

Asia-Pacific

Country Reviews September 2011

NEPAL AT A GLANCE

Total population (thousands)	29,853 (2010) ¹
Annual population growth rate	1.7% (2010-2015) ¹
Population aged 15-49 (thousands)	15,437 (2008) ²
Percentage of population in urban areas	19% (2010) ³
Crude birth rate (births per 1,000 population)	25.4 (2008) ⁴
Under-5 mortality rate (per 1,000 live births)	51 (2008) ⁵
Human development index (HDI) - Rank/Value	138/0.428 (2010) ⁶
Life expectancy at birth (years)	67.5 (2010) ⁶
Adult literacy rate	57.9% (2005-2008) ⁶
Ratio of girls to boys in primary and secondary education (%)	82 (2002) ⁴
GDP per capita (PPP, \$US)	1,154 (2009) ⁴
Per capita total health expenditure (Int.\$)	53 (2007) ⁵

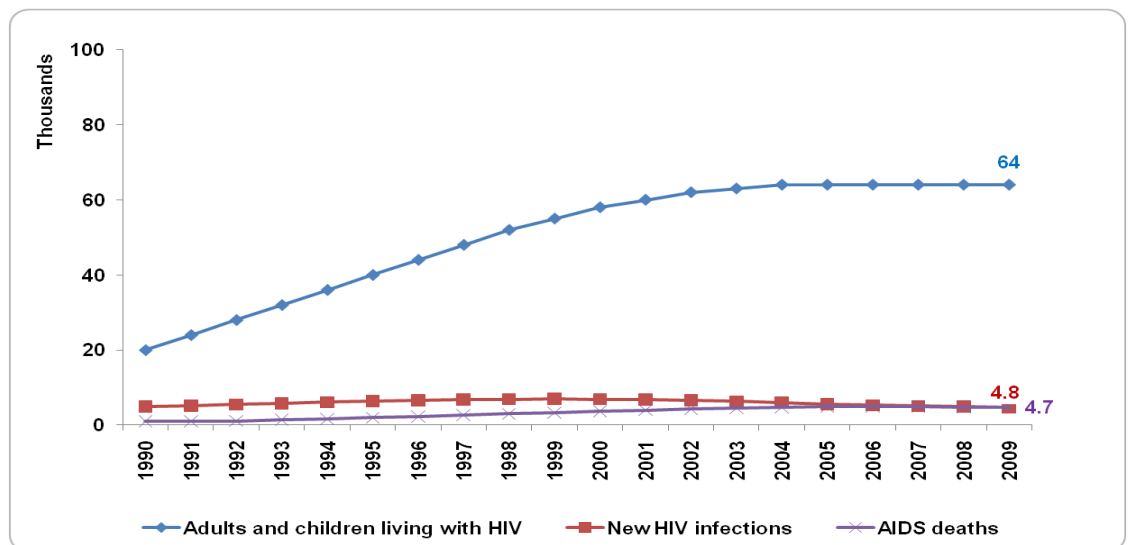


HIV EPIDEMIOLOGY AND TRENDS

Since the first case of AIDS was reported in 1988, HIV in the country has evolved from a “low” to a “concentrated” epidemic. According to 2010 UNAIDS Report on the Global AIDS Epidemic, by the end of 2009 an estimated 64,000 [51,000 – 80,000] adults and children (up from 60,000 in 2001) were living with HIV of which 20,000 [16,000 – 25,000] were women 15 years and older. In addition, there were an estimated 4,800 [2,700-7,800] people newly infected with HIV and 4,700 [3800 – 5700] deaths due to AIDS in 2009, up from 4,000 in 2001 (Fig. 1).⁷

A total of 17,058 cases of HIV had been reported by 15 December 2010 to the National Centre for AIDS and STD Control (NCASC).⁸ The sex ratio among people living with HIV and AIDS was nearly 3:1 (male: female).⁹ Almost 50% of the total HIV infections were recorded along the highway districts across the country.⁹

Figure 1: Estimated number of adults and children living with HIV, new infections and AIDS deaths, 1990-2009

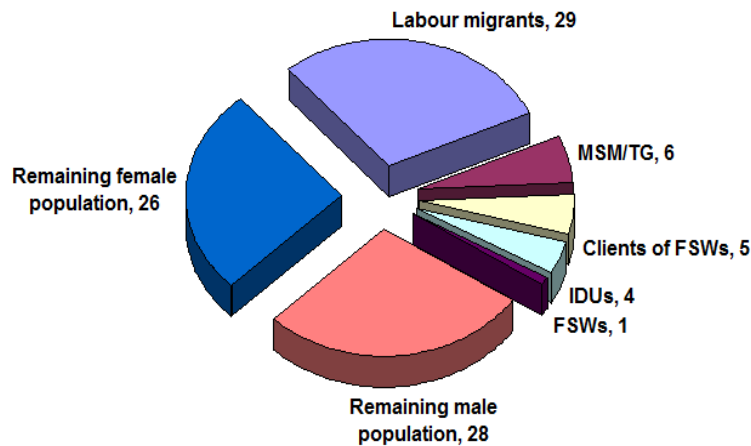


Source: Prepared by www.aidsdatahub.org based on UNAIDS, Report on the Global AIDS Epidemic, 2010

WHO IS AT RISK OF HIV INFECTION IN NEPAL?

According to the NCASC, as of 2009, an estimated 29.4% of all HIV infections occurred in labour migrants (Fig. 2). MSM accounted for an estimated 6.2% of HIV infections in 2009, followed by clients of FSWs at 5.0%. In addition, ‘low-risk’ male and female populations accounted for 26.2% and 28% of HIV infections, respectively, due to their disproportionately larger population sizes.¹⁰

Figure 2: Percentage distribution of estimated HIV cases by key affected population, 2009



Source: NCASC, National Estimates of HIV Infection 2009 Nepal, 2010

Given the diversity of the country's geography, the HIV and AIDS epidemic is concentrated among key affected populations – injecting drug users, female sex workers and their clients, and men who have sex with men – to varying degrees in different regions, zones and districts. Table 1 summarizes HIV prevalence among key populations at higher risk, as determined by Integrated Biological and Behavioural Surveillance (IBBS) survey results from 2002 to 2010. Commercial sex and the sharing of unclean needles by injecting drug users were found to be the major drivers of the HIV epidemic in the highways and major towns, while migration of people to India and other countries is the primary risk factor in selected hill districts.

Table 1: HIV prevalence among key affected populations, 2002-2010

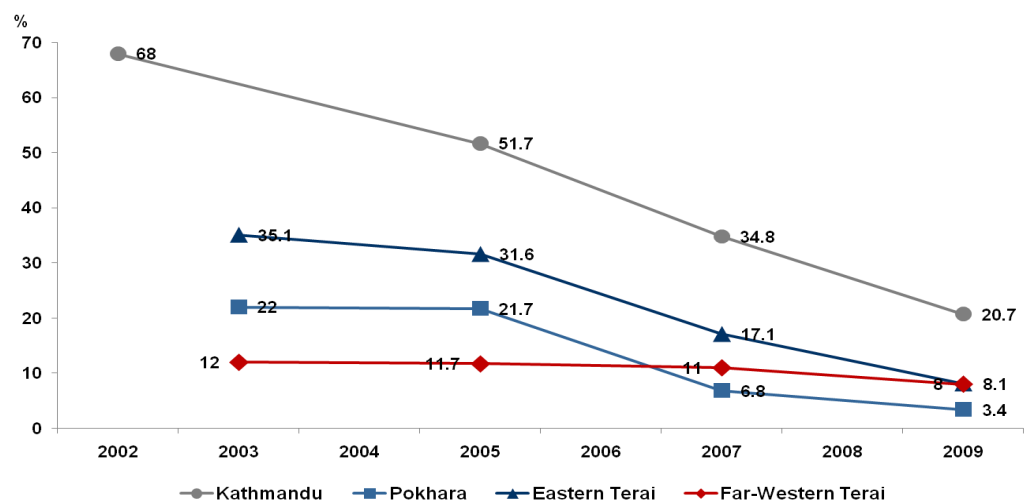
Population	Location	2002	2003	2004	2005	2006	2007	2008	2009	2010
FSWs	Kathmandu			2.0		1.4		2.2		
	Pokhara			2.0		2.0		3.0		
	22 Terai districts			2.0		1.5			2.3	
Clients of FSWs (Truckers)	Terai districts			1.8		1.0			0.0	
IDUs	Kathmandu	68.0			51.7		34.8		20.7	
	Pokhara		22		21.7		6.8		3.4	
	Eastern Terai		35.1		31.6		17.1		8.1	
	Western Terai				11.7		11.0		8.0	
MSM	Kathmandu			3.9			3.3		3.8	
MSW	Kathmandu			4.8			2.9		5.2	
Male labour migrants	Mid- and Far-Western districts					2.8		0.8		4.5
	Western districts					1.1		1.4		
Spouses of Migrants	Far West districts							3.3		0.8

Source: NCASC (2010) National estimates of HIV Infections, 2009 (cited from many rounds of IBBS surveys from 2002-2009 among sub-population groups in Nepal).

Injecting drug users

In 2009, Nepal reported more than 28,439 injecting drug users.¹¹ In 2009, HIV prevalence among IDUs was 20.7% in Kathmandu, 8.1% in Eastern Terai, 8% in Far-Western Terai and 3.4% in Pokhara Valley.¹⁰ Each of these figures reflects the steady decline in prevalence among IDUs over the all rounds of IBBS (Fig. 3). HIV prevalence is much higher among older IDUs, aged 25 years and above (33.4%) compared to those below the age of 25 (7%).⁷

Figure 3: Trends in HIV prevalence among IDUs in specific regions, 2002-2009



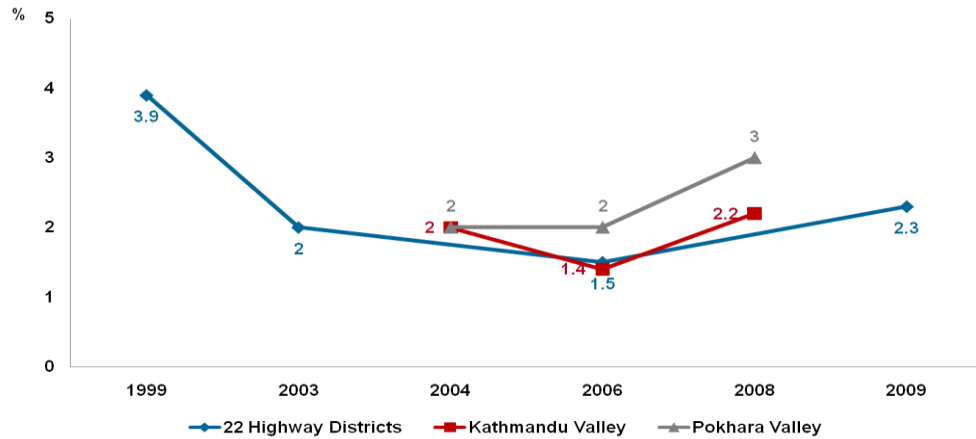
Source: Prepared by www.aidsdatahub.org based on Integrated Biological and Behavioral Surveillance Surveys among IDUs in Nepal (IBBS: 2002-2009)

Between 2005 and 2006, the United Nations Office on Drugs and Crime, Regional Office for South Asia (UNODC ROSA) carried out a rapid situation and assessment of HIV-related risk behaviours, adverse health consequences, knowledge, and attitudes relating to HIV & AIDS among drug users and their regular sex partners.¹² Nepal was one of five countries in South Asia included in the study. Assessment findings showed that of 1,330 drug user respondents, 66% were between the ages of 31-40 years, 33% were married and 5% were illiterate. In terms of injecting drug use, 80% had injected drugs, 79% of whom were current injectors with twice a day as the median frequency of injecting.

Female sex workers

As of 2009, there were an estimated 32,137 female sex workers in Nepal, most of who are either establishment-based or home-based.^{9: 10} HIV prevalence among female sex workers is currently low (Fig. 4). HIV prevalence among this group was 2.3% in Terai Highway Districts as of 2009, and 2.2% in Kathmandu and 3% in Pokhara as of 2008.^{13: 14: 15} HIV prevalence was 4.7% among FSWs aged 25 years and older, compared to 0.7% among younger FSWs.¹⁶

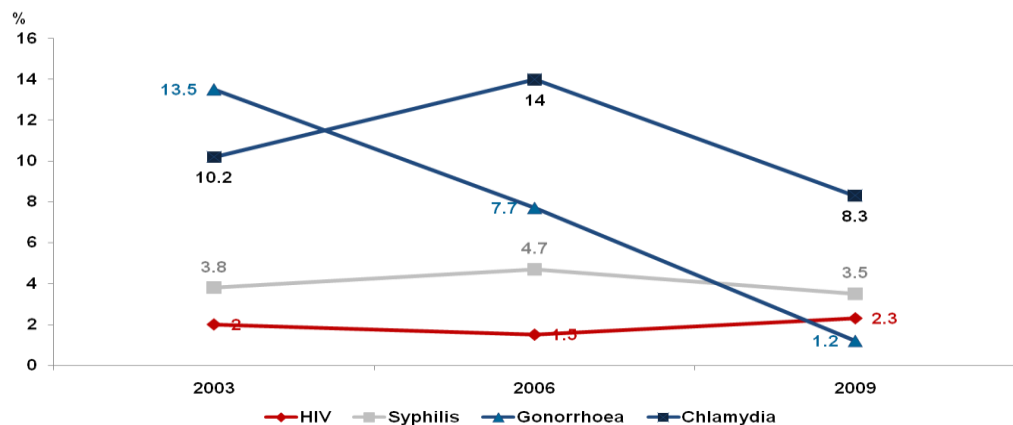
Figure 4: Trends of HIV prevalence among female sex workers in specific regions, 1999-2009



Source: Prepared by www.aidsdatahub.org based on Integrated Biological and Behavioural Surveillance Surveys among Female Sex Workers in Nepal (IBBS: 1999-2009)

Prevalence of other sexually transmitted infections was on the decline after 2006, but remains high (Fig. 5). Notably, in 2009, prevalence of Chlamydia was 8.3%, syphilis was 3.5% and gonorrhoea was 1.2%.¹³

Figure 5: Trends of HIV and STI prevalence among FSWs, 22 Highway Districts, 2003-2009



Source: Prepared by www.aidsdatahub.org based on Integrated Biological and Behavioural Surveillance Surveys among Female Sex Workers 22 Highway Districts (IBBS: 2003-2009)

According to national estimates, 727,421 males are clients of FSWs.¹⁰ In Nepal, truckers, drivers and transport workers are used as proxies for clients of FSWs. HIV prevalence among truckers in 22 highway districts was found to have declined from 1.8% in 2003 to 1% in 2006 and 0% in 2009.^{17; 18}

A major challenge to controlling HIV in the country is the trafficking of Nepali girls and women into sex work in India, and the potential risk of 're-engaging' in the practice after returning to Nepal.¹⁹ A major challenge to controlling HIV in the country is the trafficking of Nepali girls and women into sex work in India, and their return to the practice in Nepal. One 2006 study of 287 repatriated girls and women reported being trafficked from Nepal for sexual exploitation found that HIV prevalence was 38% among the group.²⁰ Most (49%) had been trafficked before the age of 17, and most (58%) were trafficked to Mumbai.

In a study of existing and emerging patterns of sex work in Nepal, it was found that sex work among women is broadly classified as either establishment-based or street-based.²¹ Although there are regional variations, most sex workers are reported to be in the range of 20-25 years old, have stayed in sex work for an average of 2-3 years, have been or are married, have two or three dependents and hold another job, which is often low paying.²¹

Men who have sex with men

MSM at a glance

HIV prevalence ^{9: 22: 23}	<ul style="list-style-type: none"> HIV prevalence among MSM in Kathmandu in 2009 was 3.8% - up from 3.3% in 2007 and 9.5 times higher than the adult national prevalence of 0.4%. MSM account for an estimated 6.2% of all HIV infections (NCASC, 2009). Prevalence of gonorrhoea was 12.5%, of Chlamydia was 5% and of active syphilis was 1.5% in Kathmandu in 2009.
Selected behaviours (2009) ²³	<ul style="list-style-type: none"> 75% of MSM reported the use of a condom the last time they had sex with a male partner. 64% of MSM had comprehensive HIV knowledge; 42% had been tested for HIV in the past year and knew the result.
National response ²³	<ul style="list-style-type: none"> 77% of MSM were reached by HIV prevention programmes in 2009 as compared to 47% in 2007 and 10% in 2004; Nepal does not have laws that criminalize male-to-male sex; MSM are formally and informally organized through social groups, NGO/CBO, and networks. The National Action Plan 2006-2011 recognizes MSM as a most-at-risk population and proposes a comprehensive approach in HIV interventions among MSM. There is a specific budget line for MSM in the National HIV plan and 6.2% (USD 550,000) of the total spending on HIV and AIDS was allocated for MSM in 2007. Supreme Court of Nepal ruling provides for national citizenship cards to include a third – transgendered - category²⁴

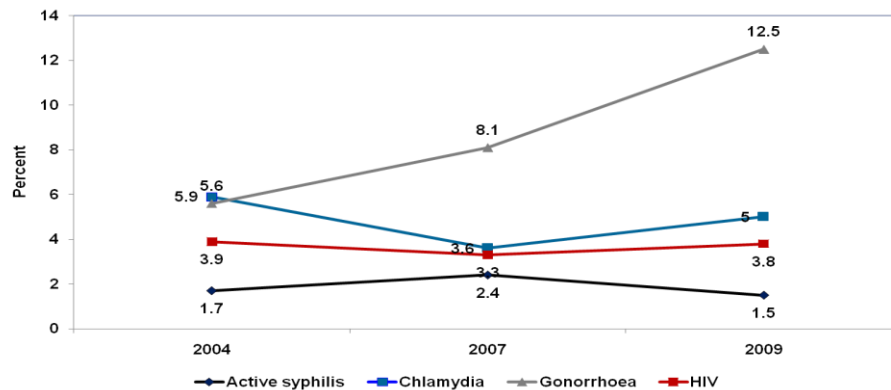
In 2009, the third round of the IBBS among men who have sex with men (MSM) and male sex workers (MSW) was conducted in Kathmandu. Overall HIV prevalence was found to be 3.8% among MSM (up from 3.3% in 2007) and 5.2% among MSW (up from 2.9% in 2007) (Fig. 6).²³ As was the case with IDUs and FSWs, HIV prevalence among MSM was higher among those aged 25 and above (6.8%) as compared to younger MSM (1.3%).²³ Similarly, among MSWs, HIV prevalence was 9.1% among those aged 25 years and above and 5.2% among those younger than 25 years of age.²³ Other sexually transmitted infections were also common among all MSM in Kathmandu: 12.5% for Gonorrhoea, 5% for Chlamydia and 1.5% for active syphilis (Fig. 7).²³

Figure 6: Trends of HIV prevalence among MSM and male sex workers in Kathmandu valley, 2004-2009



Source: Prepared by www.aidsdatahub.org based on Integrated Biological-Behavioural Surveillance Surveys among MSM and Male Sex Workers Kathmandu Valley, Rounds I to III, 2004-2009

Figure 7: Trends of HIV and STIs prevalence among MSM, Kathmandu valley, 2004-2009

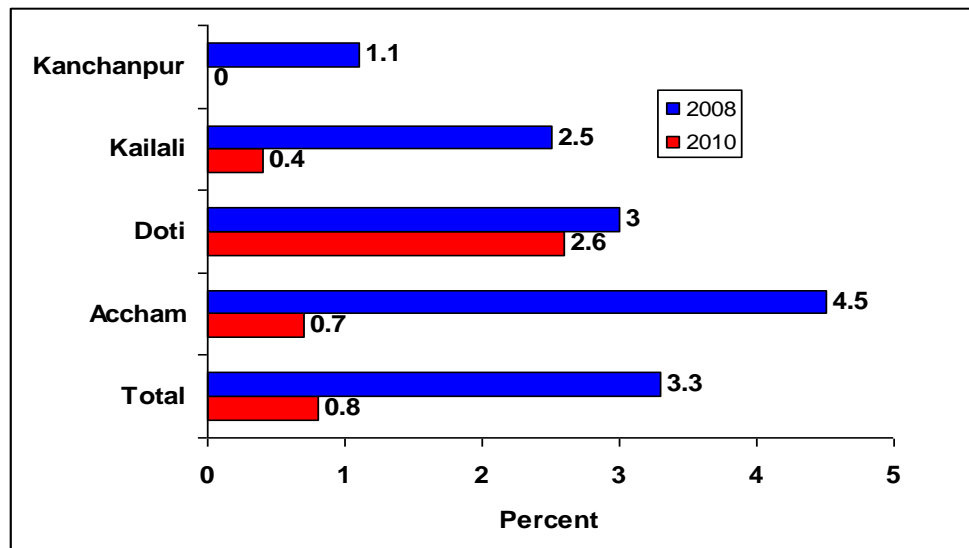


Source: Prepared by www.aidsdatahub.org based on Integrated Biological and Behavioural Surveillance Surveys among MSM and Male Sex Workers Kathmandu Valley, Rounds I to III, 2004-2009

Mobile populations and their partners

According to the 2010 IBBS, HIV prevalence among migrant males was 1.5% in Mid- to Far Western districts²⁵, up from 0.8% in 2008, and from 2.8% in 2006 and 1.4% in Western Districts (up from 1.1% in 2006).²⁶ Notably, prevalence among spouses of migrant males in four districts of Far-Western Nepal was substantially lower at 0.8% in 2010 as compared to 3.3% in 2008 (Fig. 8).²⁷

Figure 8: HIV prevalence among wives of migrant labourers in 4 districts of Western Region, 2008 and 2010



Source: Prepared by www.aidsdatahub.org based on Integrated Biological-Behavioral Surveillance Surveys 2008, 2010 among Wives of Migrant Labourers, 4 Districts of Far Western Region

Mobility has complex causes, ranging from economic and/or political reasons to "forced" displacement (e.g. conflict, trafficking). Individuals from each of these mobile groups and their families are vulnerable to HIV/STI in different ways. Estimates of internal and external migration for seasonal and long-term labour range from 1.5 to 2 million people, with 1 million estimated to have migrated to different parts of India alone.²⁸

Although information is limited about the behaviour of labour migrants in their respective host countries, the assumption is that during their long absence from their families a considerable number of them become clients of sex workers. A 2010 study among Mid-Far-Western Nepali migrants travelling to Indian cities for work found that 32.8% (up from 27% in 2006 and 22% in 2008) visited sex workers while in India.²⁵

In addition, UN Office for the Coordination of Humanitarian Affairs (OCHA) estimates that as of July 2010 there were approximately 50,000 Internally Displaced Persons (IDPs) in Nepal.²⁹ And although WHO and UNAIDS do not categorize IDPs as a key affected population, it has to be noted that the far-western region of the country – where the majority of IDPs is concentrated – has one of the highest number of HIV infections in South Asia. Nepal is considered one of eight priority countries in a report on "HIV/AIDS and IDPs" released by the UN in January 2006.

For more on HIV among migrants in Nepal, please see the HIV & Migration Country Profile, available at <http://www.aidsdatahub.org/en/regional-profile/hiv-and-migration>.

VULNERABILITY & KNOWLEDGE

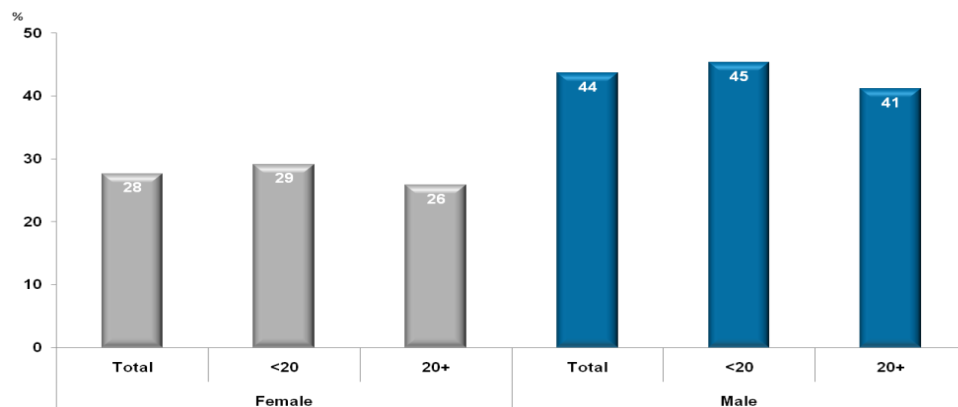
Vulnerability Factors²⁸

- High rates of migration and mobility due to poverty and lack of livelihood opportunities
- Stigma and discrimination against people living with HIV & AIDS
- Trafficking of women and girls
- Low status of women, particularly those living in rural areas
- Political instability and large number of Internally Displaced Persons
- Of approximately 32,000 FSWs, many are believed to be 'hidden' – in other words, very difficult to reach due to their remote geographical location or tenuous links with existing networks.³⁰
- In 2006, 7.5% of young women aged 15-24% and 4% of their male counterparts had had sex before the age of 15 (as high as 13% and 10% among young women and young men, respectively with no education).³¹
- While all donated blood is tested for HIV, only 38% of blood unites is screened for HIV in a quality-assured manner with reference laboratory. ⁹

Knowledge of HIV and AIDS

While the epidemic is becoming entrenched in the general population, the levels of HIV knowledge remain low – particularly among young women (Fig. 9). The Demographic and Health Survey (DHS) in 2006 found that 28% of young women aged 15-24 and 44% of men of the same age group had comprehensive HIV knowledge – that is, they could both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.³¹ Young women and men below the age of 20 had slightly higher comprehensive knowledge than those aged 20-24.³¹ The DHS also found that comprehensive knowledge among young people was highest in urban settings (43% young women; 58% young men).³¹ Lowest levels of knowledge were found in mountain regions (13% young women; 27% among young men).³¹

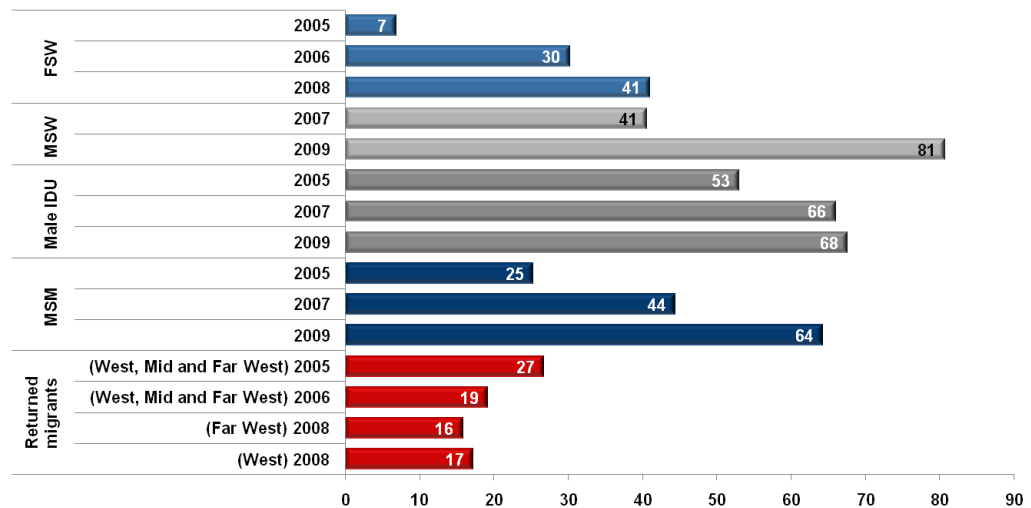
Figure 9: Percentage of young people (15-24) with comprehensive HIV knowledge by age group and gender, 2006



Source: Demographic and Health Survey (DHS), 2006

The proportions of FSWs, MSW, MSM and IDUs who have comprehensive HIV knowledge increased from 2005 to 2007 and again to 2009, with IDUs and MSM having better knowledge than FSWs (Fig. 10).^{9: 30} This continued trend of low comprehensive knowledge among FSWs can be – at least in part – attributed to the fact that about 52% of FSWs are illiterate or have no formal schooling, making them particularly hard to read with prevention communication.⁹ According to the 2010 IBBS, comprehensive knowledge among returned migrants has remained low in each of the regions surveyed²⁵, and was only 12.5% among migrants’ wives in the Far West.²⁷ When disaggregated by age, comprehensive knowledge among key affected populations is higher among older individuals (25 years old and above) compared to their younger counterparts.³²

Figure 10: Percentage of populations at higher risk with comprehensive HIV knowledge, Kathmandu, 2005-2009



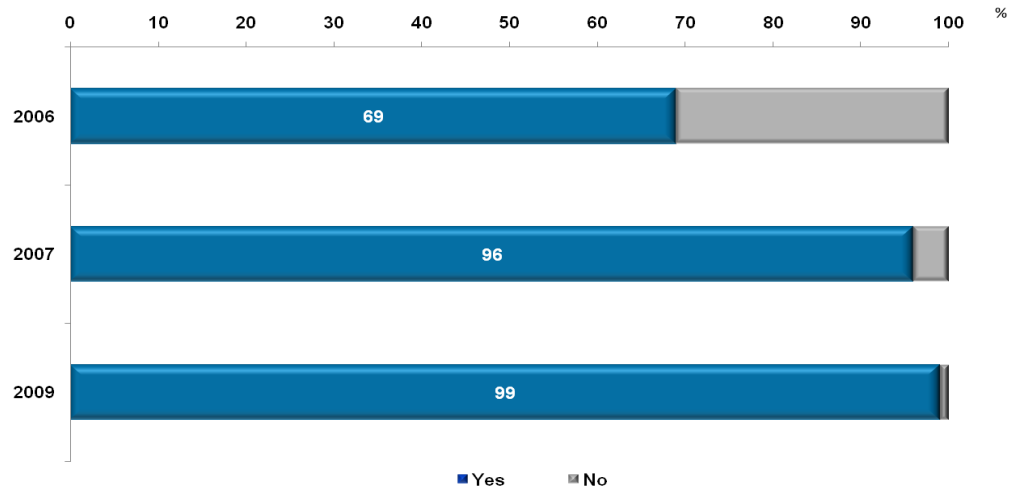
Source: Prepared by www.aidsdatahub.org based on Integrated Biological and Behavioural Surveillance Surveys, 2005-2009

RISK BEHAVIOURS

Injecting equipment

After 2006, the use of sterile injecting equipment by IDUs in Kathmandu increased markedly (Fig. 11). In 2009, 99% of IDUs in Kathmandu reported using sterile injecting equipment at last injection (98% among those younger than 25 years of age and 100% of those older than 25 years).³³ Reported figures were similarly high in Pokhara valley (99%), Western to Far-Western Terai (96%) and – to a slightly lesser extent in Eastern Terai (93%).^{34: 35: 36}

Figure 11: Percentage of IDUs reporting the use of sterile injecting equipment the last time they injected, 2006-2009



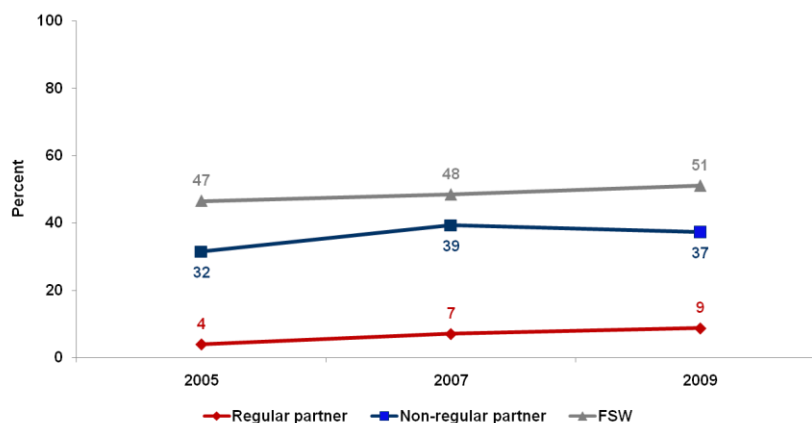
Source: Prepared by www.aidsdatahub.org based on Integrated Biological and Behavioural Surveillance Surveys, 2006-2009

Condom use

Overall in 2009, 51% IDUs in Kathmandu used a condom the last time they had sexual intercourse (down from 58% in 2008).³³ IBBS studies in four regions over four years revealed consistent trends in condom use by IDUs with different types of sexual partners. Specifically, condom use in the last year was always highest with a FSW, followed by with a non-regular partner, with usage with a regular partner always being the lowest (Fig. 12, a-d). Notably, in Kathmandu, Eastern Terai and Pokhara, condom use decreased with all types of partners from 2007 to 2009 surveys.

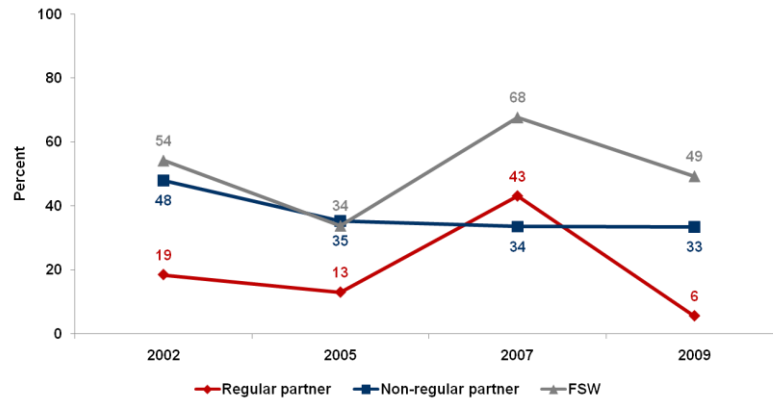
Figure 12: Percentage of IDUs with consistent condom use in the last year with different types of sexual partners, 2003-2009

a) Western to Far-Western Terai

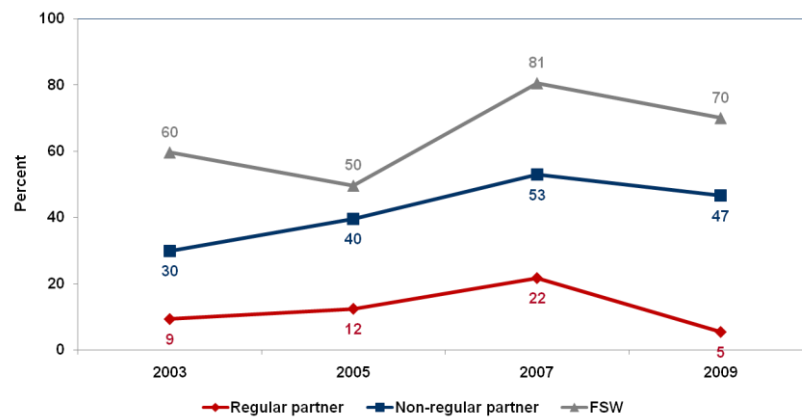




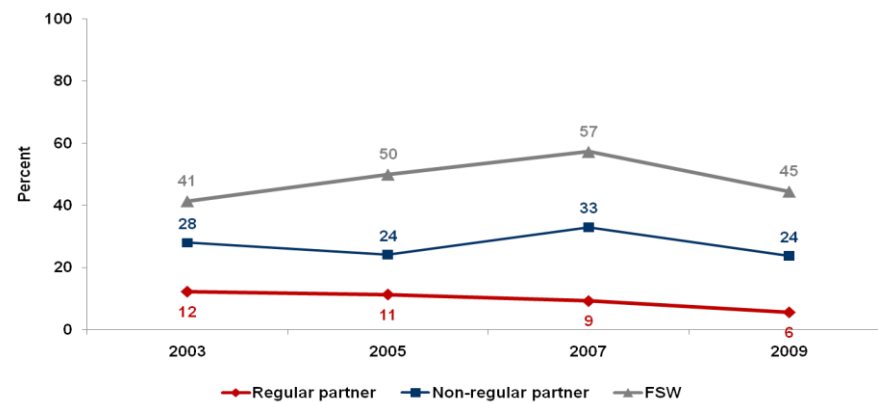
b) Kathmandu valley



c) Pokhara



d) Eastern Terai



Source: Prepared by www.aidsdatahub.org based on Integrated Biological and Behavioural Surveillance Survey among IDUs, respective regions, Rounds I to Round IV, 2003-2009

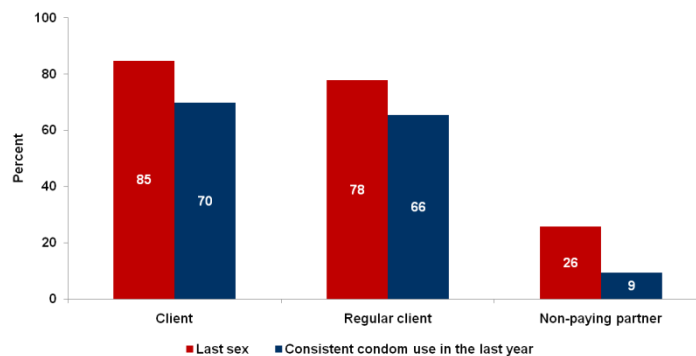
Similar to what was observed among IDUs, the percentage of MSM in Kathmandu with consistent condom use in the last year was much higher with paid male partners (77%) and non-paying male partners (65%) compared with non-paying female partners (40%).²³ Overall in 2009, 75% of MSM used a condom the last time they had anal sex with a male partner (compared to 74% in 2008).²³

This trend of low condom use with non-paying partners was also observed among FSWs, according to the latest IBBS results (Fig. 13, a-b). In Kathmandu and Pokhara in 2008, consistent condom use was lowest with non-paying partners (5% and 7%, respectively) and highest with regular clients (57% and 72%, respectively).¹⁵ In the 22 highway districts surveyed in 2009, consistent condom use was again lowest with non-paying partners (9%) and higher with regular clients (66%) and clients (70%). Overall, 85% of FSWs used a condom with their most recent client in 2009 in 22 highway districts (up from 77% in 2006); 38% of MSWs reported such usage.⁹ In 2008, this figure was 75% among FSWs in Kathmandu (down from 77% in 2006).⁹

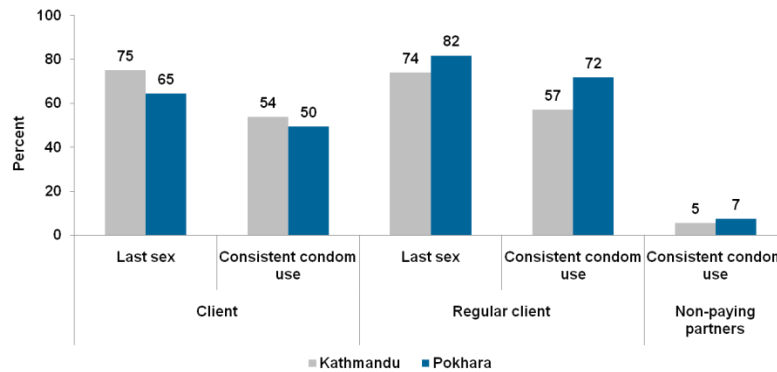
Condom use at last sex with an FSW by males in high risk occupational groups – used as a proxy for clients of FSWs – was significantly high (94%) among truckers in 2009.¹⁸ However, in 2010 migrants from the Mid to Far-Western regions reported a much lower figure at 46% (in Nepal), down from 50% in 2008 and substantially lower than the 67% reported from the Western region in 2008.^{25; 26} In addition, among the wives of migrants from the Mid to Far-Western regions, condom use at last sex with their spouse remained low at 17.2%, although up significantly from 10.9% in 2008.²⁷

Figure 13: Percentage of condom use at last sex and consistent condom use in the last year among female sex workers with different types of sexual partners

a) 22 Highway Districts, 2009



b) Kathmandu and Pokhara valley, 2008



Source: Prepared by www.aidsdatahub.org based on Integrated Biological and Behavioural Surveillance Survey among Sex Workers, 2008-2009

Among the general population of men aged 15-59 years, 71% reported condom use during high-risk sex in the past 12 months (sex with non-regular, non-cohabiting partner) in 2006.³¹ However, only 2.8% of men surveyed had more than one partner in the past 12 months and just 4.7% engaged in higher-risk sex in the past 12 months.³¹

A 2006 study of 167 HIV-positive males in Kathmandu found that unsafe sexual behaviours were common.³⁷ In particular, of the 125 participants who had had sex in the past 6 months, 47% had multiple partners and 46% did not always use condoms. Moreover, 45% of HIV-positive married men did not always use a condom in the last 6 months.

AGE DISAGGREGATION

A highlight of Nepal's monitoring and evaluation system is its use of age-disaggregated data. Table 2 summarizes most-recent data that has been disaggregated by age. As indicated, young people do not fare better than their older counterparts for almost all of the indicators – particularly those pertaining to vulnerability factors, risk behaviours and national response.

Table 2: Age-disaggregated data among key affected populations⁹

Indicators	Population	Year	Survey Site	<25 years	25+ years	Total	Young people fare better than average
HIV prevalence (%)	IDU	2009	Kathmandu	7	33.4	20.7	X
	MSW	2009	Kathmandu	1.4	9.1	5.2	X
	FSW	2008	Kathmandu	0.7	4.7	2.2	X
	MSM	2009	Kathmandu	1.3	6.8	3.8	X
Comprehensive HIV knowledge (%)	IDU	2009	Kathmandu	64	71	68	
	MSW	2009	Kathmandu	75	86	81	
	FSW	2008	Kathmandu	35	38	36	
	MSM	2009	Kathmandu	59	71	64	
Received an HIV test in the last 12 months and know the results (%)	IDU	2009	Kathmandu	19	23	22	
	MSW	2009	Kathmandu	62	68	65	
	FSW	2008	Kathmandu	29	37	32	
	MSM	2009	Kathmandu	36	50	42	
Reached with HIV prevention programmes (%)	IDU ³³	2009	Kathmandu	54	60	57	
	MSW	2009	Kathmandu	90	97	93	
	FSW	2008	Kathmandu	37	47	41	
	MSM	2009	Kathmandu	72	84	77	
	Migrants	2006	Mid-West Far-West	5 21	9 20	7 20.5	X
Used a condom with their most recent client (%)	FSW	2008	Kathmandu	78	71	75	X
Used a condom the last time they had anal sex with a male partner (%)	MSM	2009	Kathmandu	75	76	75.3	
Used a condom at last sex (%)	IDU	2009	Kathmandu	49	45	51	
		2006	Pokhara	67	57	62	X
Used sterile injecting equipment the last time they injected (%)	IDU	2009	Kathmandu	98	100	99	

HOW MIGHT HIV AFFECT NEPAL IN THE FUTURE?

The two major demographic indicators showed that Nepal will increasingly be affected by HIV in the absence of comprehensive intervention programmes. Recent research (2007) projects that, by 2015, life expectancy of Nepalese will decrease by 0.8 year while the crude death rate will increase by 0.4%.³⁸

NATIONAL RESPONSE

Law and policy implementation

Nepal does not have laws that criminalize homosexual behaviour. Sex work is legal, although forced prostitution is illegal. Public order and obscenity laws, under the *Public Offences and Punishment Act*, are sometimes enforced against those involved in sex work.³⁹

In 2002, the Supreme Court of Nepal interpreted human rights enshrined within the Constitution and enforced at that time. Due to the fact that the Constitution guaranteed the right to choose one's own profession as well as the right to equality,⁴⁰ the Supreme Court declared that sex work, 'prostitution' in some countries, is legalized. However, prostitution is a profession or occupation irrespective of whether or not it is legal".⁴¹ This decision has been interpreted as a legal acknowledgment of the existence and rights of sex workers.⁴²

Also, in December 2007, the Supreme Court established that transgendered and men who have sex with men have equality under the constitution.⁴³ The writ petition relied heavily upon Nepal's responsibility – having ratified numerous international human rights instruments – to fulfil the obligations set by such conventions.

More recently, the Supreme Court of Nepal ordered the government to promulgate laws to ensure confidentiality in the judicial process for cases involving people living with HIV.⁹ The Court also issued directives to ensure equal rights to lesbian, gay, bisexual, transgender and intersex individuals and amend all the discriminatory laws against LGBTIs.⁹

Both needle and syringe exchange programmes and substitution treatment programs are legal, and the National HIV/AIDS Strategy aims to develop and implement IDU support services including counselling, primary health care, harm reduction-based education and legal support.

Governance⁹

The main government agency responsible for HIV & AIDS and STD is the National Center for AIDS and STD Control (NCASC) under the Ministry of Health and Population. The NCASC was formed within the Department of Health to implement prevention programmes and provide technical guidance to the HIV & AIDS response. The National AIDS Coordination Committee (NACC) was established to promote a multisectoral response with participation from public and private sectors. Decentralized district AIDS coordination committees were set up. Later, in order to demonstrate leadership at the highest possible level, a National AIDS Council was set up under the chairmanship of the Prime Minister, to take the lead in policy-making and advocating for multisectoral participation²¹.

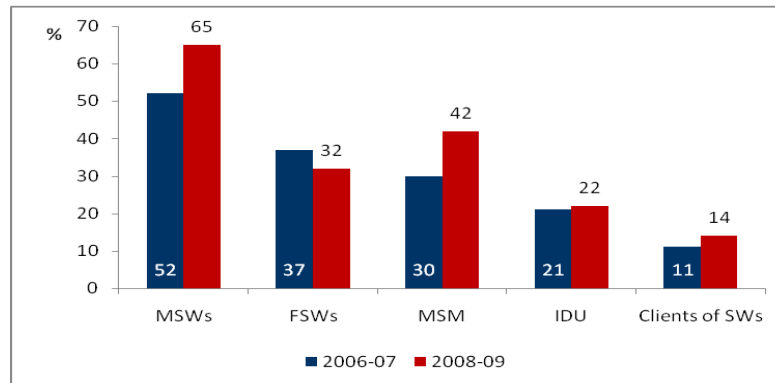
The Government's key responses to HIV & AIDS include the following:

- Development of a series of National Strategic Plans (1997-2001; 2002-2006; and 2006-2011), with recent focus on broadening multi-sector participation in the HIV & AIDS response - particularly in primary prevention and on ensuring well-targeted interventions to address the specific needs of most-at-risk populations
- Formulation of National Action Plans (2006-2008; 2008-2010) that highlight the key programmatic needs and available resources as well as financing gaps in certain intervention areas
- Development of policy and programme frameworks and strategies such as: National Workplace Policy; National Policy on Drug Control (2006); National Health Sector Programme Implementation Plan (2005), among others
- Setting up and strengthening of structures and institutional arrangements to manage, coordinate or support national responses to HIV/AIDS: National AIDS Coordinating Committee (1992); and more recently, the National AIDS Council; HIV/AIDS and STD Control Development Board (2007); several technical working groups
- Establishment of the "Three Ones":
 - One strategic plan: National Strategy 2006-2011 and National Action Plan 2008-2011 to operationalise the, national strategy;
 - One coordinating authority: Setting up of the HIV AIDS and STI Control Board under the leadership of the Ministry of Health, with representation from civil society and other vulnerable communities; and
 - One monitoring and evaluation framework: a National M&E framework is under development
- Increase in coverage/expansion of prevention, treatment and care services in line with universal access targets⁴⁴

HIV Prevention programmes

Similar to other countries in the region, scaling up and sustaining HIV programmes at a high level are a challenge in Nepal. Among the key affected populations, MSWs are those who most often are tested for HIV and knew their results (65%) (Fig. 14). Although HIV testing increased since 2007 among all groups except for FSWs, the percentage of those who have been tested in the last 12 months remained low: 42% among MSM, 32% among FSWs, 22% among IDUs and 14% among clients of sex workers. In contrast, 7.4% of migrant's wives in the Far West had received an HIV test in the last year and knew the result in 2010, a substantial increase from 0% in 2008.²⁷

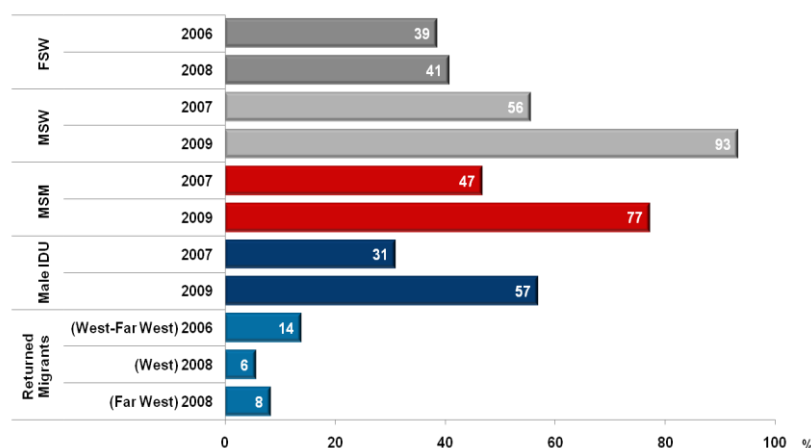
Figure 14: Percentage of key affected populations who have been tested for HIV in the last 12 months and knew their results, 2006-2009



Source: Prepared by www.aidsdatahub.org based on UNGASS Country Progress Reports, 2008 and 2010

In terms of percentage of populations reached with HIV prevention programmes, coverage mirrors the trends in HIV testing, increasing among all populations while remaining low among returned migrants (Fig. 15). MSWs and MSM received the most coverage (93% and 77% in 2009, respectively), with IDUs and FSWs falling behind at 57% (in 2009) and 41% (in 2008), respectively. Returned migrants were the population with the poorest coverage of prevention programmes, with only 6% and 8% reached in 2008 in the West and Far West, respectively. In addition, 4% of migrants' wives in the Far West were reached with HIV prevention programs in 2010, a decrease from 7% in 2008.²⁷

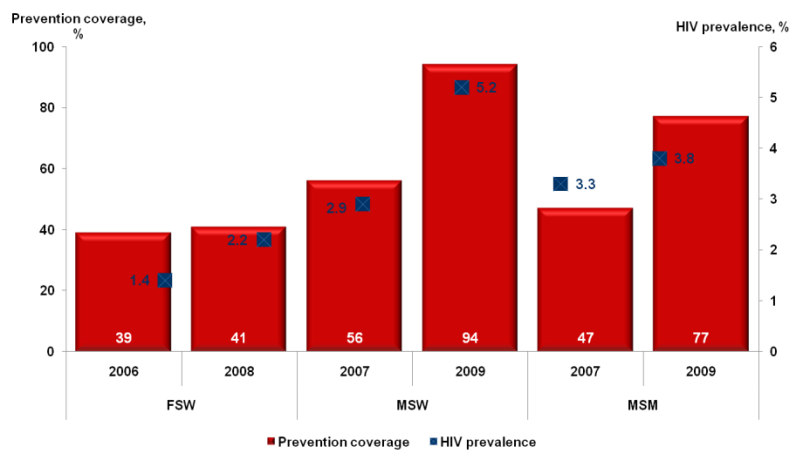
Figure 15: Percentage of selected populations reached with HIV prevention programmes, Kathmandu, 2006-2009



Source: Prepared by www.aidsdatahub.org based on Integrated Biological-Behavioral Surveys among key affected populations, 2006-2009

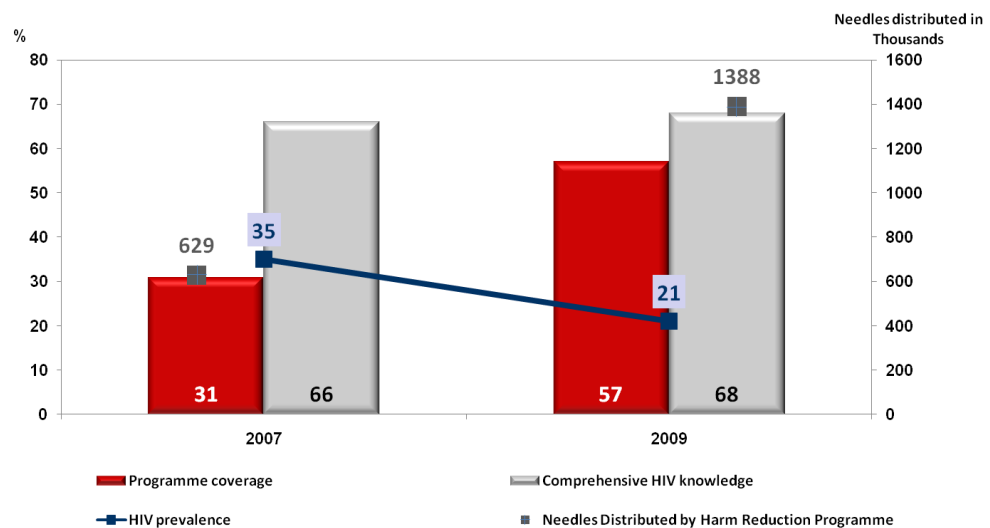
Successive IBBS results in Kathmandu have demonstrated that HIV prevalence among FSWs, MSWs and MSM has risen despite increased prevention efforts (Fig. 16)³². On the other hand, HIV prevalence has declined among IDUs alongside increased programme efforts (Fig. 17)^{9, 33}. This is likely associated with the fact that systematic HIV prevention programmes have primarily focused on IDUs nation-wide. Indeed, in the early 1980s, Nepal was the first country in the region to establish a harm reduction program with needle exchange for injecting drug users (IDUs)⁹. In addition, a multitude of vulnerability factors, including illiteracy, mobility, and stigma and discrimination play a role in the viability of prevention programmes among key populations.

Figure 16: Trends in HIV prevalence and programme coverage among key affected populations, Kathmandu, 2006-2009



Source: Prepared by www.aidsdatahub.org based on Integrated Biological-Behavioral Surveys among key affected populations, 2006-2009

Figure 17: Decline in HIV prevalence among IDUs following programme efforts, Kathmandu, 2007-2009



Source: Prepared by www.aidsdatahub.org based on Integrated Biological-Behavioral Surveys among IDUs, 2007 and 2009

Antiretroviral treatment, Prevention of Mother-to-Child Transmission

The initiation of care and support programmes for infected and affected groups only started in a systematic manner in 2003. Although national guidelines for antiretroviral treatment (ART) were developed and finalized in 2004, ART was started in 2003 for 77 people living with HIV (PLHIV). By November 2009, 3,048 adults and 178 children were accessing ART from 23 ART sites throughout the country.⁹ These figures represent only 19% of those in need of treatment, which – despite having increased from 12% in 2008 and 6% in 2007 – is far below the Universal Access target of 80%. Out of the total individuals tested for HIV, 20% of males and 26% of females have accessed ART services.⁹

There are an estimated fewer than 1,000 up to 2,100 HIV-positive pregnant women in need of ART for the prevention of mother-to-child transmission (PMTCT) of HIV; however, only 56 – between an estimated 3% and 10% of pregnant women living with HIV – had received it.⁴⁵ Of those pregnant women in need of PMTCT, many are from vulnerable groups such as FSW, wives or partners of IDUs and wives of migrants. This very low PMTCT coverage highlights the urgent need for scaling up the programme.

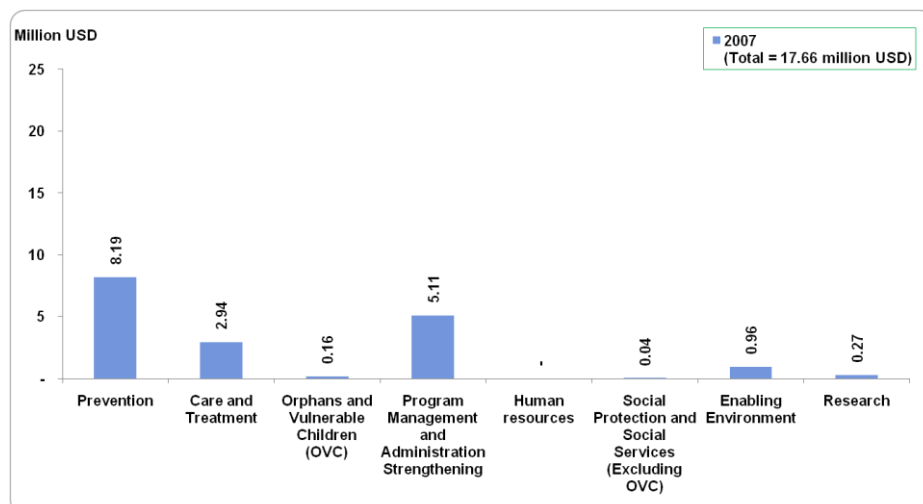
With support from UNICEF, the life skills-based education programme, being implemented through formal curricula or extracurricular activities, has expanded to 7.6% in 2009 (from 5.7% in 2007 and 3.1% in 2006).⁹

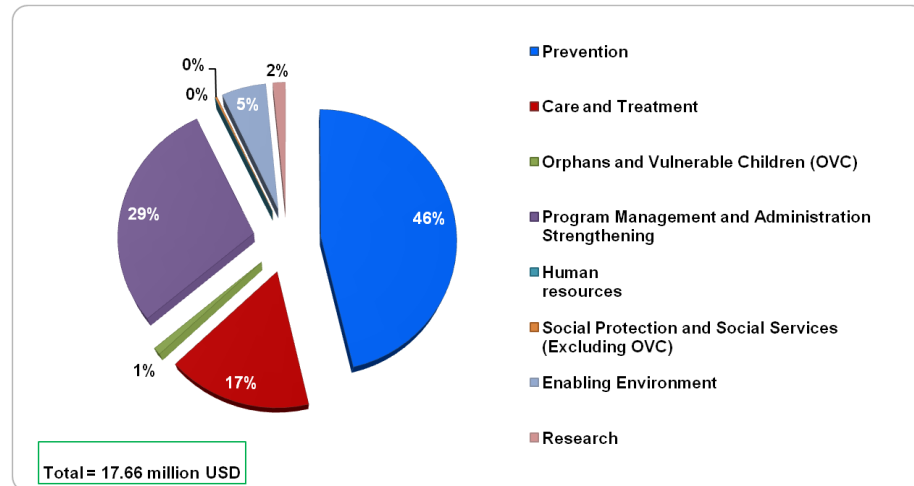
ECONOMICS OF AIDS

Overall spending for AIDS in Nepal in 2007 was US\$ 17.7 million⁷. The majority (96.5%) of total AIDS spending was financed by international sources⁷. In terms of HIV-related activities in 2007, prevention received the largest share of funding (46%), followed by care and treatment related activities (17%) (Fig. 18, a-b)⁴⁶. Notably, over 28% was spent on programme management and administration⁴⁶.

Figure 18: (a) Amount and (b) Percent distribution of total HIV expenditures by major spending category, 2008 and 2009

(a)



**(b)**

Source: Prepared by www.aidsdatahub.org based on UNAIDS, Report on the Global AIDS Epidemic, 2010

ISSUES AND CHALLENGES FOR HIV & AIDS PREVENTION PROGRAMMES

Key facilitating factors

- The 2006-2011 National HIV/AIDS Strategy clearly identifies the vulnerable groups and specifically targets 4 out of 5 of these groups for services (sex workers and their clients; IDUs; mobile populations; and MSM)
- National government's commitment to develop and gradually implement appropriate support services for most-at-risk groups
- Active participation of civil society groups in the HIV and AIDS response
- Improvement and increase in voluntary counselling and testing (VCT) services, particularly among vulnerable populations

Key inhibitory factors

- Ongoing political instability and civil unrest in the country, which have exacerbated the continuing vulnerability of girls and young women to HIV and AIDS, and contributed to growing numbers of mobile populations⁴⁷
- Stigma and discrimination as well as a lack of policies and programmes to reduce them
- Lack of sufficient infrastructure and coordination of HIV & AIDS with other national policies
- Large gap between reported cases and estimated cases making it difficult to track the Millennium Development Goal of halting and reversing the spread of HIV/AIDS by 2015.

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