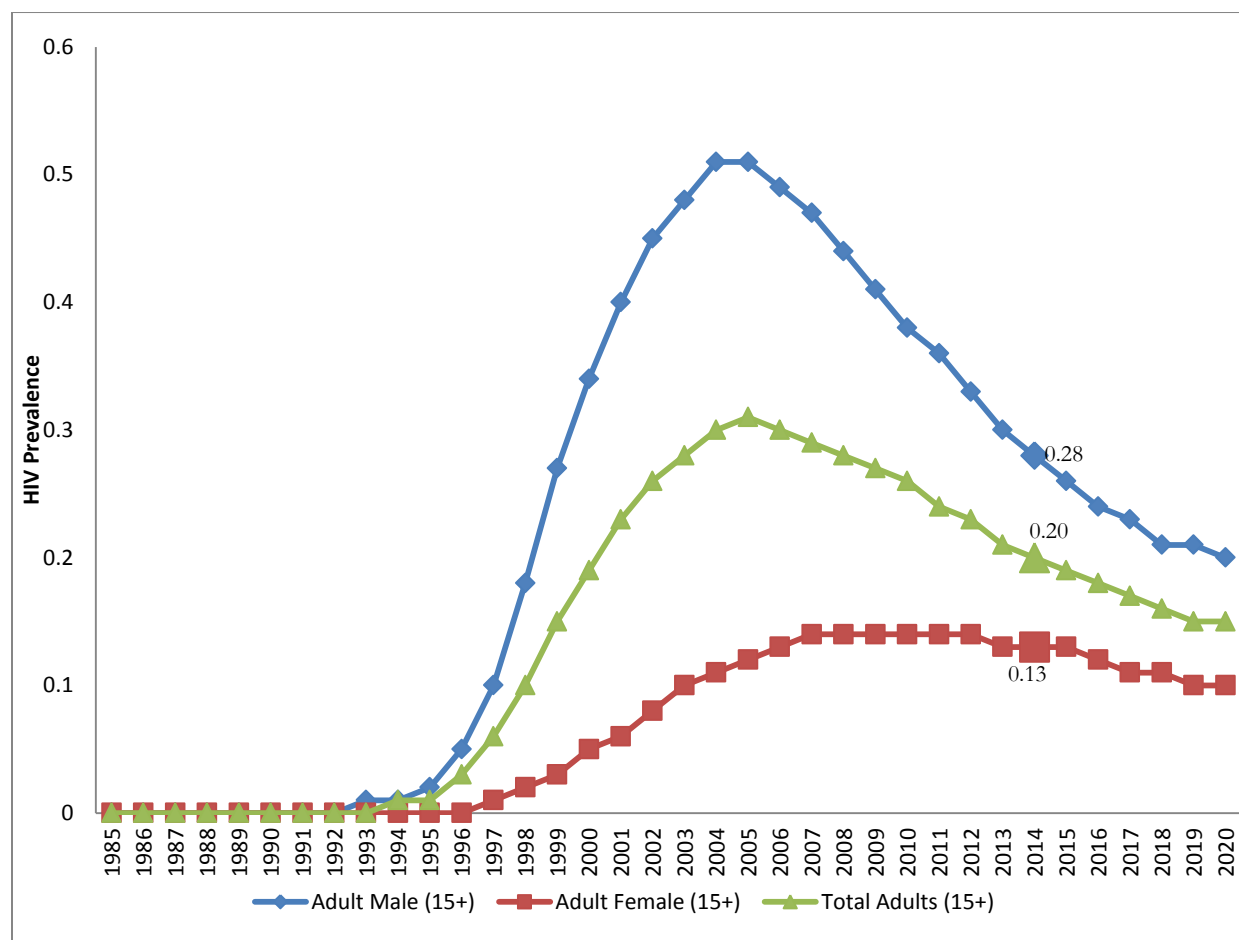
Note: NA=Not Available

II. OVERVIEW OF THE AIDS EPIDEMIC

Overview

Overall, the epidemic is largely driven by sexual transmission that accounts for more than 85% of the total new HIV infections. The HIV epidemic in Nepal remains concentrated among the key affected populations notably; 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. With an overall national HIV prevalence of 0.20 % (adult male 0.28%, adult female 0.13%) in the year 2014, currently there are an estimated total of 39,249 people living with HIV. As shown in Figure 1, the estimated HIV prevalence among adult aged 15-49 years has dropped from a peak (0.35%) in 2005, and is likely to remain around 0.13 % in 2020.

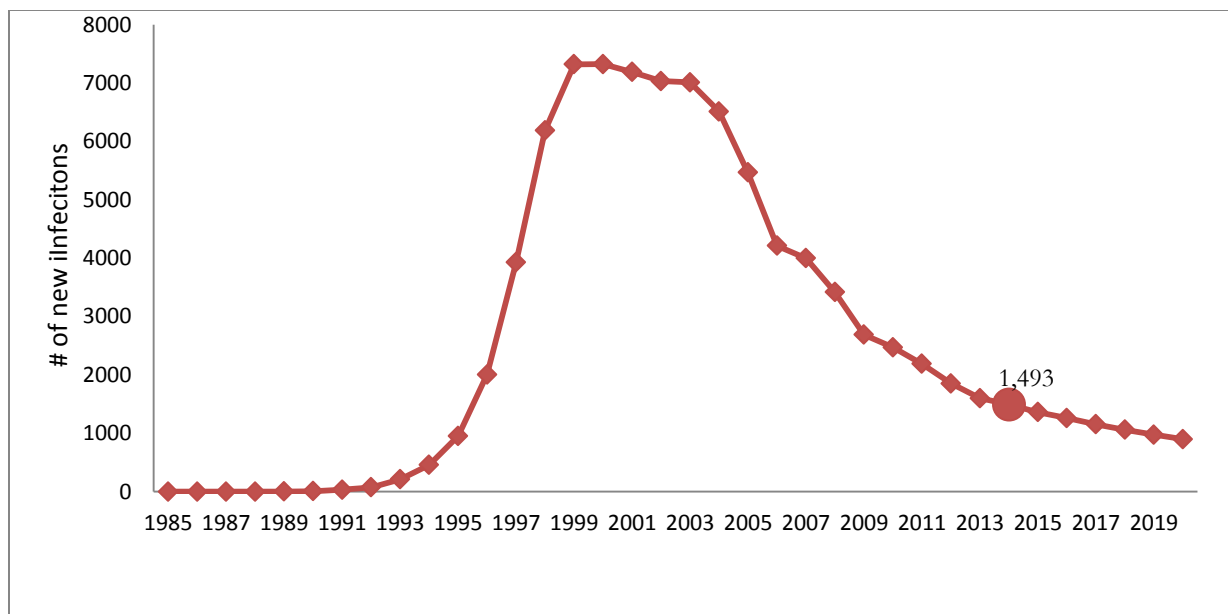
Figure 1: Estimated HIV infections among adult aged 15-49 years, 1985-2020



(Source: HIV Estimates 2014, NCASC)

The new infection estimates also suggest that the trend of annual new infection is declining and will continue to drop further if the same level of intervention is maintained. The annual new infection in 2014 is estimated at 1,493 and is expected to decline to 899 by 2020 (Figure 2). An estimated number of 2,576 deaths were caused by AIDS in 2014, lower compared to estimated 3,362 deaths in 2013, which is largely due to increased access to treatment.

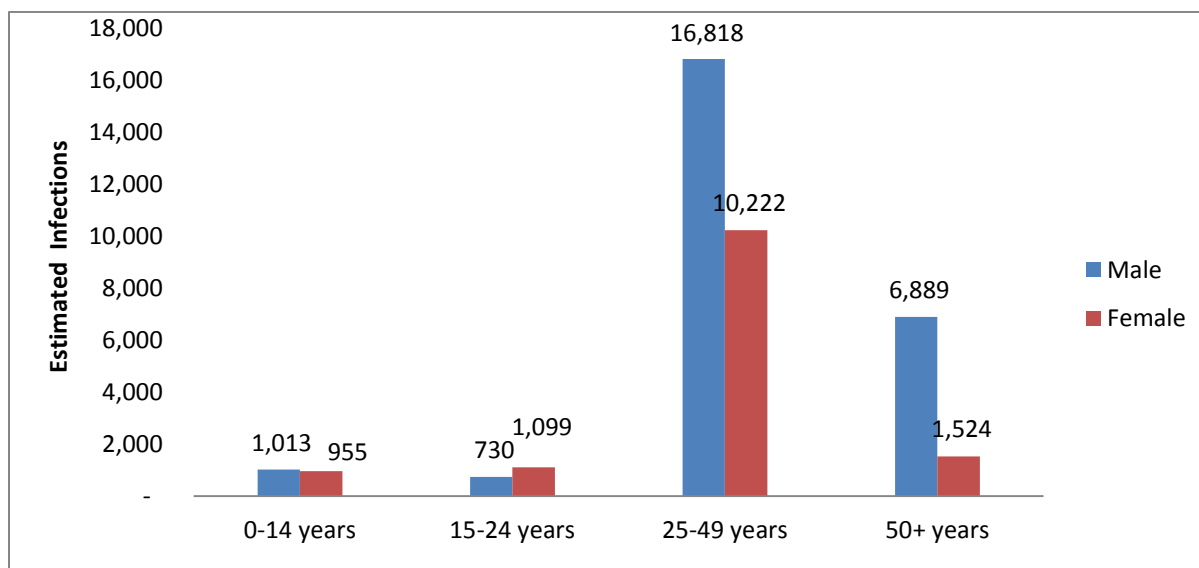
Figure 2: Trends of new infections 1985-2020



(Source: HIV Estimates 2014, NCASC)

Out of the total estimated infections of 39,249, there are a total of 1,968 children in the 0-14 year's age group (5%). The age group comprising of adults 15 years and above makes remaining 95% of the estimated infections (Figure 3). It should be noted that 8,413 infections are amongst people over the age of 50 years (21%). By sex, 65% of infections have occurred among males; and 35% of infections are in females, out of which around 26% are in the reproductive age group of 15-49.

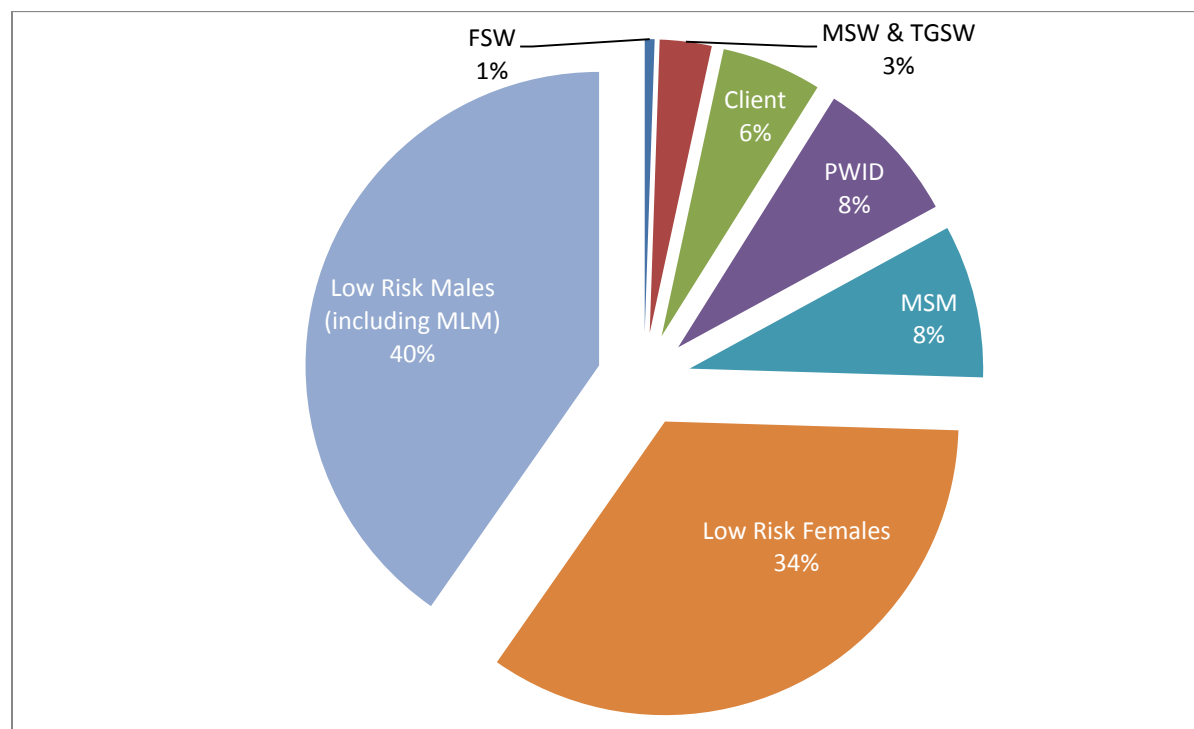
Figure 3: Estimated HIV infections by age group for the year 2014



(Source: HIV Estimates 2014, NCASC)

The estimates also indicate that 26% of total infections are distributed among PWID (8%), MSWs & TGSW (3%), Clients (6%), MSM (8%), and FSWs (1%) (Figure 4). These apart, low risk males including MLM account for 40% and low risk females account for 34% of the remaining infections.

Figure 4: Distribution of HIV infection among key populations in 2014



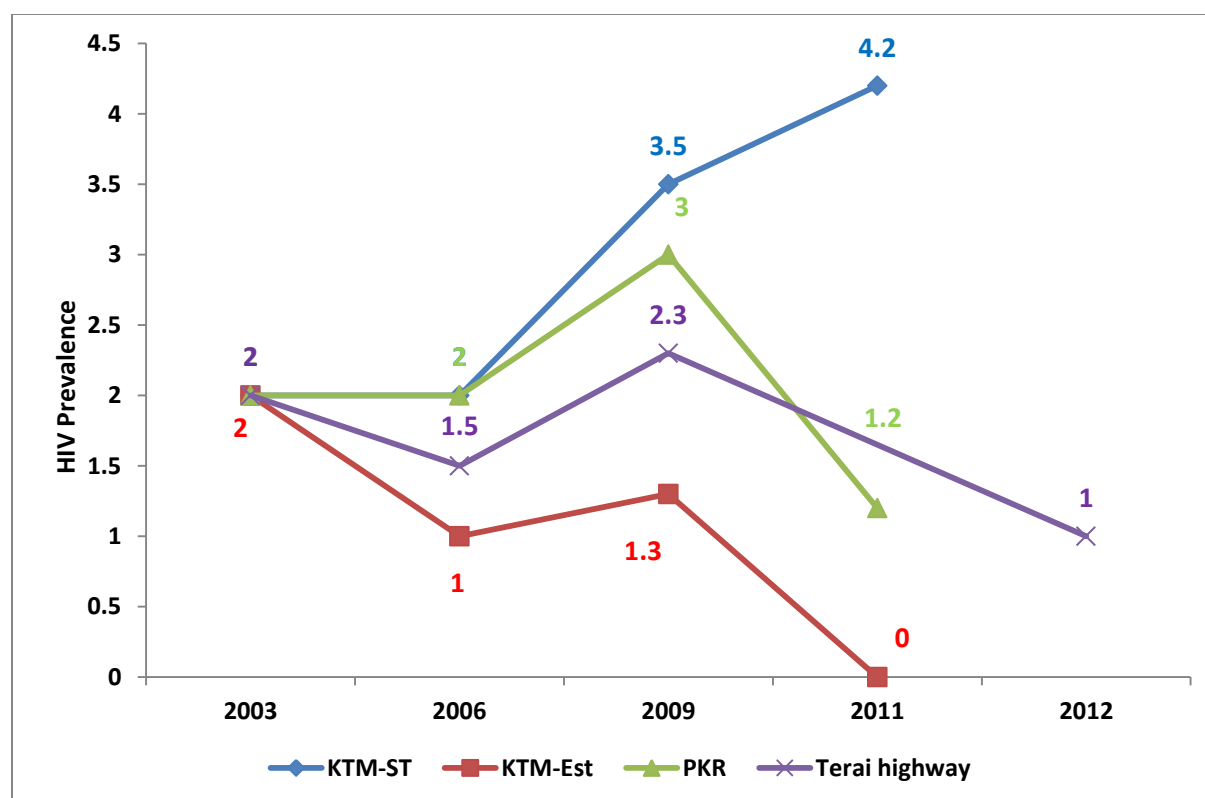
(Source: HIV Estimates 2014, NCASC)

Female Sex Workers (FSW) and their Clients

Mapping and Size Estimation conducted in 2010 estimated that there were around 27,175 FSWs in Nepal, 40% of which operate from establishments and homes, and 20% of them were street-based. The latest Integrated Biological and Behavioural Surveillance (IBBS) Surveys conducted in 2011 and 2012 showed that overall HIV prevalence among female sex workers in Nepal although remains within 2% (Figure 5), however, there is an increase of HIV prevalence among street-based FSW. In 2006, there was a 2% HIV prevalence among street-based FSW in Kathmandu, which increased to 3.5% in 2008 (Figure 5), and further 4.2% in 2011 (IBBS 2011, 2008, 2006).

Overall HIV and active syphilis prevalence among FSW are declining. In 2009, an IBBS survey conducted in 22 Terai high-way districts revealed 2.3% HIV prevalence and 3.5% syphilis prevalence among FSW. Likewise, HIV prevalence among FSW in Pokhara Valley is also declining (3% in 2009 to 1.2% in 2012). In 2012, HIV prevalence among FSW had decreased to 1%; of which only 0.75% had laboratory test indicative of syphilis history, and 0.3% had active syphilis. Among truckers, considered as a proxy group for clients of sex workers, the HIV prevalence also dropped from 1.8% in 2006 to 0% in 2009 (IBBS 2006, 2009).

Figure 5: HIV prevalence among Female Sex Workers



(Source: IBBS among Female Sex Workers, 2003- 2012)

People who inject Drug (PWID)

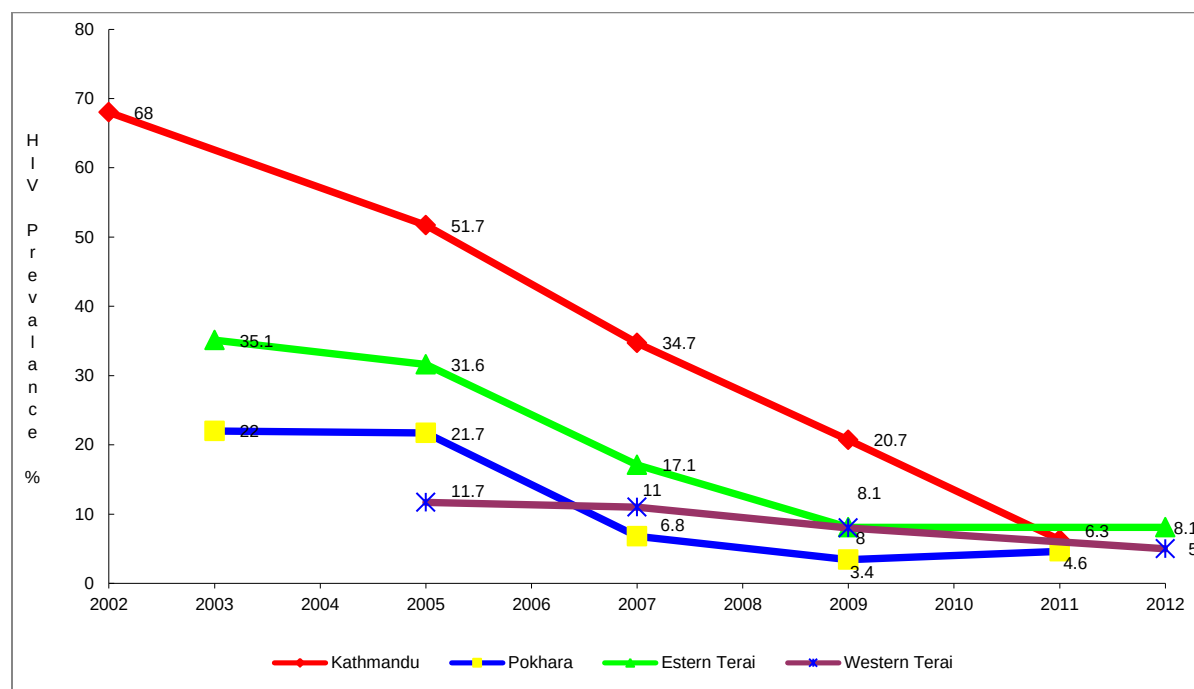
The survey conducted by Central Bureau of Statistics in 2012 estimated that there were around 52,174 PWID in the country. Nepal has successfully reduced the HIV prevalence among PWID since 2002 when HIV prevalence was recorded 68% in Kathmandu data (Figure 6). In the same period of time the behavioral indicators (condom use, needle syringe, prevention reach) showed consistent improvement. In the Eastern Highway districts, the HIV prevalence declined from 35.1% in 2002, to 8.1% in 2009, and has remained around 8.1% since then (IBBS 2002, 2009, and 2012). In the Western Highway districts, the HIV prevalence also declined from 8% in 2009 to 5% in 2012 (IBBS 2009, and 2012). In both regions, the prevalence of active syphilis has remained below 2% (IBBS 2012). In Kathmandu, the HIV prevalence declined from 68% in 2002, to 6.3% in 2011 (IBBS 2002, 2011). Likewise, the HIV prevalence in Pokhara has dropped from 22% in 2003 to 4.6% in 2011.

Females account for 7% of the total PWID of Nepal (CBS 2012). Nepal has little data on Female PWID as they were covered along with Male PWID only in the first IBBS survey conducted in 2002 in Kathmandu. That apart, Female PWID have not been included in any IBBS surveys conducted thereafter. However, a study conducted by UNODC in 2011 reported 4% HIV prevalence among female who inject drugs.

Viral Hepatitis is strongly associated with HIV, particularly among people who inject drugs, due to common routes of transmission. Apart from Viral Hepatitis, the prevalent co-infections among PWID living with HIV have been Tuberculosis (TB) as well. Studies have shown varying ranges of prevalence for the Hepatitis C (HCV) among PLHIV. A study on Co-infection of Hepatitis C Virus among HIV positive people in the Kathmandu Valley revealed that 43.3% out of 319 PLHIV were infected with also HCV (Poudel KC et al, 2013). Prior to that, UNDP conducted a survey across 18 districts of five regions among 677 PLHIV of

which 83% were PWID; and found 19% were infected with HCV (UNDP/DFID/CMDN. 2012). A 2010 study conducted by UNODC among female who injects drugs showed that 15% of them were also found to be infected with Hepatitis C.

Figure 6: HIV prevalence among People Who Inject Drugs

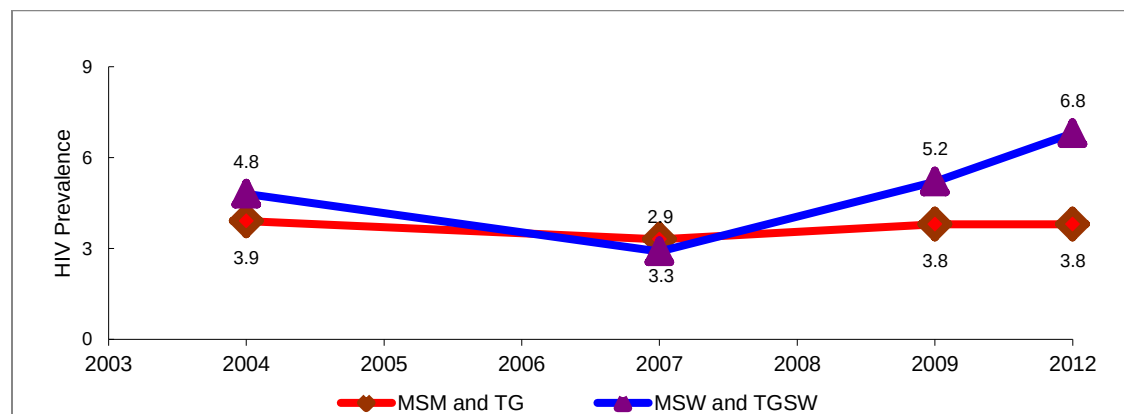


(Source: IBBS among Male Injecting Drug Users, 2002- 2012)

Men who have sex with men (MSM), Transgender and Male Sex Workers

Men who have sex with men in Nepal are comprised of the following sub-populations: a) Male Sex Workers (MSW) (estimated population size of 12,639), b) transgender people and transgender sex workers (TGSW) (estimated population size of 9,474) and c) Men Who Have Sex with Men (MSM) with the population size estimated at 196,270 (NHIP, 2014). Data from Kathmandu Valley shows that overall HIV prevalence among MSM has not changed much and remains around 3.8% since 2009. However, the prevalence among MSW, showing an increasing trend, has increased from 4.8% in 2004 to 6.8% in 2012.

Figure 7: HIV prevalence among MSM and MSW and TGSW in Kathmandu Valley



(Source: IBBS among Men Having Sex with Men and Transgender People in Kathmandu Valley, 2004- 2012)

A series of IBBS surveys conducted in the Kathmandu valley have shown that prevalence of active syphilis among the MSM and TG population overall has declined from 1.7% in 2004 to 0.8% in 2012. Likewise among MSW and TGSW, it has fallen from 2.4% in 2004 to 2.2% in 2012 and among non-sex worker MSM and TG from 1.5% in 2004 to 0% in 2012 (IBBS 2004, 2012).

Male Labour Migrants and their spouses

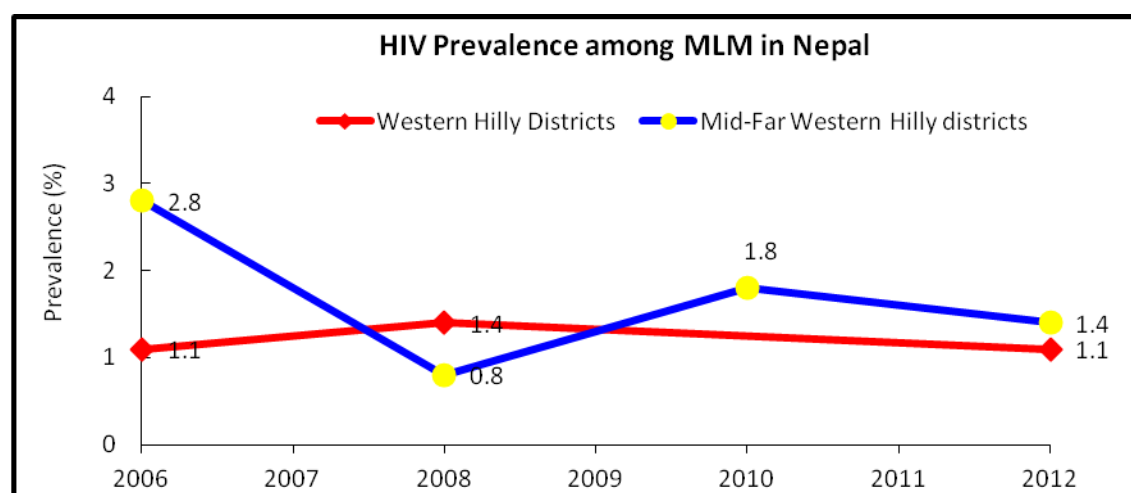
A large number of Male Labour Migrants (MLM) from Western, Mid and Far-Western regions migrates to HIV burden areas of India. Due to their mobility and frequent returning to their families, spouses are also at a higher risk of HIV transmission. The size of these returnee male labour migrants were estimated to number around 505,728 in 2011 (CBS, 2011 and NDHS, 2011).

As shown in Figure 8, the HIV prevalence among male labor migrants in the mid and Far-West regions varies over time, being 1.4% in 2012, 0.8% in 2010, 1.8% in 2008, and 2.8% in 2006. In contrast, HIV prevalence among male labor migrants in Western Hilly has remained within 1.5% since 2006 to 2012 (IBBS 2012, 2010, 2008 and 2006). HIV prevalence among male labor migrants in both regions is within 2% though is factually correct. But at the same time it may not be telling enough to convey an important message that even a small prevalence of HIV in the large population of male labor migrants (of 505,728) obviously translate into a large number of people living with HIV.

Other Populations

Prisoners and uniformed forces have been also parts of targeted interventions over the years, though the intervention targeted to prisoners came to its closure during April 2014. Street children are other populations that need a close attention in the national response to HIV. However, not enough studies have been conducted among street children and prisoners to capture the HIV prevalence and risk behaviors.

Figure 8: HIV prevalence among Male Labour Migrants



(Source: IBBS among Male Labour Migrants in Western and Mid to Far western region, 2006- 2012)

TB in people living with HIV

Tuberculosis (TB) is a prevalent opportunistic co-infection among people living with HIV. Prevalence of TB is estimated at 11.5% among PLHIV, and while HIV prevalence among TB patients is estimated at 2.4% (National Tuberculosis Center, 2013). More than 50% of PLHIV had their TB status accessed in their last visit (till 2014) and it has been planned to access more than 90 % from 2015 onwards.

HIV infection is the most potent risk factor for converting latent TB into active TB and at the same time, TB accelerates the progression of HIV. It is one of the leading causes of death among people who are HIV positive and the co-infection exerts a negative impact on TB and HIV control programmes. For reducing the risk of TB among HIV patients the government has started (Isoniazid Preventive Therapy (IPT) services from five sites which is planned to scale over all ART sites during 2015.

III. NATIONAL RESPONSE TO THE AIDS EPIDEMIC

Policy and structural response

National Policy on HIV and STI, 2011 has made a structural arrangement involving key entities notably: National AIDS Council (NAC), HIV/AIDS and STI Control Board (HSCB), NCASC; and District AIDS Coordination Committees (DACC) for the effective implementation of the national response. The NAC has remained passive for the long time and HSCB no longer remains active, leaving the NCASC and DACCs, only two organizations presently functional among these organizations. In this context, the NCASC, under the MoHP, is the coordinating entity that supports the overall implementation, monitoring and oversight of HIV and STI activities. At the district level, there is DACC which works as a coordinating mechanism for generating local responses to HIV.

The policy and structural environment to ending HIV is guided by the frameworks in The National Policy on HIV and STI 2011, the National Strategy Plan 2011-2016 (NSP), and the Nepal HIV Investment Plan 2014-2016 (NHIP).

Several other policies with their enactments precede the reporting cycle of this report; notably the National Policy on HIV in the Workplace (2007), and the National Drug Control Policy (2006) are working in tandem with the National Strategy Plan 2011-2016. In this reporting period, the MoHA endorsed the National Guidelines on Opioid Substitution Therapy (OST-2014), which is expected to facilitate the implementation of OST programmes by creating an enabling environment. NCASC has finalized “The National Consolidated Guidelines for Treating and Preventing HIV in Nepal” in 2014 to provide updated and evidence-based clinical recommendations for HIV prevention and treatment, in particular for ARV drugs. This national guideline is based upon the recommendations of “Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection” published by the WHO in June 2013. The new clinical recommendations of the guidelines expand the eligibility for treatment initiation (e.g. to CD4 threshold of 500 cells/mm³ or less from the previous CD4 threshold of 300 cell/mm³ or less) and it has been put into practice accordingly.

Emergence and transmission of HIV drug resistance (HIVDR) is an unavoidable consequence of ART in the context of ever increasing number of patients on ART, even when appropriate drugs are prescribed and adherence is maximally supported. Taking the looming threat of unavoidable consequence of ART that obviously arises in the context of increasing number of patients enrolled in ART, Nepal has endorsed “National Strategy on HIV Drug Resistance Monitoring and Surveillance (2014-2020)” in the year 2014. This national strategy provides a strategic framework for the monitoring of and maintaining surveillance on the emergence and transmission of HIV drug resistance that comes as the use of ART.

Also in 2014, HIV Viral Load testing scale-up plan (2014-2018) has been prepared with the joint efforts of National Public Health Laboratory (NPHL) and NCASC. Technical assistances from the WHO and logistical assistance from The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) were provided for the preparation of this scale -up plan. Further in this context, standard operation procedures (SOPs) have been developed to streamline Viral Load testing for all the clients on treatment by introducing Viral Load testing referral forms.

1. Prevention, treatment, care and support

A. Prevention

Targeted interventions have been in implementation for more than one and half decades, aiming primarily at the prevention of new infections, particularly among KPs. These interventions entail comprehensive packages tailored specifically for KPs and include Behavior Change Communication (BCC) activities, condom promotion and distribution, HIV Testing and Counselling, and referrals to a range of other critical services including ART, HIV care and support, family planning/sexual and reproductive health (SRH), sexually

transmitted infections (STI) and TB. For PWID it also includes needle exchange programme (NSP) and opioid substitution therapy (OST) in the harm reduction programme.

Female Sex workers (FSWs)

The government and its partners, including the USAID-funded Saath-Saath Project (SSP), and Save the Children under GFATM are implementing interventions through NGOs for female sex workers (FSWs).

Table 2: below shows the services delivered to FSWs and their clients for the period of July 2011 to July 2014. Following table also shows that the number of FSWs and their clients reached through prevention programmes have increased gradually for the last three years.

Table 2: Service for FSWs and their clients for the period of July 2011 to July 2014

Indicator	16 July 2011-15 July 2012		16 July 2012-15 July 2013		16 July 2013-15 July 2014	
	FSWs	Clients of FSWs	FSWs	Clients of FSWs	FSWs	Clients of FSWs
Number of districts covered	29		29		29	
Reached by prevention programme	22,573	49,319	28,686	69,631	30,416	77,002
Condom distributed	1,987,163	1,058,879	2,813,118	1,502,802	3,434,421	19,55,697
HIV tested and Counseled	6,066	8,100	7,720	10,553	9,970	11,076
STI diagnosed and treated	6,260	7,915	7,769	729	10,037	595

(Source: NCASC Factsheet 2014)

People Who Inject Drug (PWID)

During 2014, for PWID, needle syringe exchange and OST (Methadone and Buprenorphine) services were provided for harm reduction along with BCC activities, condom promotion and distribution, HIV Testing and Counselling, and referrals to a range of other critical services including ART, HIV care and support, family planning/sexual and reproductive health (SRH), sexually transmitted infections (STI) and TB. Save the children under GFATM and NCASC from the Pooled Fund and UNODC were implementing Targeted Intervention (TI) of needle syringe exchange programmes in 23 districts through their implementing partners. OST programmes are currently running in six sites; namely; Bheri Zonal Hospital, Banke; Lumbini Zonal Hospital, Rupandehi; Western Regional Hospital, Kaski; Tribhuvan University Teaching Hospital, Kathmandu; Koshi Zonal Hospital, Morang; and Patan Mental Hospital, Lalitpur. Since July 2014, NCASC is taking a lead on the OST programme with the support from GFATM. Table 3 below, shows the services delivered to PWID for the period of July 2011 to July 2014. The number of PWID reached through prevention has declined from 11,832 in 2012/2103 to 6,570 in 2013/2014. More importantly, the numbers of newly enrolled clients on both oral substitution programmes i.e., Methadone and Buprenorphine have gone down in 2013/2014 compared to that of 2012/2103.

Table 3: Services for PWID for the period of July 2011 to July 2014

Indicator	16 July 2011- 15 July 2012	16 July 2012- 15 July 2013	16 July 2013- 15 July 2014
Number of districts covered	23	23	23
Reached by prevention programme	6,064	11,832	6,570
Condom distributed	226,258	535,824	610,557
HIV tested and Counseled	1,731	4,561	5,332
STI diagnosed and treated	2,192	1,111	1,143
Needle/Syringe exchanged/provided	159,892	2,033,101	1,731,095
Newly enrolled on Methadone (Cumulative)	NA	421	404
Newly enrolled on Buprenorphine (Cumulative)	NA	550	465

(Source: NCASC Factsheet, 2014)

In addition to NSP and OST services, after a long joint advocacy by different partners from 2015 through the Global Fund support, the government will be providing Hepatitis C treatment to 150 HIV and Hepatitis co-infected people. Nepal has also initiated the validation process of the HCV treatment protocol in 2014, which is a fundamental step for the roll out of HCV treatment. Moreover, the validation process is based upon the ‘Guidance on care for adolescents and adults living with HCV Genotype 1 or 3 in Nepal 2014’.

Men who have sex Men, Transgender People and Sex workers

Through the NHIP 2014-2016, the country has disaggregated the MSM population by sub categories in order to better plan and strategize the HIV response among the subgroups. Therefore, the categories of men who have sex with men in Nepal are comprised of several sub-populations: male sex workers (MSW), transgender people (TG) and transgender sex workers (TGSW), and gay men and other men who have sex with men (MSM). Priority to create an enabling legal environment for this population has been highlighted through reviews such as the Legal and Policy Environment in Response to HIV in Nepal.

The Blue Diamond Society (BDS) is implementing targeted interventions for this population with the support from the government, under the Pooled Fund and the GFATM. Table 4 shows that the HIV and STI prevention and services, except for numbers of condoms distributed, among MSM and TG increased from 2011/ 2012 to 2012/ 2013 but has decreased from 2012/ 2013 to 2013/ 2014. For the year 2014, a total of 31 districts were covered by the targeted interventions.

Table 4: Services for Men who have sex with men for the period of July 2011 to July 2014

Indicators	16 July 2011- 15 July 2012	16 July 2012- 15 July 2013	16 July 2013- 15 July 2014
Number of districts covered			31
Reached by prevention programme	40,827	44,496	34,427
Condom distributed	1,123,306	2,012,381	2,046,540
Lubricants distributed	NA	NA	943,123
HIV tested and Counseled	8,451	9,810	7,574
STI diagnosed and treated	8,135	8,348	5,426

(Source: NCASC Factsheet 2014)

Male labor Migrants (MLM) and their spouses

The Government and its partners through the pool fund mechanism, Save the Children, and the Saath-Saath project are implementing intervention through NGOs among migrants and their spouses. The TI programme for migrants covered 58 districts during July 2013 – July 2014. Table 5 below shows that the number of migrants and spouses reached through prevention programmes increased significantly from 79,076 in 2011/2012 to 309,954 in 2012/2013; however, it decreased to 285,623 in 2013/2014. Likewise the number of migrants and spouses tested and counseled dropped from 60,929 in 2012/2013 to 42,679 in 2013/2014.

Table 5: Services for labor migrants and spouses for the period of July 2011 to July 2014

Indicator	16 July 2011- 15 July 2012	16 July 2012- 15 July 2013	16 July 2013- 15 July 2014
Districts Covered			58
Reached by prevention programme	79,076	309,954	285,623
Condom distributed	673,076	1,215,896	2,991,704
HIV tested and Counseled	59,415	60,929	42,679
STI diagnosed and treated	40,113	40,701	21,757

(Source: NCASC Factsheets 2014 and Programme Data 2011- 2014)

As mentioned earlier, uniformed forces and prisoners have been parts of targeted interventions over the years. In this context, a total of 12,420 personnel including 8,243 army personnel and 4,177 police personnel have been tested for HIV during the period of 16 Dec 2013 to 15 Dec 2014 (Source: Save the Children/ GFATM Programme 2014). Prisoners of three districts, notably; Kaski, Chitwan and Tanahun districts had been reached with a comprehensive programme before the programme came to its closure in April 2014.

B. Test, Treat and Retain

HIV Testing and Counseling (HTC)

There are currently 263 HTC sites operating in the country, out of which 133 sites are operated by NGOs while 130 sites are run by the government. These HTC sites are the entry point to the “treatment care and support” as they conduct HIV testing and counseling, as well as maintain linkages with KPs, ART, TB and eVT sites. The

Table 6 depicts the total number of people tested for HIV has gone down from 281,609 in 2013 to 270,003 in 2014. This reduction in the total number of people tested for HIV may have occurred due to an under reporting that could arise in the transition of HIV related reporting system to Health Management Information System (HMIS). Throwing further light in this context, The Table 7 shows that the total cases of HIV detected has come down to 1,861 in 2014 from 2,426 of 2013; and 2,433 in 2012.

In the backdrop of low HIV Testing coverage among KPs, The Test, Treat and Retain paradigm described in the NHIP represents a change in practice where the emphasis on sharing information as the main preventive measure through BCC activities has been shifted towards linking individuals to services and treatment through HIV testing and counselling sites (HTC). Further in this line, the Community-based Testing (CBT) approach is being planned to rapidly scale up the number of people getting tested for HIV, particularly among KPs. Community-led HIV testing and counselling is to be achieved through public-private partnerships, thus representing a radical shift of the traditional responsibilities of peer educators and outreach workers for the in-reach their own communities. A test for HIV will be performed by trained and qualified community workers to increase the coverage of the “Test, Treat and Retain” paradigm among KPs. People who test HIV positive will be accompanied to public or private health facilities for confirmatory testing and further to ART treatment. Individuals with a non-reactive test will be given their results and HIV prevention services by the same community in-reach workers.

Table 6: Service Statistics HIV Testing and Counseling for the period of 2008 -2014 by year

Indicators	2008	2009	2010	2011	2012	2013	2014
Testing from HTC sites	53,309	102,512	106,325	95,499	120,450	139,566	111,857
Testing from eVT sites	42,733	65,791	94,511	124,025	129,131	142,043	158,146
Total Tests	96,042	168,303	200,836	219,524	249,581	281,609	270,003
HIV positives	2,387	2,110	2,015	2,060	2,433	2,426	1,861

(Source: NCASC, 2015. Routine HIV Testing and Counseling Programme Monitoring Data 2008 -2014)

Table 7: Diagnosis of HIV for the period of 2012 -2013 by year

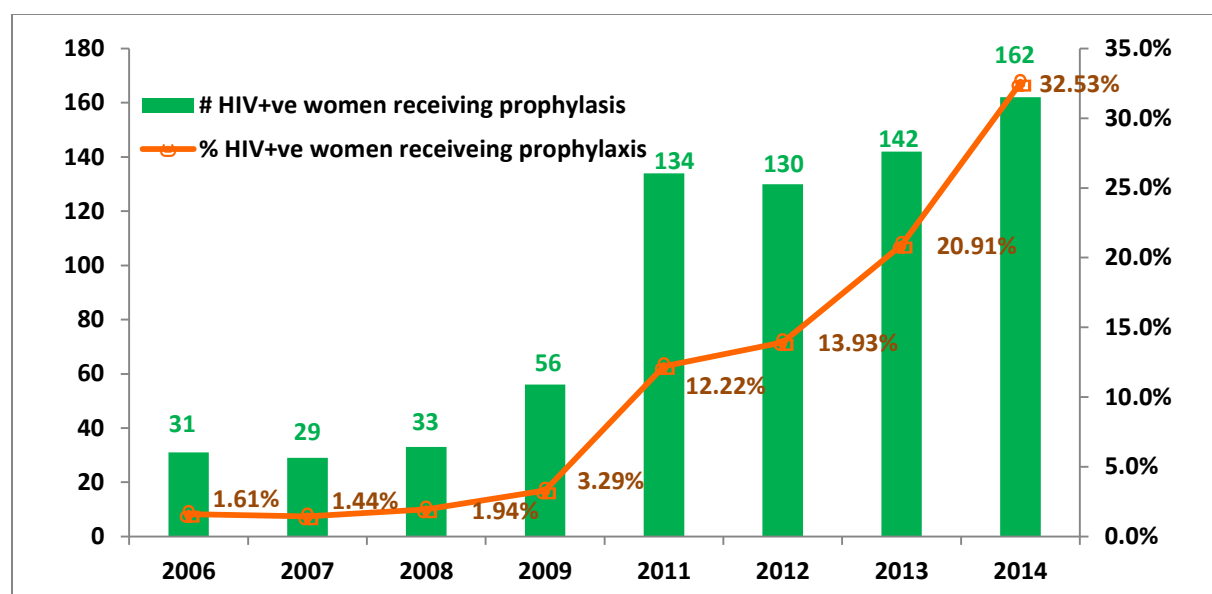
Sex	2008	2009	2010	2011	2012	2013	2014
Male	1388	1,236	1,199	1,241	1,416	1,403	1,104
Female	999	874	816	819	1,001	1,006	744
TG people					16	17	13
Total	2,387	2,110	2,015	2,060	2,433	2,426	1,861

(Source: NCASC, 2015. Routine HIV Testing and Counseling Programme Monitoring Data)

Elimination of Vertical Transmission (eVT)

The number of sites offering ‘eVT’ services has gone up to 95 across 45 districts in 2014, compared to 65 sites in 33 districts in 2013; and 41 sites in 2012 (HLM Mid-term Review Report, 2013, NCASC; Programme Data NCASC 2014). As a result of this scale up, the number of women attending ANC who were tested increased from 142,043 in 2013 to 158,146 in 2014 (NCASC Programme Data 2014). Despite this increase in uptake, the coverage for “eVT” is relatively low though improving over the last three years. During the entire period of 2014 only 162 pregnant women received ARV prophylaxis compared to 142 pregnant women in 2013; and 130 in 2012 (Figure 9). Likewise, with 162 pregnant women receiving ARV prophylaxis out of 498 pregnant women needing eVT services, the eVT coverage in 2014 has reached to 32.5%, an increase from 20.9% in 2013 (Figure 9). By the end of 2014, 127 (25.5%) infants born to these pregnant women received ARV prophylaxis whereas 136 (20%) infants received in 2013 (NCASC Program Data 2013- 2014). In 2014, 32 out of 131 infants (24.4%) born to HIV-positive mothers received an HIV test compared to 3% in 2013 (NCASC Routine Programme Monitoring 2014, 2013). As of the end of 2014, there were 6 sites providing early infant diagnosis (EID) service in Nepal. Option B+ (Lifelong ART) for pregnant women living with HIV has been formalized in the National Consolidated Guidelines for Treating and Preventing HIV in Nepal, which recommends that all HIV-infected pregnant women immediately start life-long ART regardless of WHO clinical stage and CD4 cell count.

Figure 9: eVT Coverage for the period of 2006 to 2014 in Nepal

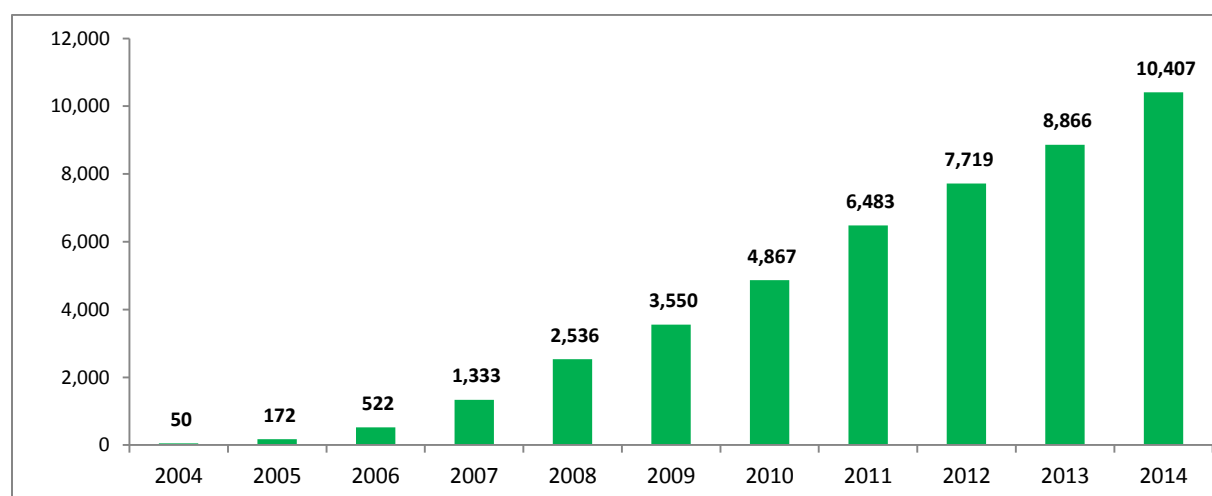


(Source: NCASC Programme Data 2006 -20014)

Treatment, Care and Support

Nepal has seen gradual increases in the number of people who are on ART every year during the last decades (Figure 10). By the end of 2014, there were 10,407 people on ART which accounted for 26.5% ART coverage. Out of this total of 10,407 who are on ART, 5,535 are adult male and 4,872 are adult female. There are 36 transgender people and 783 children of under -15 years on ART.

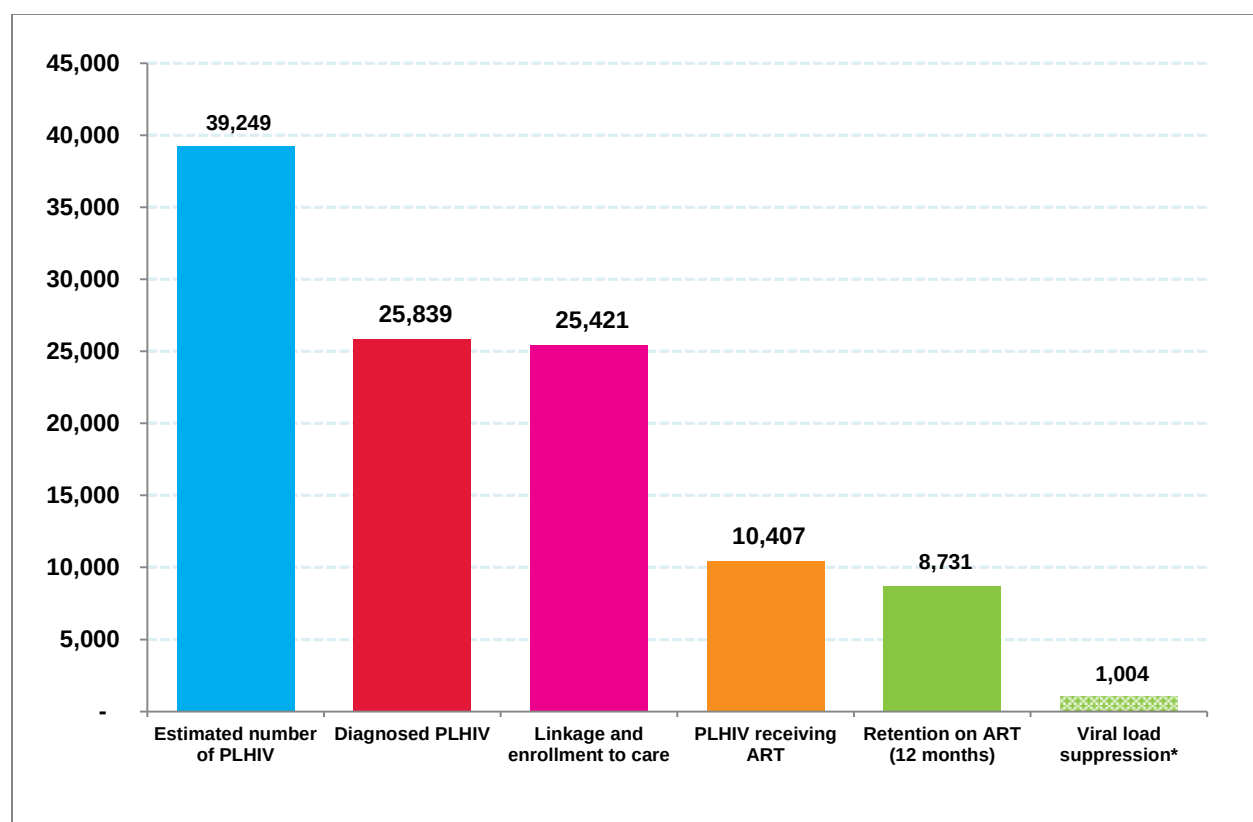
Figure 10: People on ART for the period of 2004 to 2014



(Source: Source: NCASC Programme Data 2004 -20014)

The National Estimates 2014 reveal that out of an estimated population of 18,952 who were in the need of ART - according to the criteria of $CD4 \leq 350$ - only 10,407 were them on ART. In the light of adoption of the new criteria of $CD4 \leq 500$ from 2015, it is estimated that 32,884 PLHIV will be in the need of ART for 2015.

Figure 11: HIV Treatment Cascade-2014



(Source: National HIV Programme Data, 2014 and National Estimates 2014)

Moreover, the treatment cascade shows (Figure 11) out of the estimated figure of 39,249 PLHIV only 25,839 are diagnosed with HIV. This suggests more than one-third of PLHIV are yet to be diagnosed. This calls for rapid scaling up the HIV testing through different approaches. In order to meet the NSP targets as well as the global ambitious target of 90-90-90 by 2020, HIV testing also has to be scaled up rapidly.

Report from a total of 53 ART sites across 45 districts for the year 2014, shows that out of 13,650 ever registered PLHIV on ART, 14% of those on ART died and 9% have been lost to follow-up, while 76% are alive on treatment. Furthermore, 0.2% people have stopped treatment (Table 8). However, the recent cohort analysis shows that around 83.9% of people who started ART in last 12 months and 83.5% who stated in last 24 months are still alive and on treatment.

Table 8: ART Profile for the period of 2011 to 2014

Indicators	2011	2012	2013	2014
People living with HIV ever enrolled on ART (cumulative)	8,232	9,986	11,704	13,650
People with advanced HIV infection receiving ARV (cumulative)	6,483	7,719	8,866	10,407
People lost to follow up (cumulative)	718	908	1,159	1,242
People stopped treatment	12	21	25	33
Total deaths (cumulative)	980	1,305	1,613	1,932

(Source: NCASC, Routine Programme Data 2011- 2014)

Aiming at supplementing the ART management programme, 18 CD count machines across 18 different ART sites are operating along with a viral load testing machine placed at the National Public Health Laboratory. Portable CD4 counting machines have been stationed in hilly western, mid-western and far western districts of Nepal to provide timely CD4 count service to monitor the effectiveness of ARV.

The new clinical recommendations in the comprehensive guidelines which expand eligibility for treatment initiation to a CD4 count threshold of 500 cells/mm or less (from previous threshold of 350 cells/mm³ or less) for adults, adolescents and children older than 5 years have come into standard practice from March 15, 2015. The new clinical recommendations of ART to be initiated regardless of CD4 count for: i) people with active Tuberculosis disease who are living with HIV; ii) people with both HIV and hepatitis B virus infection with severe chronic liver disease; iii) HIV-positive partners in sero-discordant couples; iv) pregnant and breastfeeding women, and v) children younger than five years of age have been effective from March 15, 2015.

TB HIV Co-infection

A National Tuberculosis Programme (NTP) is currently implementing TB/HIV activities in 30 high TB burden districts, and plans to scale up activities in another 10 districts by 2015. Meanwhile the NCASC aims to implement TB/HIV activities in 8 districts by 2015. Programmatic data from the National Tuberculosis Programme shows that 25% of TB patients were tested for HIV in the fiscal year 2011/2012 and 138 HIV positive cases were found among them. Similarly, in the fiscal year 2012/2013, 11% of TB patients were tested for HIV and 65 HIV positive cases were found to be positive (NTC, Annual Progress Report of TB/HIV co-infection, 2010-11).

The sentinel site survey conducted in 2011/2012 showed that 2.4% TB patients are living with HIV and 11.5% of people living with HIV are co-infected with TB (NTC, 2013). Currently TB/HIV programme is implemented in 38 districts (30 of NTC and 8 of NCASC). From the HIV programmes almost all known HIV positives were screened for TB however, only 11% of TB patients had been screened for HIV.

Currently Isoniazid prevention therapy (IPT) services are running in 5 sites of 3 districts (Kathmandu, Kaski and Kailali) through ART Centers. The main objective of IPT implementation is to prevent TB infection among HIV positives. More than 50% of PLHIV who have been on HIV care were screened for TB signs and symptoms. The IPT assessment, which was carried out recently, with financial support from the WHO, recommends scaling up of IPT services. As a result of the recommendation, IPT services are planned to be scaled up to run in all the ART sites in the country through the support of Global fund and the WHO.

Care and Support: Cash Transfer Programme to Children Affected By AIDS (CABA)

Since April 2014, Nepal has launched a cash transfer programme targeting Children Affected by AIDS (CABA) based on the endorsed CABA Operating Guideline 2010. Each of the total 1,090 children living with HIV (CLHIVs) aged between 0-18 years, across 45 districts, are getting a monthly amount of NRs 1,000 (roughly US 10\$) on their individual bank accounts. CABA implementation committees formed in the programme districts are responsible for the selection of eligible candidates. With the help of implementing NGOs, a mechanism with monitoring and complaints checklists has been put in place to ensure that any cash transferred is righteously utilized for education, nutrition or the health of the beneficiaries. At present, this cash transfer programme is being implemented by Save the Children with financial support from GFATM. However, the Government of Nepal is to takeover in near future.

Intimate partner violence in Nepal

Intimate partner violence which is habitually considered as a potential barrier to women's access to health services was included in the Demographic Health Survey 2011 (DHS 2011). The DHS 2011 has recorded that 14 % of ever-married women reported experiencing spousal physical and/or sexual violence within 12 months prior to the survey, while 11 % having experienced violence sometimes and 3% has experienced it

often. DHS 2011 further elaborates that half or more of women who have ever experienced any form of spousal violence have experienced the violence within the 12 months prior to the Survey.

Elimination of Stigma and Discrimination

Networks of KPs, networks of people living with HIV; and agencies involved in combating have been engaged in a national effort to empower these populations for ensuring their access to HIV prevention and treatment services in an environment free of prejudice and discrimination. 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.

Ensuring Coordination for the National Response

The National Health Sector Programme Implementation Plan (NHSP-IP) provides an overall coordination framework for the response to HIV. The NCASC, being a national entity under the MoHP and managing the health sector response to HIV, plays an important coordinating role among different sections of MoHP, external development partners, civil societies, local authorities and DACCs to ensure that their activities are well aligned to the NSP and NHIP as well as the National Policy on HIV and STI 2011. At the local levels, DACCs are active in a number of districts and putting their efforts for generating coordinated and cohesive local responses.

A number of other stakeholders also contribute in the coordination of the national response to HIV. The Country Coordination Mechanism – established primarily to facilitate the implementation of GFATM funded projects but with its broad representations from government, donors, private sectors, affected and infected population and its civil societies– has been serving in ensuring coordination among a range of diverse stakeholders in the national response. The Pooled fund, working under the auspices of the Sector Wide Approach (SWAp), also allows for a better coordination among its partners and moreover, minimizes the scope for vertical financing in the national response to HIV and the entire health budget. Agencies like FHI360 SSP and Save the Children maintain coordination at the central level as well as the local level aiming at avoiding duplication and fragmentation of services that they deliver to KPs. Finally, the UNAIDS country office also ensures coordination among UN agencies and other partners in the national response to HIV.

Integration of the AIDS response into the health sector

Several activities are being carried out within the MoHP simultaneously, in order to integrate HIV related components into the appropriate health sectors. For instance, the Family Health Division (FHD) and the NCASC have produced national guidelines and standard operating procedures to integrate HIV and Sexual Reproductive Health (SRH) services. A coordination mechanism has also been established to integrate reproductive health services with HIV programmes, and an implementation modality for the transfer of responsibility from NCASC to FHD for the integration of HIV into Maternal and Neonatal Care (MNC) services is being developed. This apart, under the leadership of the Department of Health Services (DoHS); FHD and NCASC are collaboratively working on strengthening the integration of Family Planning and HIV services in HIV service delivery sites. Also worthy to mention in this context is SSP provides integrated family planning and HIV services to KAPs and PLHIV.

“One-stop-shop” has been put into practice where a continuum of services has been pulled together from prevention, treatment, care and support. In this context, a community led NGO in Lalitpur, has been providing, under one roof, a comprehensive range of services notably: STI treatment, HTC, NSP, OST, Directly Observed Treatment, Short-course (TB DOTS), ART, Community Care Center (CCC), and Community Home Based Care (CHBC). It also maintains referral linkages for family planning and other sexual and reproductive health related services. Moreover, by adding an HCV clinic it will also start providing treatment for co-infections of HCV and HIV in 2015. By integrating services from STI Clinics, NSP, OST, TB DOTS, CHBC, and CCCs at an ART site, this NGO is making a significant difference with regard to monitoring of and supporting to ART adherence.

In the context of ART services integration, ART centers have adopted an integrated approach to work on a “one-stop-shop” modality by providing ART including pediatric ART, eVT, STI and HTC services together in most of the ART centers.

HIV recording and reporting system is being integrated into the Health Management Information System (HMIS) and most of the HIV related indicators have been included in HMIS system. Whereas previously, the NCASC and other agencies recorded and stored their data according to their own needs, now HIV related data are integrated and available on an online reporting system. Furthermore, HIV programme reviews will be conducted annually at national and regional levels to inform and refine HIV programme planning. As a result, HIV integration in other health programmes and coordination with other concerned programmes will become more systematized during annual HIV programme planning.

NCASC is gradually transferring its procurement and supply chain management functions to the Logistics Management Division (LMD). The Logistic Task Force oversees the drugs and supply chain of HIV commodities. It is comprised of representatives from WHO, UNICEF, NPHL, LMD, Save the Children, FHI360, and Health for life; and chaired by NCASC. The committee provides its oversight supports on: i) reviewing the stock of HIV/AIDS commodities, ii) quantification and forecasting of the commodities; and iii) the supply of the commodities catering to the needs of service delivery sites. Additionally, it has also been planned that all HIV-related training components will be integrated into the training curriculums of all the different health service providers and will be implemented through the National Health Training Centre (NHTC).

2. National Programme and Achievements

Quality improvement and Capacity Enhancement of Viral Load Testing

The National Public Health Laboratory (NPHL) is the leading organization for the country's laboratory services including enhancing capacity of laboratory personnel and ensuring quality assurance through an external quality assurance system (EQAS) for public and NGO-run HIV testing laboratories. The NPHL and NCASC, with technical assistance from the WHO and logistical assistance from The Global Fund and WHO, carried out a number of initiatives in 2014 with the purpose of capacity and quality enhancement of Viral Load Testing, such as developing a standard operation practice (SOP) to streamline Viral Load Testing for all patients on treatment. Furthermore, NPHL and NCASC recently developed a Viral Load Testing Scale-up Plan for Nepal (2014 to 2018). The capacity of the NPHL was enhanced, in November 2014, from conducting 60-80 viral load tests per month, to 400 viral load tests per month. An HIV Viral Load Testing Referral Database has been designed for the use of ART clinics and the NPHL. This database will be used for monitoring viral load test results. In particular, this will also be used to stipulate follow-up actions that should be taken by the ART clinics for PLHIVs whose viral load is more than 1,000 copies per milliliter.

Legal Literacy Toolkit

A legal Literacy Toolkit was developed for Women Living with HIV in Nepal to improve awareness of, and access to, their legal rights to health. This toolkit was prepared with the involvements of legal experts, KPs, and Women Living with HIV and several development partners including UNDP, UNFPA and UNAIDS. Roll out of this tool kit to the women living with HIV up to the VDC level and also its adaptation to other KP women groups like female who inject drugs, transgender females and female sex workers is urgently needed for the protection and promotion of rights of these key vulnerable women groups.

Expansion of Early Infant Diagnosis (EID) Service Sites

The National Public Health Laboratory (NPHL) is in the process of expanding the service sites of EID from 6 to 20 sites in the near future. In this context, NPHL is getting technical support from SSP, FHI360. The technical support includes oversight from the Regional Office of FHI360 in Bangkok, capacity enhancing of laboratory staff members, and assistance in putting the external quality assurance system (EQAS) in place.

Piloting of Unique Identification Code for tracking patients

The government of Nepal, with technical supports from SSP, FHI360; has implemented a pilot initiative to improve tracking of the patients enrolled in pre-ART and ART, and to retain them on treatment. This system assigns a unique identification code to each patient enrolled for HIV treatment, combined with relevant information about the patient. This initiative is being piloted in one ART site in Kathmandu, namely; Maiti Nepal. Building on the success of this initiative, the government is planning to scale up the Unique Identification Code system for all patients enrolled in all ART sites nationwide in 2015.

IV. BEST PRACTICES

1. Scaling up Monitoring of HIV DR related Early Warning Indicators

National Centre for AIDS & STD Control, Ministry of Health & Population reported that 9,880 PLHIVs were receiving Anti-Retroviral Therapy (ART) from 52 ART clinics by July 2014. Emergence and transmission of HIV drug resistance (HIVDR) is an unavoidable consequence of ART, even when appropriate drugs are prescribed and adherence is maximally supported. It was of paramount importance that National programme embarked on monitoring of HIV Drug Resistance. With the technical assistance from WHO, Nepal has developed its “National Strategy on HIV Drug Resistance monitoring & surveillance – 2014-2020” and a pilot survey of monitoring of Early Warning Indicators (EWIs) was conducted in 3 ART clinics during November – December 2013. During 2014 it was scaled up to 24 ART clinics by training 2 data abstractors from each clinic on EWI monitoring. During this training data abstractors were trained to calculate sample sizes for each indicator, entering data in EWI monitoring software package developed by WHO and preliminary analysis of the data for each ART clinic. By training data abstractors and conducting EWI monitoring in these 24 clinics, EWI monitoring was completed for all the ART clinics in Nepal which initiated ART for PLHIVs during the period 2011-2012.

Out of 5 EWIs complete data was available for only 4 indicators, they are – EWI 1 – On time pill pick up (adults & pediatric), EWI 2 – retention in care, EWI 3 - Pharmacy stock-out and EWI 4 – Dispensing practices.

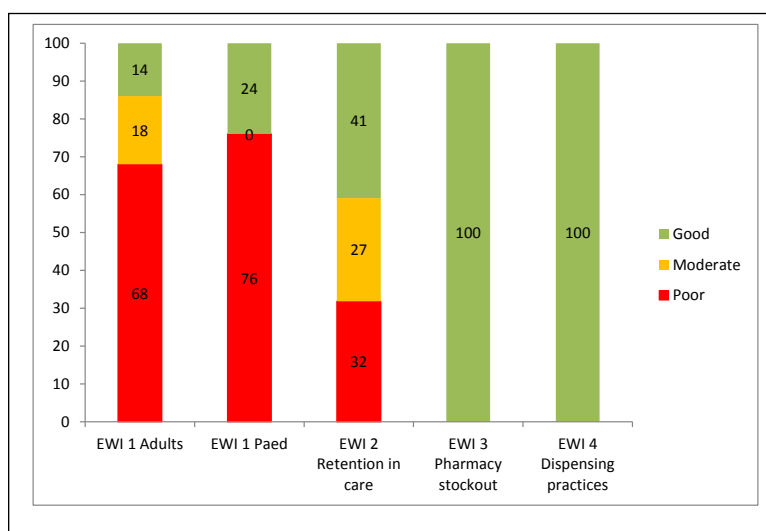


Figure – Summary analysis of the of EWI monitoring for 24 ART clinics

Among the 24 ART clinics only 14% of adults reported on-time pill pick up $\geq 90\%$ and for children it was 24%. Overall on-time pill pick up for pediatric PLHIVs was poor - 76%. 41% of the ART clinics reported that $\geq 90\%$ of PLHIVs retained in their care alive for 12 months. Not a single clinic reported drug stock-out on adults and pediatric formulas during 2011-2012 and dispensing of mono or dual treatment.

2. Saath-Saath Project Festival Campaign 2014 - Urging the Migrant Workers and their Spouses to get Tested for HIV and STI

National HIV/AIDS Strategy 2011-2016 and Nepal HIV Investment Plan (NHIP) 2014-2016 identify migrant workers as one of the Key Affected Populations (KAPs). Migrant workers particularly those traveling to high HIV prevalence areas in India, where they often visit female sex worker (FSWs); are acting as bridging populations to transmit HIV infections to their spouses. The low level of comprehensive knowledge on HIV and AIDS and exposure to HIV programme put them at higher risk. Due to wide dispersion as well as high mobility of the migrant workers, the HIV

programme often face challenges to reach migrant workers, thus there is a need for innovative approaches and activities to reach the migrants.

The USAID-funded Saath-Saath Project (SSP), to cater to the pressing need to reach the migrants workers , planned and successfully implemented the SSP Festival Campaign 2014 from September 22 to October 31, 2014 in the four SSP's migrant focused project districts – Bara, Nawalparasi, Kapilbastu and Palpa. SSP seized the opportunity of the festival seasons *Dasain*, *Tihar*, *Chhat*, and *Bakra-Eid* to raise awareness among the migrant workers and their spouses on prevention of HIV and STI. As numerous migrant workers had returned home to celebrate festivals with their families, the campaign provided an excellent opportunity to reach out to approximately over 15,000 people including migrant workers, their spouses and general public in the four districts. The campaign urged them to get themselves and their families tested for HIV and STI thus was conducted under the tagline: “Get yourself and your family tested for HIV and STI. Enjoy the festival season”.

The series of events that were strategically planned and conducted during the SSP Festival Campaign 2014 in the four districts include display of hoarding board with HIV prevention messages and services sites in strategic locations, outreach sessions with greeting cards, street drama followed by group educational contacts in strategic locations, information, education and communication/behaviour change communication (IEC/BCC) materials stall exhibition, IEC/BCC materials and condom distribution and Public Service Announcement (PSA) airing through different local FM radios.

During the campaign, new collaborations were formed with the Himalayan Bank Limited in Kathmandu as part of SSP's Public-Private-Partnership (PPP) initiative and with International Organization of Migration (IOM)'s Migrant Resource Center (MRC) in Kapilbastu district in an attempt to identify innovative ways to reach out to wider audiences with messages related to prevention of HIV and STIs.

3. Using Geographical Information System (GIS) in HIV Programme in Nepal: A Saath-Saath Project Experience

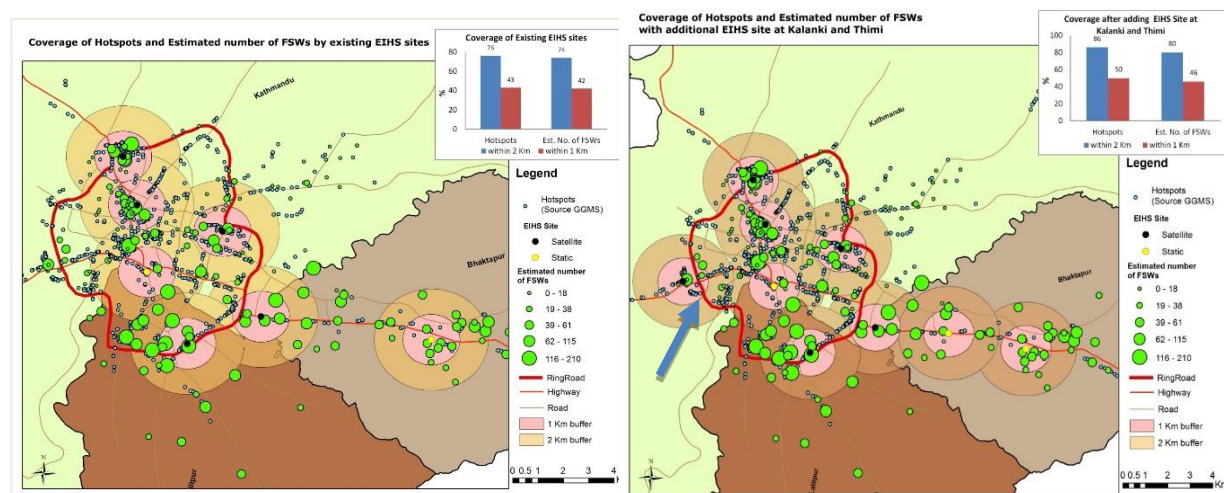


Figure 1: An example of service coverage analysis of HIV service sites in Kathmandu Valley. As a result, two satellite sites were expanded in the strategic locations of the valley

As epidemiology links directly with people and places, using GIS for public health programmes contributes greatly to generate valuable information for improved decision making and rational allocation of resources. GIS products are being used progressively under United States Agency for International Development (USAID)-funded Saath-Saath Project (SSP) and its predecessor. SSP currently uses this mapping technology for decision making and to monitor and present HIV programme results and service coverage. The project has been using geo-enabled reporting of HIV Prevention, STI, VCT and family planning (FP) services and

providing technical support to strengthening the capacity of government and NGOs working in HIV in Nepal.

SSP has been collecting geo-reference data from its expanded integrated health services (EIHS) sites in all working districts. Location information of all SSP- managed EIHS sites are collected either through GPS device or by taking references from Google Earth software. Additional information such as village development committee (VDC) and municipality level outreach coverage details, estimated size of key affected population, location of health facilities, hotspots and geographical boundaries are also compiled.

Following the information collected, a GIS-database is created using information relevant to the project. Data collected through routine reporting is compiled and fed-into the database to generate maps and analyzed extensively before making any decision i.e., to establish additional site, expanding outreach locations, reviewing coverage, presenting to the stakeholders and so on.

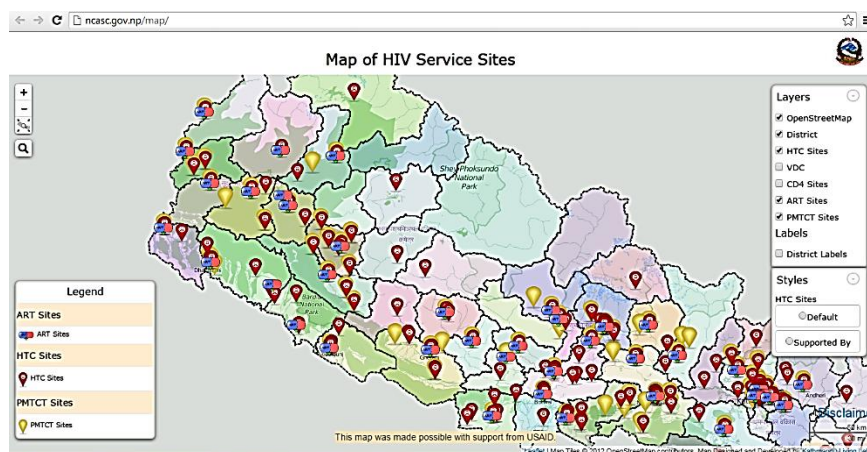


Figure 2: Screenshot of web-map of HIV Service Sites in Nepal. It is available at <http://ncasc.gov.np/map/>

The project has been able to develop a variety of maps that helped perform geo-enabled data analysis and regular reporting. These maps also assist to monitor project progress, identify gaps, and improve overall project performance. A few examples of use of GIS under SSP are mapping distribution of PLHIV and ART sites; coverage of key affected populations and hot-spots by districts, mobility patterns of outreach workers, distance between service sites and beneficiaries, and assessment of service availability. Recently SSP in collaboration with National Centre for AIDS and STD Control (NCASC) developed web-map of national HIV service sites in Nepal which is available in NCASC website for public access. Mapping also provided opportunity to conduct proximity analysis that helped develop strategies to increase service utilization, expand outreach and monitoring progress. In addition, using the institutional experiences, the project explored opportunities to expand the skills of GIS use in HIV programmes at national level for NCASC as well as SSP partner NGOs through two rounds of trainings on Arc-GIS and Quantum GIS software and regular onsite technical support and mentoring.

GIS maps are strong tool used for planning and monitoring of HIV-interventions. Use of geo-spatial information contributes significantly for improved decision-making capacities. It is realized that the interest in the use of GIS increases when it is used for programme designing, planning and monitoring by the programme managers. However, there is need for strengthening skills and advocacy at various levels to realize the importance of incorporating GIS in projects as well as national M&E systems.

4. Clinical Placement for Mid-level Healthcare staff of Antiretroviral Therapy (ART) centers for better clinical management of HIV

In 2014, there were 53 ART centers providing services to over 1,040 People Living with HIV (PLHIV) in the country. Well managed ART centers lead to better outcomes in ART therapy. The majority of ART centers are managed by mid-level health staff, namely Health Assistants, Staff Nurses and Senior Auxiliary Health

Workers (AHWs). This healthcare staffs are responsible for most of the activities of clinical management of HIV including ART. The challenges they face for better clinical management of HIV include human resource and infrastructural challenges including having trained human resource in place. Many of the providers are newly trained and due to high turnover of service providers, they have not had adequate exposure to treating PLHIV. Therefore, in collaboration with NCASC, the USAID-funded Saath-Saath Project (SSP) is providing support to further build capacity of the healthcare service providers, including national level clinical management training, on-site mentoring and coaching, warm-line support, clinical placement and support to the sites by community and home based care (CHBC) teams.

The Saath-Saath Project in coordination with NCASC, developed a package targeting the mid-level health care personnel working in peripheral ART centers, to provide them with a two-week-long clinical placement at tertiary level referral facilities, to enhance their knowledge and skills for clinical management of HIV. A Memorandum of Understanding (MoU) between SSP and Shukraraj Tropical and Infectious Disease Hospital (Teku Hospital) in Kathmandu was signed to provide clinical placement to the staff selected and nominated by NCASC from the peripheral ART centers. The number of participants is three at a time so that each participant gets adequate time for observation, practice and discussion. Teku Hospital being one of the largest ART site in Nepal, the participants benefit from getting exposure in dealing with more clients and learning how to diagnose and treat different Opportunistic Infections among PLHIV.

5. Online Programme Management Information System (OPMIS) for the Global Fund HIV Programme of Save the Children

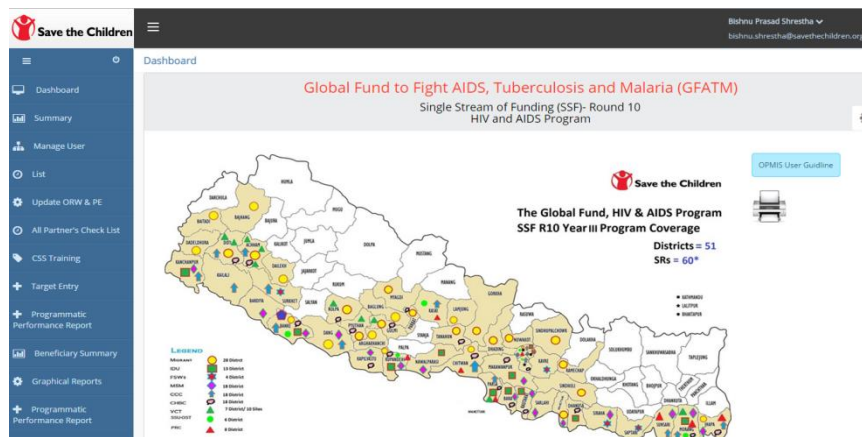
Save the Children has established Online programme management information System (OPMIS) across all programmes including Global Fund HIV & AIDS programme effective from 16th July 2013 (i.e. SSF Year III of phase-I) to all the 70 SR Users managing comprehensive programme for migrants/spouse of migrants, FSWs, PWIDs, CCCs and MSM/TG/MSWs.

The main features of OPMIS is the web based case basis recording and reporting where each SR enters the data in OPMIS using individual username and password. .

There are two distinctive criteria for recording the intervention. *Case recording:* The SRs managing programme for PWIDs, FSWs, MSM/TG/MSW, CCC, CHBC, VCT and STI, records the data for each case with unique client code generation. *Cumulative recording:* The SRs managing programme for migrants and spouse of migrants, the SRs record the monthly total reached by OWs, CMs and PEs.

In case of meeting, training, workshop and orientation, the SRs records the name of the participants with specific date/time and venue of such events.

The SRs submits the OPMIS monthly report online to the respective focal person in the region and after the verification, the focal person submits that to Deputy COP. Once it is submitted the data is automatically locked but the Save the Children staffs, auditors and LFA can access the report of all the SRs for any period and component.



This has resulted in an efficient data reporting and feedback system, verification process, resulting in lesser errors and level of effort, quicker data management and analysis.

6. Cash transfer support for children living with HIV

Social protection is recognized for its capability to address HIV related vulnerabilities, especially among children. From April 2014, Save the Children with the support of GFATM started cash transfer programme in 45 districts based on the endorsed CABA Operating Guideline 2070. As of 15 December, 2014, 1,090 children living with HIV (CLHIV) have been receiving monthly NRs. 1,000/= cash. A majority of HIV positive children (64%) enrolled in cash transfer were orphaned by HIV & AIDS, of which nearly 20 percent had both their parents deceased. Around half of all children enrolled in cash are aged between 6 to 12 years.

The main objective of the cash transfer programme is to increase the quality of life of children living with HIV and to reduce HIV related morbidity and mortality in Nepal. This programme is linked with other care and support services in the district to maximize its effectiveness. In absence of any national social protection programme for people living with HIV, this is a timely intervention which has had some visible outcomes. In specific, the scheme has played an important role in improving treatment outcomes and adherence among children and in addressing the priority needs of children, especially nutrition, health and education of children.

7. Community-based Prevention of Mother to Child transmission of HIV services in Nepal

Since 2009, UNICEF Nepal, FHI360 and other partners have supported the MoHP to provide and expand community-based PMTCT services. As per Nepal HIV Investment Plan (NHIP), it is envisaged that the vertical transmission of HIV will be eliminated and that mothers will be kept alive and well: eVT. In the mountainous district of Accham, access to eVT services have been improved by offering HIV testing in ANC at lower level health posts, through the support of Female Community Health Volunteers (FCHVs) and Community Home Based Care (CHBC) teams. As a result, women living with HIV receive counselling, adherence support, commodities such as condoms, iron pills and tetanus vaccines, and more children are born HIV free. Since 1988, Female Community Health Volunteers (FCHVs) have been instrumental to Nepal's community-based primary health care system and bridging the gap between health services and the needs of community members. Decentralizing services such as PMTCT services to such community-based support has been effective and even necessary in the context of Nepal. Some other innovative approaches were launched in 2014 aiming at expanding the services of HTC, such as community-based campaigns for "HIV testing at Street" and "HIV testing at festivals" in Kathmandu.

V. MAJOR CHALLENGES AND REMEDIAL ACTIONS

Strategic information reveals that although the prevention coverage (number of HTC sites) in Nepal is increasing, the utilization of HIV testing and STI services, however, is reportedly low. Due to inadequate coverage of HTC, ART coverage is only meeting a fraction of the estimated people who need it. Interviews with MSM, TG, TG SW, and MSW indicate that prejudice and discriminatory attitudes were prevailing at health service delivery points and were hindering factors for them in accessing health care services, especially regarding seeking STI treatment. Important gaps in the provision of accessible testing facilities for migrant workers, PWID, MSM, and SW can be filled by a more prominent involvement of the communities themselves who can link KPs to the appropriate health services. The roll out of Community based testing (CBT) is expected to expand the coverage range of HTC and the ART coverage too. Another challenge is the timely disbursement of funds, as consultations with relevant stakeholders of targeted interventions implemented through the Pooled Fund for MSM, TG, TGSW, MSW, and their clients, showed that frequent interruptions of payments and delayed payments further disrupted HIV prevention services.

Consultation with relevant stakeholders revealed that the clinical services for FSWs are designed to serve in places with higher concentration of FSWs in a defined area. There are provisions of static and satellite clinics. Even with these provisions, there are places in highway districts where FSWs are scattered along the stretch, for some of them visiting the clinics for regular follow up is a challenge due to travel distance and time.

Consultation meeting revealed with FSWs that service delivery to them also gets disrupted especially after law enforcing agencies' take actions against FSWs. For illustration; police raids against FSWs invariably force them to flee their sites of operation imposing a challenge to service providers of tracing them again for the resumption of services delivery.

The current OST programme implemented in 12 OST sites (6 MMT and 6 Buprenorphine) is also grappling with problems of low uptake and low retention rates for a number of reasons such as accessibility to the available sites, a lack of strategic communication, inadequate unified medical and social services, insufficient incentives for retention, and an absence of female-friendly services. A major step will be to expand OST sites to more strategic locations along with addressing above mentioned challenges.

Though HIV prevalence among PWID has remarkably decreased, high prevalence of viral hepatitis has been observed among PWID and in particular among those co-infected with HIV. Addressing diagnostic challenges has become a major issue in the management of TB-HIV co-infections as well. Co-infections of Viral hepatitis among PWID living with HIV and co-infection of TB among people living with HIV in general, have to be systematically addressed.

VI. SUPPORT FROM THE COUNTRY'S DEVELOPMENT PARTNERS

Most of the resources for the national response to HIV in Nepal come from external sources (bilateral, multilateral, and INGOs). Among external development partners GFATM, USAID, and GIZ have been the main contributors. UN agencies, the Pooled fund partners of NHSP-IP II (the World Bank, DfID, AusAID, and KfW) are also external sources that are contributing to the national HIV response. Other partners include Care International, AIDS Health Foundation (AHF) and Family Planning Association Nepal (FPAN), which are also contributing to the national response to HIV.

The GFATM, also referred to the Global Fund is working in the area of HIV, TB, and Malaria. As a key partner of the national response to HIV, the Global Fund is supporting the country's HIV interventions for all KPs (e.g. MSM, MSW, TG, FSW, Migrants and PWID). It is the only source for all the major commodities of HIV services which include ARVs, test kits, and laboratory equipment. Additionally, it has also been providing its financial support with the purpose of strengthening the capacities of government and key organizations, including civil societies. During the reporting period, Global Fund has implemented a programme through the MoHP and Save the Children, where the MoHP is responsible for Treatment Care and Support interventions and Save the Children is responsible for prevention interventions focusing on KPs.

USAID has been a long standing partner in the national response to HIV since 1993. It contributes directly to Nepal's National HIV and family planning (FP) responses, and the USAID Nepal Country Development Cooperation Strategy. USAID is currently implementing its five year HIV and FP intervention, through "Saath-Saath Project (SSP)", since October 2011. The project aims to reduce the transmission and impact of HIV and improving reproductive health among selected key populations. The project works in partnership with the Government of Nepal at both the national and local levels, to provide HIV prevention, care, support, and treatment services along with FP services to key populations (FSWs and their clients, migrant workers and their spouses and PLHIV) in 33 districts across Nepal. SSP is managed by the FHI360 Nepal and works with the Association of Medical Doctors of Asia as a core partner, as well as more than 40 local NGO partners and national networks.

The Pooled fund - working under the auspices of the Sector Wide Approach (SWAp) and comprising funds from government as well as external resources, including the World Bank, KfW, AusAID, and DFID – has been supporting the national response through NHSP-IP II until December 2014, with some components extended to 2105. The Pooled fund's contribution to the national response comes as a part of NHSP-IP II, in which the Pooled funding partners i.e., KfW, AusAID, and DFID, committed USD 19 million for a period of five years for the activities ranging from supporting the implementation of targeted intervention programmes to strengthening the national surveillance system. Furthermore, currently next NHSP-IP III is under development which can continue ongoing HIV services.

The Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) is another bilateral donor which has been supporting the National Opioid Substitution Therapy (OST) programme in Nepal. The GIZ along with GFATM is also providing its support for setting up a system in place for diagnosis and treatment of viral hepatitis primarily for managing co-infections of HCV among PWID.

The UN agencies have been key partners in supporting the HIV response in Nepal from the early days of the epidemic in diverse areas notably; preparing a national strategy; size estimation of key affected populations; contributing to elaborating guidelines and directives; and expanding services related to the elimination of vertical transmission. The main activities they supports for this reporting period are: preparation for HIV Viral Load Testing Scale-up Plan 2014-2018, technical support in scaling up monitoring of HIV Drug Resistance; development of National Consolidated Guidelines for Treating and Preventing HIV in Nepal, and Epidemiological Analysis of HIV in Nepal.

AIDS Healthcare Foundation (AHF) Nepal has been working with the government of Nepal, civil societies and affected communities for devising public health interventions to promote “stay negative, test and treat” campaign and also to provide access to treatment and care services for PLHIV. In this context, with the aim of increasing access to treatment and care services, AHF Nepal is working with different ART centers at Kathmandu, Chitwan, Rupandehi and Kailali districts. One of the focuses of this foundation is to build capacity of health care workers include doctors and nurses.

VII. MONITORING AND EVALUATION ENVIRONMENT

An overview of the Strategic Information System

The strategic Information System for the HIV Response in Nepal entails three components: a) second generation surveillance, b) programme monitoring and evaluation; and c) strengthening HIV research for the informed planning and reviewing of the national response. The Strategic Information Unit at NCASC functions with the responsibility of: i) monitoring the case reporting of HIV and STI, ii) conducting HIV surveillance, behavioral surveillance and STI surveillance, population size estimation of high risks populations; and iii) carrying epidemic analysis and modeling for improved understanding of the HIV epidemic for public health actions. Moreover, the Programme Monitoring and Evaluation section of SI Unit at NCASC monitors the interventions of HIV prevention, treatment, care and support to track the progress against the targets stipulated by the NSP.

Case reporting of HIV and STI

Routine reporting of HIV and STI from HTC and eVT sites as well as other service sites are being done on a monthly basis and analyzed regularly to keep a close watch on the HIV situation among different KPs. A five-day training event on “STI and HIV Surveillance in Nepal” was organized from May 15 to 19, 2014 for a total of 19 HIV focal points from districts and regions with the aim of improving HIV Surveillance System. NCASC also organized a workshop on May 27-29, 2014 with the objective of reviewing and updating the recording and reporting templates of routine programme monitoring of HIV/STI prevention and treatment among KPs.

Integrated Biological and Behavioral Surveillance (IBBS)

IBBS is one of the major sources of strategic information for HIV response in Nepal. Nepal has been conducting IBBS among KPs since 2002, in various regions of the country. Nepal is currently in the process of conducting the next round of IBBS studies to the following key populations in order to fill the current information gaps:

- 1) People who Inject Drugs (PWID-Male) in Kathmandu Valley
- 2) People who Inject Drugs (PWID-Male) in Pokhara Valley
- 3) People who Inject Drugs (PWID-Male) in Eastern Terai Highway Districts (Jhapa, Morang and Sunsari)
- 4) Men who have sex with Men (MSM) and Transgender in Kathmandu Valley
- 5) Male Labor Migrants (MLM) in Western (Syngja, Kaski, Gulmi, Palpa, Kapilvastu), Mid to Far Western Regions (Banke, Surkhet, Doti, Accham, Kailali, Kanchanpur)
- 6) Female Sex Workers in Kathmandu valley

IBBS is conducted in every two to three years depending on the key population; however Nepal is exploring and planning to set up surveillance sites to track the required information as an alternative method.

HIV Drug Resistance monitoring

Building on a pilot survey monitoring Early Warning Indicators (EWIs), conducted in 3 ART clinics in 2013; Nepal scaled up the monitoring of EWIs up to 24 ART clinics by training 2 data abstractors from each clinic on EWI monitoring in 2014. The monitoring of EWIs is based on the “National Strategy on HIV Drug Resistance monitoring & surveillance (2014-2020)”.

HIV Infection Estimations and Projections

HIV Infections Estimation for the year 2013 for Nepal was updated in April 2014, with the technical support from development partners, and based on available data. Previously, Nepal has been using the Spectrum/Estimation and Projection Package (EPP) model for HIV Infections Estimation. However, this year Nepal applied AIDS Epidemic Model (AEM) which also analyzes factors affecting behavior, social,

cultural and economic aspects of the country while estimating the infections. The model also provides a projection of the resources need in response to the epidemic.

Programme Monitoring and Evaluation (M&E)

Monitoring and evaluation of the national response to HIV involves the structural arrangement of Programme Monitoring and Evaluation section of SI Unit at NCASC that is tasked with monitoring the interventions of HIV prevention, treatment, care and support to track the progress of the national response. Further in the context, National Guidelines on Monitoring and Evaluation of HIV Response (2013) provides the guiding framework for monitoring and evaluation. Premised upon these arrangements, NCASC sets up a system of monitoring on its regular programmes through monthly and bimonthly reports, regular field visits to sites for supportive monitoring, and comprehensive annual review of programmes by districts. This apart, it also conducts external reviews (mid-term review, terminal review and assessments) with the objective of tracking the progress of national response. The apart, SSP, Save the Children and Pooled fund have put in place their own stringent systems of monitoring and evaluation of their respective programmemes.

Mainstreaming HIV recording and reporting into greater Health Information System has seen further progresses in 2014. Apart from the integration of most of HIV related indicators in previous years, all HIV-related service reporting into the revised HMIS was incorporated in 2014. Further in this context, service delivery points have been reporting directly to the HMIS system since July 2014.

Two-day training on Data Quality Assurance (DQA) was conducted from March 6-7, 2014 with the participation from 22 DACC coordinators. Several events of one-day Data Validation Workshops were organized in all 75 districts with the aim of validating data from district level stakeholders including NGOs and government sites. These workshops were conducted with the purpose of providing validated data into regional reviews in the four regions, during June and July 2014.

Research/ Assessment

Isoniazid Prevention Therapy (IPT) was implemented in 5 ART clinics as a pilot project during 2013. An assessment of the pilot IPT programme was carried out in July 2014. Based on the findings, the government has planned to scale up IPT to other ART clinics nationwide.

Likewise, a study supported by GIZ and executed by CMDN, analyzed the inter-relations of risky behaviors, status of HIV, and viral hepatitis B and C, among 412 PWID in three regions: Mid-western Terai (Nepalgunj), Eastern Region (Dharan, Biratnagar) and Central Region (Kathmandu, Lalitpur and Chitwan) of Nepal. The main objective was to enhance knowledge on the prevalence of viral hepatitis among PWID in Nepal.

In addition, an HIV epidemiological analysis was conducted in 2014, with support from the WHO, to analyze the epidemic's scenario and preparing the HIV concept note to be submitted to the Global Fund. Following this analysis, a "Technical Report on the Epidemiological Analysis of HIV in Nepal & the Way Forward of NCASC" was prepared with recommendations for further programming and planning.

Challenges and Remedial Actions

Evidence Gaps

Review of the National Response to HIV in Nepal 2013 and other studies have pointed out relevant knowledge gaps and more studies are needed in order to inform the planning of the national response. Some key assessments recommended by the Mid-term review and other similar studies are as mentioned below.

- Update HIV expenditure (last study: NASA 2007, and RTS in 2010);

- Explore and conduct studies among emerging populations (uniformed services, people on tourist/trekking routes, migrants to destinations other than India, women who inject drugs);
- Bio Behavioral study among the prison population, female drug users and MSM and TG outside Kathmandu Valley;
- Study on Attitudes of health care workers towards PLHIV;

Size estimation

Size estimation has not been conducted since 2011, although the National surveillance guideline recommends conducting once in every 3-5 years. For overcoming the information gap Nepal is planning to conduct the size estimation of KPs (FSW, MSM and PWID) in 2015 through the support of Global Fund.

Transition of HIV information to HMIS

Recently, the HIV information system has been integrated into HMIS. The integration is being done to streamline all the recording and reporting systems into one national health management information system. However, the integration of HIV information system into HMIS has brought about a number of changes including in reporting lines and data entry procedures. As a result of these changes, HIV related information is yet to be comprehensively reflected in the HMIS. Some efforts such as training to data collectors, and monitoring and coaching to sites are also needed.

VIII. REFERENCES

- Central Bureau of Statistics (2012). National Census Report 2011, Kathmandu.
- Central Bureau of Statistics/ Ministry of Home Affairs (2013). Survey on Current Hard Drug Users in Nepal 2069, Kathmandu Nepal.
- HSCB/NCASC (2011). Mapping & Size Estimation: Most at risk Populations: Volume I,II and III
- MoHP/New Era (2012). National Demographic and Health Survey 2011, Kathmandu Nepal.
- NCASC (2011). National HIV/AIDS Strategy Plan 2011-2016, Kathmandu Nepal
- NCASC (2013). National Country Progress Report 2012, Kathmandu Nepal
- NCASC (2013). National Estimates of HIV Infections, 2012, Kathmandu Nepal
- NCASC (2014). National Estimates of HIV Infections, 2013, Kathmandu, Nepal
- NCASC (2013) 2013 Mid-Term Review of the 10 Targets and Elimination Commitments: Nepal Country Report, Kathmandu Nepal
- NCASC. 2012. Integrated Bio-behavioral Survey (IBBS) among Men who have Sex with Men in and Transgender Population in the Kathmandu Valley. Round-IV, Kathmandu, Nepal,
- NCASC. 2012. Integrated Biological and Behavioral Survey among Female Sex Workers covering 22 Districts of Nepal, Round-V 2012. Kathmandu, Nepal,
- NCASC/Save the Children (2011) Integrated Biological and Behavioral Surveillance Survey among Male labor Migrants in Mid and Far Western Regions Round-3, 2010
- NCASC (2012) Integrated Biological and Behavioral Surveillance Survey, 2012, Kathmandu Nepal
- NCASC (2013). The Nepal HIV Investment Plan 2014-2016, Kathmandu Nepal
- NCSAC (2013). Review of the National Response to HIV in Nepal: May - June 2013, Kathmandu Nepal
- NCASC (2014). EPI Factsheets (1-8)
- NTC (2014) Annual Progress Report on TB/HIV co-infection in FY 2071-2072
- Poudel KC et al. 2013. Coinfection of Hepatitis C Virus among HIV-Positive People in the Kathmandu Valley. 2013
- USAID/NCASC. 2011. Integrated Biological and Behavioral Survey among Female Sex Workers, Pokhara Valley, Round-IV 2011. Kathmandu, Nepal
- USAID/NCASC. 2011. Integrated Biological and Behavioral Survey among Female Sex Workers, Kathmandu Valley, Round-IV 2011. Kathmandu, Nepal,
- USAID/NCASC. 2011. Integrated Biological and Behavioral Survey among Female Sex Workers, Kathmandu Valley, Round-IV 2011. Kathmandu, Nepal, HIV and STI Control Board/NCASC. 2011. Mapping & Size Estimation: Most at risk Populations: Volume III, MOHP/New ERA/ICF International Inc. (2012). Teku, Kathmandu: HSCB/NCASC
- UNAIDS (2011). Migration and HIV Related Risk and Vulnerability among Migrants from Nepal, Kathmandu, Nepal

UNDP et al (2013). Sex work and violence in Kathmandu, Nepal: Understanding factors for safety and protection (Draft report 2013)

UNODC/Ministry of Home Affairs (2011). Profile, Drug Use Pattern, Risk Behavior & Selected Bio-Markers of Women Drug Users from Seven Sites in Nepal, Kathmandu Nepal

WHO (2013). Consolidated Guidelines on the use of Antiviral drugs for treating and preventing HIV. Geneva

WHO Regional Office for South East Asia (2013). TB/HIV in the South- East Region: A status Report, New Delhi India