Nepal Country Progress Report 2012

(To contribute to Global AIDS Response Progress Report 2012)

Ministry of Health and Population
National Centre for AIDS and STD Control
Teku, Kathmandu

FOREWORD

It is our privilege to present the first National AIDS Response Progress Report (to contribute to the Global AIDS Response Progress Report, 2012) as a part of the country's commitment to 2011 UN General Assembly Political declaration; reflecting our progress with respect to the commitments and challenges faced while responding the epidemic. Prior to this, Nepal has successfully submitted four UNGASS reports, and this report will provide a useful cohort for tracking the progress over the past a decade. The report highlights our efforts and achievement in the areas of prevention, treatment, care and support, human right issues, Civil Society Organization (CSO) involvement, enabling environment, policy and strategy status in the country. This report is in keeping with the new UN Political Declaration on HIV/AIDS of "Intensifying our efforts to eliminate HIV/AIDS" to reshape the AIDS response to achieve the three zeros by 2015: zero new HIV infections, zero discrimination and zero AIDS-related deaths.

Over the past two years, Nepal has made substantial progress in the areas of policy, strategy and resource mobilization by launching a new AIDS policy and a five-year national strategy to fight HIV and AIDS. Moreover, we have been able to secure funding for the next five years from external development partners. We are extremely pleased by the continuous support extended by the external development partners in terms of enhancing the capacity of the national programme by providing the requisite technical and financial assistance for implementing the programme more effectively.

Programme coverage has been expanded and a considerably larger number of people who require services are being able to access them. The scaling of services such as prevention, care, support and programme is also being prioritized. Significant progress has also been made in terms of programme monitoring and evaluation as well as HIV surveillance, data collection, analysis, and its uses to monitor and evaluate prevention, treatment and care programmes. Though the overall response is improving, over 80 per cent of the AIDS money is being spent/channelized outside the public sector, which is alarming. The Government is committed to increasing the funding of the AIDS response through its regular budget to increase the role of the public sector in coordinating the national response and sustaining the programme.

This report is a result of a joint and collaborative process, and the support and active involvement of all stakeholders including government agencies, MARPs and their networks, UN Agencies, bilateral and multilateral organizations and national and international NGOs working on AIDS.

We would like to express my gratitude to UNAIDS, WHO and UNICEF for their technical and financial support in the preparation of this report. We would also like to thank the Advisory Committee and Technical Working Team for their hard work and dedication to the timely preparation of this quality report.

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List of acronyms

AG	Advisory Group
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral
ASHA	Advancing Surveillance, Policies, Prevention, Care and Support to Fight HIV/AIDS
AusAID	Australian Agency for International Development
BDS	Blue Diamond Society
CABA	Children Affected by AIDS
CB-PMTCT	Community Based-Prevention to Mother-to-Child Transmission
CBO	Community-based Organisation
CCC	Community Care Centres
CCM	Country Coordination Mechanism
CD4	Cluster of Differentiation 4
CHBC	Community Home-Based Care
CHD	Child Heath Division
CMDN	Center for Molecular Dynamics Nepal
CSO	Civil Society Organisation
DACC	District AIDS Coordination Committee
DBS	Dried Blood Spot
DFID	UK Department for International Development
DHS	Demographic and Health Survey
DoE	Department of Education
DoHS	Department of Health Services
DQA	Data Quality Audit
EDP	External Development Partners
EID	Early Infant Diagnosis
EPP	Estimation and Projection Package
FCHV	Female Community Health Volunteers
FGD	Focus Group Discussion
FHD	Family Health Division
FP	Family Planning
FPAN	Family Planning Association of Nepal
FSW	Female Sex Worker
GARPR	Global AIDS Response Progress Reporting
GAVI	Global Alliance for Vaccines and Immunization
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria

GIS	Geographical Information System
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit
GoN	Government of Nepal
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HSCB	HIV/AIDS and STI Control Board
HTC	HIV Testing and Counselling
IBBS	Integrated Biological and Behavioural Surveillance
ILO	International Labour Organisation
IPT	Isoniazid Preventive Therapy
INGO	International Non-Governmental Organization
IPV	Intimate Partner Violence
KAP	Key Affected Population
KfW	Kreditanstalt für Wiederaufbau
LGBTI	Lesbian, Gay, Bisexual, Transgender and Intersex
MESS	Monitoring and Evaluation System Strengthening
MNCH	Maternal, newborn and child health
MoHA	Ministry of Home Affairs
MoHP	Ministry of Health and Population
MOT	Mode of Transmission
MIS	Management Information System
MSM	Men who have Sex with Men
MSW	Male Sex Worker
MTC	Male Sex Workers, Transgender and their Clients
MTCT	Mother-to-Child Transmission
M&E	Monitoring and Evaluation
NAC	National AIDS Council
NAP	National Action Plan
NAP+N	National Association of People Living with HIV/AIDS in Nepal
NASA	National AIDS Spending Assessment
NCASC	National Centre for AIDS and STD Control
NCPI	National Commitments and Policy Instruments
NDHS	Nepal Demographic and Health Survey
NFWLHA	National Federation of Women Living with HIV/AIDS
NGO	Non-Governmental Organization
NHSP-IP	National Health Sector Programme Implementation Plan
NJA	National Judicial Academy
NSA	National Strategic Application
NSP	National Strategic Plan
NTP	National Tuberculosis Programme
OI	Opportunistic Infection
OST	Opoid Substitution Therapy
OVC	Orphans and Vulnerable Children
PHC	Public Health Centre

PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
PMU	Programme Management Unit
PWID	People Who Inject Drugs
PR	Principle Recipient (of Global Fund grant)
PRSP	Poverty Reduction Strategy Plan
PSI	Population Services International
PWID	People who Inject Drugs
SAARC	South Asian Association for Regional Co-operation
SCN	Standing Committee on Nutrition
SI	Strategic Information
SI-TWG	Strategic Information Technical Working Group
SOP	Standard Operating Procedure
SSF	Single Stream of Funding
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
ToRs	Terms of Reference
TSF	Technical Support Facility
TWT	Technical Working Team
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
WB	World Bank
WHO	World Health Organization

Chapter I Status at a glance

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

The Ministry of Health and Population (MoHP) had assigned the process of leading the preparation and submission of the Nepal Country AIDS Response Progress Report 2012 to the National Centre for AIDS and STD Control (NCASC) in November 2011. The main objective of the report is to express the highest-level accountability for the political commitment for effectively responding to the HIV epidemic in Nepal. In early January 2012, NCASC/MoHP formed an Advisory Group (AG) and a Technical Working Team (TWT) with defined terms of reference (ToRs). The road map and the ToRs were developed in consensus with the AG & TWT (ToRs, composition of the AG & TWT, and the road map of the process are presented in Annexures 1 & 2). During the data collection process for the reporting of the core indicators, the National funding matrix and National Commitments and Policy Instruments (NCPI) participation of relevant stakeholders were ensured by different mechanisms such as by holding a series of consultations, focus group discussions (FGDs), etc. A data validation workshop was held for all the stakeholders who participate in the National response to HIV/AIDS in Nepal. The draft report was shared with the stakeholders and a timeline was provided to them for submitting their comments. The relevant comments from the stakeholders were incorporated in the final report.

B. The status of the epidemic

HIV is characterized as a concentrated epidemic in Nepal with HIV prevalence of 0.30 per cent among adult aged 15–49 years in 2011. There are approximately 50,200 people estimated to be living with HIV, where four out of every five infections are transmitted through sexual transmission. People who inject drugs (PWIDs), men who have sex with men (MSM) and female sex workers (FSWs) are the key populations who are at a higher risk of acquiring HIV. Male labour migrants (who particularly migrate to high HIV prevalence areas in India, where they often visit FSWs) and clients of sex workers in Nepal are playing the role of bridging populations that are transmitting infections to low-risk general populations. The rate of occurring new HIV infections throughout Nepal has reduced significantly during the last five years essentially owing to the targeted prevention interventions among key population groups. However, it is critical to improve the effective coverage of proven prevention interventions, especially among new entrants engaging in high-risk behaviours, and to sustain these interventions for achieving the national target of halving new HIV infections by 2015.

C. The policy and programmatic response

The national response to HIV/AIDS is guided by “National Policy on HIV and STI, 2011” and “National HIV/AIDS Strategy 2011–2016”, which uses the principles of universal access, that is, using a rights-based approach and encompassing a multisectoral approach to combat the epidemic.

D. Indicator data in an overview table

Table 1: Status of Nepal Country AIDS Response Progress Indicators

Indicator #	Indicator Titles	Value of		Data Source
		2012	2010	
Target 1. Reduce sexual transmission of HIV by 50 per cent by 2015				
Indicators for the general population				
1.1	Young people: Knowledge about HIV prevention	Male = 33.9% Female = 25.8%	Male = 43.6% Female = 27.6%	Nepal Demographic and Health Survey (DHS) 2011
1.2	Sex before the age of 15	Male=3.7% Female=7.0%	NA	Nepal Demographic and Health Survey (NDHS) Report 2011
1.3	Multiple sexual partners	Male = 3.8%	NA	Nepal Demographic and Health Survey (NDHS) Report 2011
1.4	Condom use during higher risk-sex	Male = 26.5%	NA	Nepal Demographic and Health Survey (NDHS) Report 2011
1.5	HIV testing among the general population	Male=7.5% Female= 2.9%	NA	Nepal Demographic and Health Survey (NDHS) Report 2011
1.6	Reduction in HIV prevalence	NA	NA	
Indicators for sex workers				
1.7	Sex Workers: Prevention programmes	MSW = 93.3% FSW = 60%	MSW = 93.3% FSW = 40.8%	Integrated Bio-behavioural Survey (IBBS) among MSM in Kathmandu (Ktm), 2009 IBBS among FSW in Ktm, 2011, 2009
1.8	Sex workers: Condom use	MSW = 37.8% FSW = 82.6%	MSW = 37.8% FSW = 75.0%	IBBS among MSM in Ktm, 2009 IBBS among FSW in Ktm, 2011, 2009
1.9	Sex workers: HIV testing	MSW = 65.2% FSW = 54.6%	MSW = 65.2% FSW = 32.4%	IBBS among MSM in Ktm, 2009 IBBS among FSW in Ktm, 2011, 2009
1.10	Sex workers: HIV prevalence	MSW = 5.19% FSW = 1.69%	MSW = 5.19% FSW = 2.2%	IBBS among MSM in Ktm, 2009 IBBS among FSW in Ktm, 2011,2009
Indicators for men who have sex with men (MSM)				
1.11	MSM: prevention programmes	77.30%	77.30%	IBBS among MSM in Ktm, 2009
1.12	MSM: Condom use	75.30%	75.30%	IBBS among MSM in Ktm, 2009
1.13	MSM: HIV testing	42%	42%	IBBS among MSM in Ktm, 2009
1.14	MSM: HIV prevalence	3.80%	3.80%	IBBS among MSM in Ktm, 2009
Target 2. Reduce transmission of HIV among people who inject drugs (PWIDs) by 50 per cent by 2015				
2.1	PWIDs: Prevention programmes (number of syringes distributed per IDU annually by Needle and Syringe Programmes)	71.38	NA	Routine Programme Data Jan–Dec 2011 (Save The Children (SCN) and United Nations Office on Drugs and Crime (UNODC)

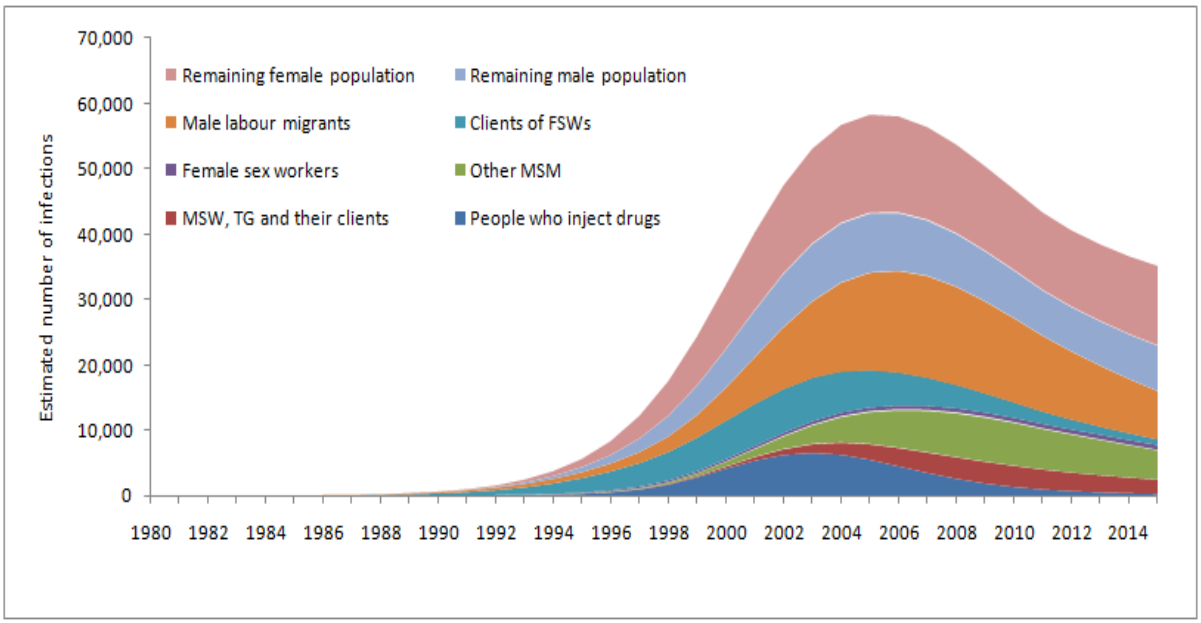
Indicator #	Indicator Titles	Value of		Data Source
		2012	2010	
2.2	PWIDs: Condom use	46.50%	51.90%	IBBS among male injecting drug users (IDUs) in Ktm, 2011, 2009
2.3	PWIDs: Safe injecting practices	95.30%	89.0%	IBBS among male IDUs in Ktm, 2011, 2009
2.4	PWIDs: HIV testing	21.40%	21.50%	IBBS among male IDUs in Ktm, 2011, 2009
2.5	PWIDs: HIV prevalence	6.30%	20.70%	IBBS among male IDUs in Ktm, 2011, 2009
Target 3. Eliminate mother-to-child transmission (MTCT) of HIV by 2015 and substantially reduce AIDS-related maternal deaths				
3.1	Prevention of Mother-to-Child Transmission (PMTCT)	134 (12.2%)	3.29%	NCASC monthly PMTCT report (Jan-Dec 2011)
3.2	Early infant diagnosis	22 (2.4%)	NA	2011 data, FHI 360/US Agency for International Development (USAID) (5 sites)
3.3	MTCT rate (modelled)	39.70%	NA	Estimation and projection package (EPP) 2011
Target 4. Have 15 million people living with HIV (PLHIV) on antiretroviral therapy (ART) by 2015				
4.1	HIV Treatment: ART	23.70%	19.03%	NCASC monthly ART report (Dec 2011) and 2011 EPP
Target 5. Reduce tuberculosis deaths in PLHIV by 50 per cent by 2015				
5.1	Co-Management of tuberculosis and HIV treatment	NA	NA	
Target 6. Reach a significant level of annual global expenditure (USD 22–24 billion) in low and middle-income countries				
6.1	AIDS Spending: Domestic and international AIDS spending by categories and financing sources	USD20.45 million	USD17.6 million	Resource inflow of HIV AIDS, 2010
Target 7. Critical enablers and synergies with development sectors				
7.1	National Commitments and Policy Instruments (NCPI)	Completed	Completed	Separate consultation with Government of Nepal (GoN) and Civil Society Organisations (CSO), UN agencies, bilateral/multilateral agencies was conduced
7.2	Prevalence of Recent Intimate Partner Violence (IPV) (Proportion of ever-married or partnered women aged 15–49 who experienced physical or sexual violence from a male intimate partner during the past 12 months)	28.2%	NA	Nepal Demographic and Health Survey (NDHS) Report 2011
7.3	School attendance of orphans and non-orphans	NA	NA	
7.4	Economic Support for Eligible Households	NA	NA	

Note: Value of indicator 4.2 "Percentage of adults and children with HIV known to be on treatment 12 months after initiating antiretroviral therapy" will be posted in online by 20 April 2012.

Chapter II Overview of the AIDS epidemic

In Nepal, the first-ever AIDS case was reported in 1988. Ever since, the nature of the HIV epidemic in the country has gradually evolved from being a "low-prevalence" to "concentrated" epidemic. Over 80 per cent of the HIV infections are transmitted through heterosexual transmission (Figure 1). People who inject drugs (PWIDs), men who have sex with men (MSM) and female sex workers (FSWs) are the key populations at higher risk spreading this epidemic. Male labour migrants (who particularly migrate to high HIV prevalence areas in India, where they often visit FSWs) and clients of FSWs in Nepal are playing the role of bridging population groups that transmit infections from the key populations at higher risk to the low-risk general population. As the epidemic is maturing—approximately 24 years have elapsed since the first HIV case was reported in 1988—increasing number of infections are being recorded among the low-risk general population. However, the spread of the epidemic is primarily driven by the infections among key populations at higher risk and their sexual partners, rather than by heterosexual transmission among the general population in Nepal (Figure 1).

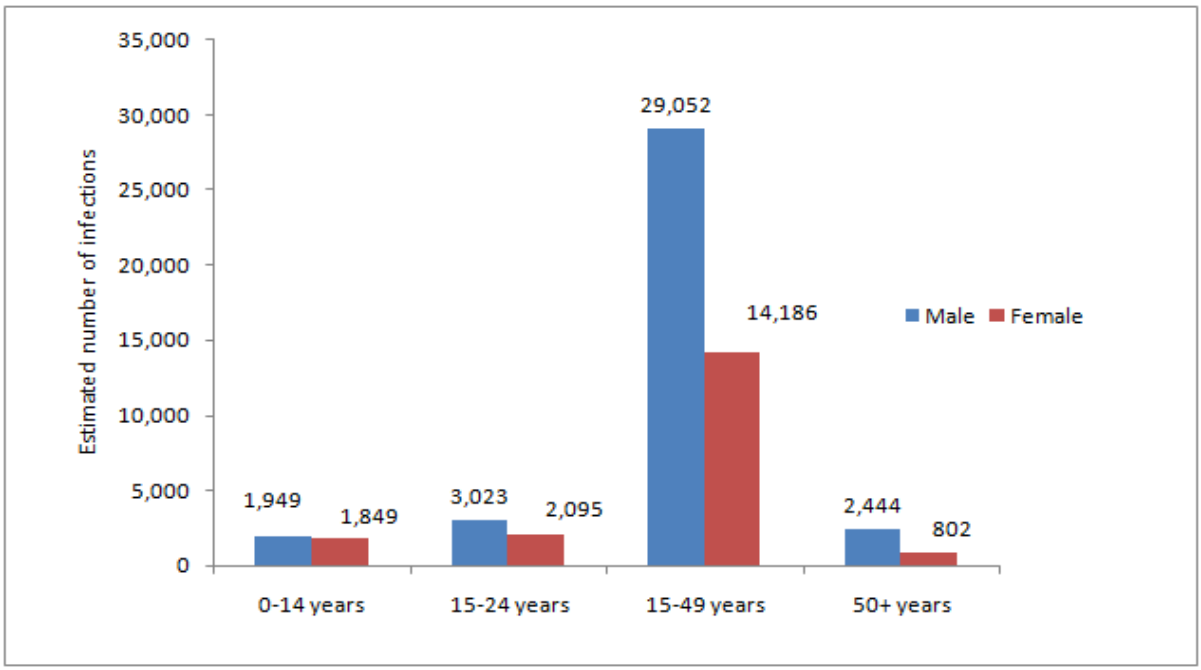
Figure 1: Distribution of estimated HIV infections among risk population groups aged 15–49 years: 1980–2015



As of 2011, there were approximately 50,200 adults and children living with HIV in Nepal, with an estimated overall prevalence of 0.30 per cent among the adult (15–49 years)[1] population. As shown in Figure 2, the prevalence of HIV infection among adult (15–49 years) males (58%) and females belonging to the reproductive age group (28%) was the highest, whereas children aged under 15 years accounted for approximately 8 per cent of the total infected population in 2011.

[1] NCASC (2012) National Estimates of HIV Infections in Nepal, 2011. March 2012.

Figure 2: Estimated HIV infections by age groups in Nepal, 2011



In 2011, the key populations at higher risk (PWIDs, MSM, FSWs, male labour migrants and clients of FSWs) accounted for 58 per cent of all HIV infections among adults (Table 2), whereas the low-risk general male and female populations accounted for 42 per cent of all estimated infections. The prevalence of HIV infection was estimated to be the highest among the adult segment aged 25–49 years who are economically productive and sexually active. The prevalence of HIV infection among the youngest stratum of the population, that is, below the age of 15 years, was the lowest; a majority of the HIV infections among children in this age group were owing to mother-to-child transmission (MTCT).

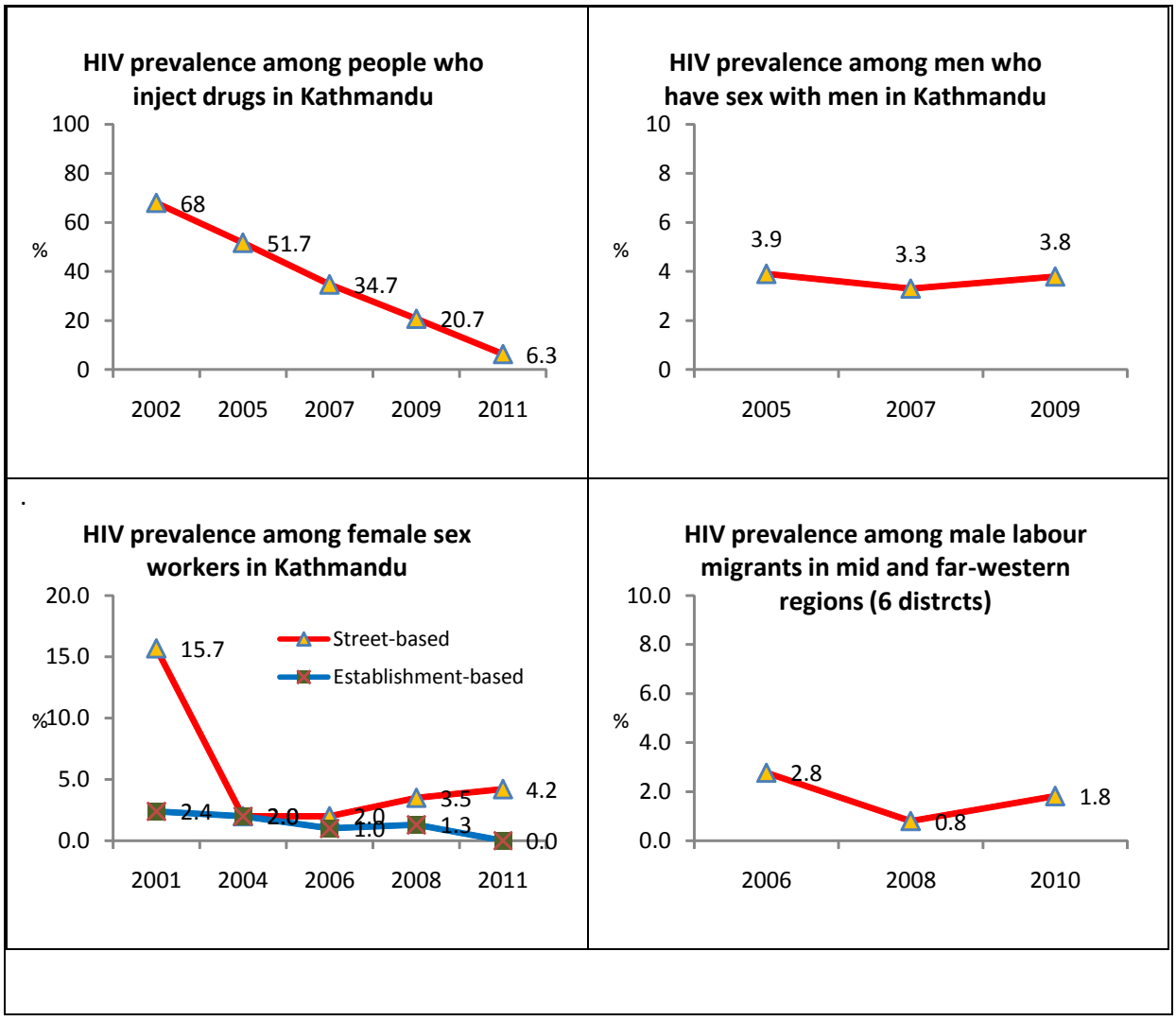
Table 2: Estimated HIV infections by population groups in Nepal, 2011

Population Groups	Estimated HIV infections (15–49 years)	% of total infections
People who inject drugs (PWIDs)	939	2.2%
Male Sex Workers, Transgender and their Clients (MTCs)	3,099	7.2%
Other men who have sex with men (MSM)	6,245	14.4%
Female Sex Workers (FSWs)	647	1.5%
Clients of FSWs	1,915	4.4%
Male Labour Migrants	11,672	27.0%
Remaining Male Population	6,914	16.0%
Remaining Female Population	11,808	27.3%
Total	**43,239**	**100.0**

Nepal has produced evidence[2] that effective prevention interventions are effective in restraining the spread of HIV, particularly among key populations at higher risksuch as PWIDs, FSWs and their clients (Figure 3). Overall, HIV prevalence among adults (15–49 years) began declining gradually from around 2006 (Figure 4), whereas prevalence of HIV has been declining more rapidly among the younger population group (15–24 years) (

Figure 5). In order to achieve the national HIV/AIDS strategic goal of halving the number of new infections by 50 per cent and reducing AIDS-related deaths by 25 per cent by 2015, it is critical to ensure the effective coverage (availability, accessibility, affordability and usage) of proven prevention interventions among key populations at higher risk to HIV, and scaling up of antiretroviral therapy (ART).

Figure 3: Changes in HIV prevalence among key populations at higher risk in Nepal, 2001–2011



[2] NCASC (2011) National HIV/AIDS Strategy, 2011–2016, December 2011.

Figure 4: Declining HIV prevalence among the adult (15–49) population group in Nepal: 1985–2015 (NCASC, 2011)

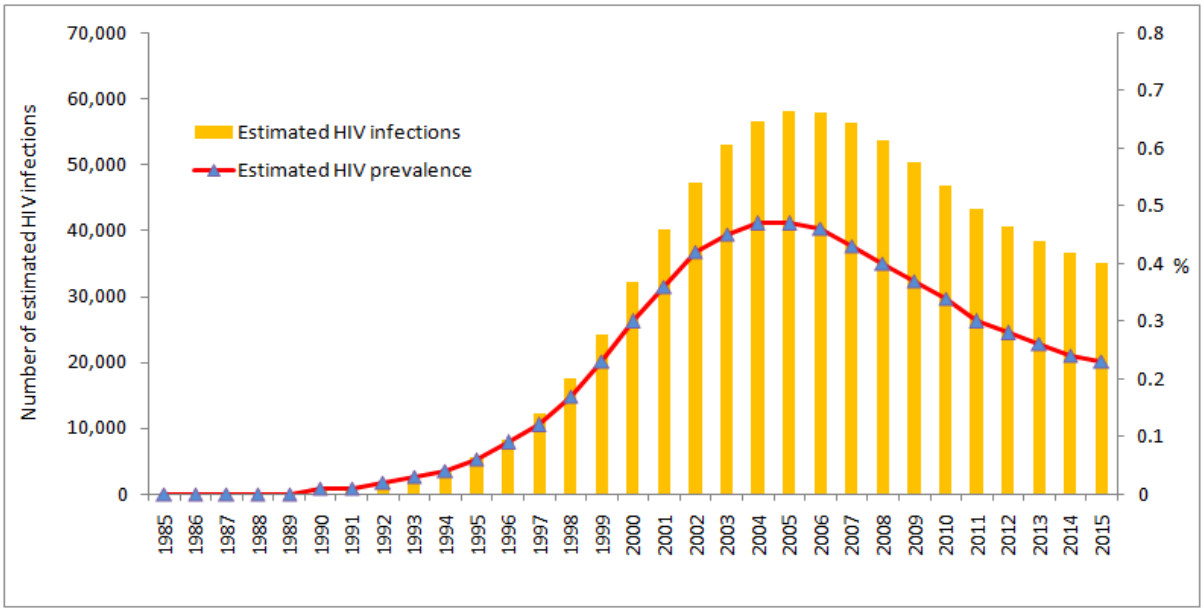
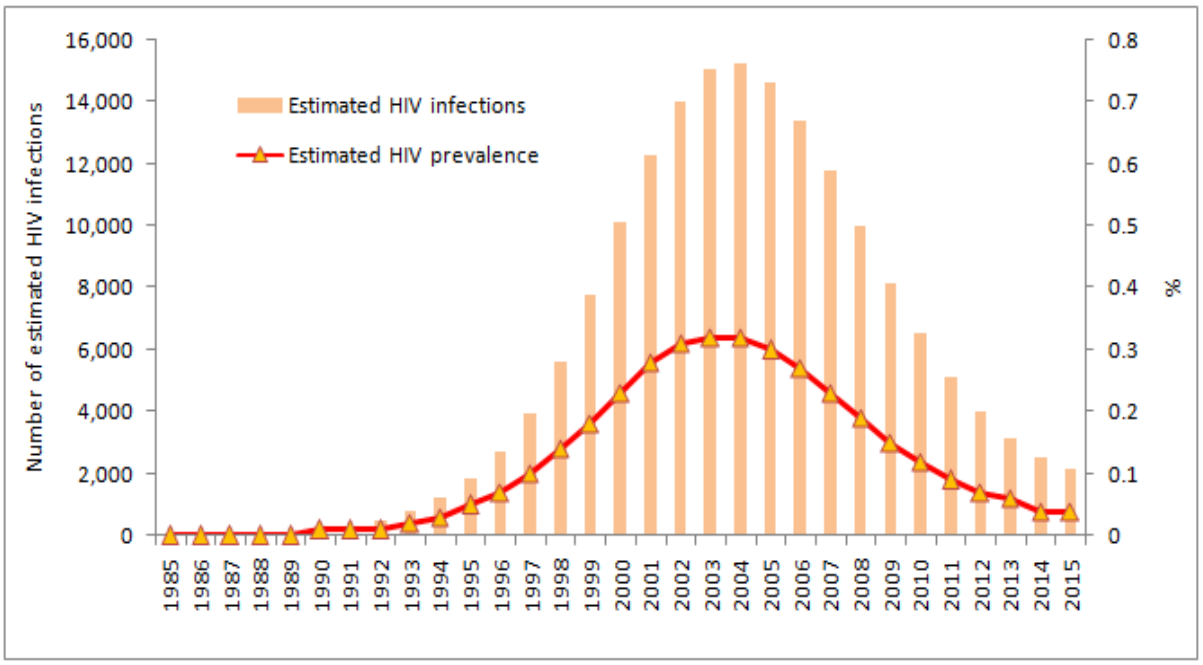


Figure 5: HIV prevalence among the young (15–24) population group in Nepal: 1985–2015



Challenges and Remedial actions

- Conducting Integrated Biological and Behavioural Surveillance (IBBS) surveys among key populations at higher risk and in higher risk areas is a major strength and component of

Nepal's current surveillance system. However, sustaining these resource-intensive IBBS surveys is a critical challenge. More innovative approaches are necessary for improving the quality and coverage of routine programme monitoring data with key behavioural information and optimal use for surveillance.

- The ART programme began in Nepal in February 2004 and as of December 2011, over 8,000 people had ever enrolled for ART. Of the total 6,483 people currently undergoing ART, 0.67 per cent people are on the second-line regimen, whereas approximately 9 per cent of those who ever enrolled are lost to follow-up. The development and implementation of the national strategy for HIV drug resistance surveillance, including effectively monitoring the early warning indicators, is essential.
- Thus far, HIV sentinel surveillance among antennal attendees and patients of sexually transmitted infections (STIs) have not been reinitiated.
- A fair amount of financial support is currently available for various surveillance activities. However, effective and timely implementation of planned surveillance activities by the current limited number of technical staff is a challenge. An adequate number of technical staff at NCASC is necessary for planning, implementing and disseminating appropriate surveillance data for informing policies and improving programmes.

Chapter III National response to the AIDS epidemic

A. Policy and structural response

Policy

The 1995 National AIDS policy was revised in 2011. Now termed the "National Policy on HIV and STI, 2011", it elucidates the roles and linkages of structures such as National AIDS Council (NAC), HIV/AIDS and STI Control Board (HSCB) and National Centre for AIDS and STD Control (NCASC). In order to execute the new policy, the following four policy directives have to be instituted: (1) amendment of the Cabinet Formation Order on the creation of HSCB, (2) operational guideline for the NAC, (3) directives for the Monitoring and Evaluation (M&E) of HIV and AIDS response and (4) operational guideline for the District AIDS Coordination Committee (DACC). These policy directives have been drafted; however, their finalization and endorsement by the MoHP is pending.

Some progress in terms of acceptance of the third gender has been achieved after the Supreme Court directives ensuring the rights to life of Lesbian, Gay, Bisexuals, Transgender and Intersexes (LGBTIs) according to their own identities were passed in 2007. The third gender has now been included in the census and in the issuance of a national citizenship card.

The National Judicial Academy (NJA) has developed a draft of Standard Operating Procedure (SOP) in consultation with the stakeholders, including civil societies and media, for protecting the rights to confidentiality of victims of violence and cases related with children and HIV infected and affected people during the legal recourse process.

In late 2011, a roundtable dialogue was conducted on "The Legal and Policy Barriers to the HIV Response" and the eight South Asian Association for Regional Co-operation (SAARC) countries participated in this dialogue. Legal and policy barriers to HIV prevention and treatment and care services for people living with HIV (PLHIV), MSM, transgender persons, sex workers and PWIDs were discussed, and strategies and initiatives to strengthen the rights-based response to HIV were drafted for addressing these barriers in the SAARC countries.

Strategic Plan

The review of the previous National HIV/AIDS Strategy, 2006–2011 informed the development of the National HIV/AIDS Strategy, 2011–2016. The national goal of this strategy is to achieve universal access to HIV prevention, treatment, care and support and its programmatic objectives are to achieve the following targets by 2016: (1) reduce new HIV infections by 50 per cent, (2) reduce AIDS-related deaths by 25 per cent and (3) reduce new HIV infections among children by 90 per cent. In order to achieve these, three strategic directions were highlighted, which are also aligned to Nepal's commitment to achieving the targets of the 2011 AIDS Political Declaration. The development of a National Action Plan (NAP) on HIV/AIDS, 2011–2013 is in progress.

Besides the National HIV/AIDS Strategy, 2011–2016, the country's three-year Interim Plan 2010/11–2012/2013, Poverty Reduction Strategy Paper (PRSP), and the National Health Sector Programme-Implementation Plan (NHSP-IP) all ascribe priority to the HIV and AIDS program.

Programme focus

The programmatic response on HIV and AIDS in Nepal is anchored mainly on the type of HIV epidemic that the population in the country is experiencing. With 6.3 per cent HIV prevalence among PWIDs (in Kathmandu), Nepal's epidemic is characterized as "concentrated". Hence, prevention continues to be the cornerstone of its program and the approaches are primarily targeted towards the traditional key populations at higher risk): PWIDs, MSM, MSWs, FSWs and their clients. With increasing evidence being obtained regarding the risk and vulnerabilities of migrant workers and their spouses, priority programmatic attention had also been accorded to this population. Treatment, care and support services for HIV infected people, and the referral system are continuing to expand across the country.

The current strategy is envisaged to focus on the following: (1) addressing the complete continuum from prevention to treatment, care and support, (2) strengthening the health system and community system, (3) integrating HIV services into the public health system in a balanced manner to meet the specific needs of the target population and (4) creating a strong accountability framework with robust HIV surveillance, program monitoring and evaluation to reflect the results into the National Health Sector Programme II (NHSP II) and national plan.

B. Prevention, Treatment, Care and Support

Prevention

Since the HIV epidemic in Nepal is characterized as "concentrated", HIV epidemic prevention programmes targeting key populations at higher risk (PWIDs, MSM, FSWs, MSWs and clients of FSWs) have been developed. Male labour migrants is one of the key population groups that is exposed to a higher risk of acquiring HIV infection and is playing the role of a bridging population group by spreading HIV infection to the low-risk population, especially their spouse and partners.

The National HIV/AIDS Strategy, 2011-2016 also highlights prevention as a key strategic direction. Resource inflow for HIV/AIDS programs in Nepal 2010 indicates a national spending of approximately 54 per cent in prevention programs. A considerable portion of the prevention programme is currently supported by four major grants from Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) (single stream of funding (SSF)), United States Agency for International Development (USAID), United Nations (UN) agencies and UK Department for International Development (DFID). Over 200 national non-governmental organisations (NGOs), NGO networks and community-based organizations (CBOs) are the main implementers of the fund.

The national guidelines on prevention of mother-to-child transmission (PMTCT) and HIV testing and counselling have been updated by adapting the new World Health Organization (WHO) guidelines on PMTCT and infant feeding. The development of national standard operational guidelines for targeted interventions has also shown progress.

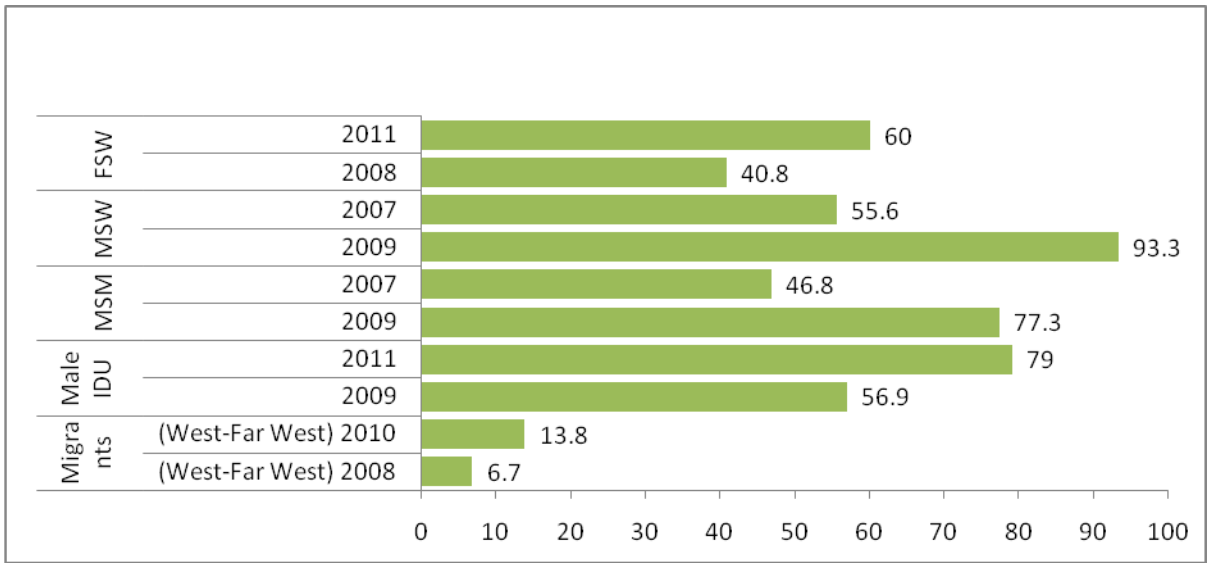
Reducing Sexual transmission of HIV

Programme coverage data (from various IBBS surveys conducted by NCASC) indicate considerable variations among the key populations at higher riskgroups and between the 2008 and 2011 reporting periods. Generally, the coverage of key populations at higher riskhas increased over time. For example, the coverage for FSWs in Kathmandu has increased from 40.8 per cent in the 2009 to 60 per cent in the 2011 . The reports of IBBS survey in Kathmandu also show that in 2009, 93.3 per cent and 77.3 per cent of MSWs and MSM respectively have been reached by the prevention program.

With regard to condom use, 83 per cent (2011) of and 37.8 per cent of MSWs (2009) reportedly used a condom with their most recent clients in Kathmandu. Furthermore, 53 per cent of the male labour migrants reported the use of a condom the last time they had sex with a non-regular sexual partner.

Owing to an increase in the availability of counselling and testing centres throughout the country between 2009 and 2011, the coverage of key populations at higher riskby HIV testing and counselling services expanded during this period. The provider-initiated testing and counselling is being implemented through Antenatal Care (ANC) services and TB/HIV centres. The IBBS report from Kathmandu valley shows that 54.2 per cent and 65.2 per cent of the FSWs and MSWs respectively have been tested for HIV during the last 12 months and they know their test results. Similarly, 42 per cent and 13.8 per cent of MSM and male labour migrants respectively have been tested for HIV during the last 12 months and they know their test results in Kathmandu.

Figure 6: Key populations at higher risk reach with HIV prevention programme



The country has approximately 196 HIV testing and counselling centres and approximately 70 of these centres are located in public healthcare facilities, and other centres are operated through NGO partners that target key populations at higher riskin selected districts. Efforts are being made for facilitating coordination among different implementing partners and stakeholders in order to minimize the duplication of services from NGOs and to focus on increasing the geographic coverage

of counselling and testing. The integration of STI with counselling and testing, and the referral and linkage to continuum of care for the identified positives are also being implemented through some interventions.

Reducing the incidence of HIV infection through injecting drugs

It has observed a significant reduction in the prevalence of HIV among PWIDs in Kathmandu from 68 per cent in 2003, 20.7 per cent in 2009 to 6.3 per cent in 2011. Approximately 95 per cent of the users reported that they had used sterile equipment when they last injected drugs. The rate of needle syringe exchange per PWID per year in 2011 was 71.3 per cent. Although this data is calculated using the estimated number of PWIDs, if we consider this figure for PWIDs covered by HIV prevention programs on the basis of the needles used (24,262), the needle syringe exchange per PWID per year is 94. In 2011, the Opiod Substitution Therapy (OST) programme reached 349 people from 3 OST sites; this figure is the same as that in 2009, that is, 349 people enrolled for OST in 2009.

Frequent coordination meetings among MoHP/NCASC, Ministry of Home Affairs (MoHA), hospitals and stakeholders have been held during the last two years for strengthening the harm-reduction activities among PWIDs, focusing especially on OST. The revision of national guidelines, development of training curriculums and steering of the OST are all underway and progressing. Similarly, initiatives have been taken for developing the National Harm Reduction Strategy.

Reducing vertical (mother-to-child) transmission of HIV

The Government of Nepal has shown their commitment for the virtual elimination of MTCT of HIV by 2015, and PMTCT is a priority programme for NCASC.

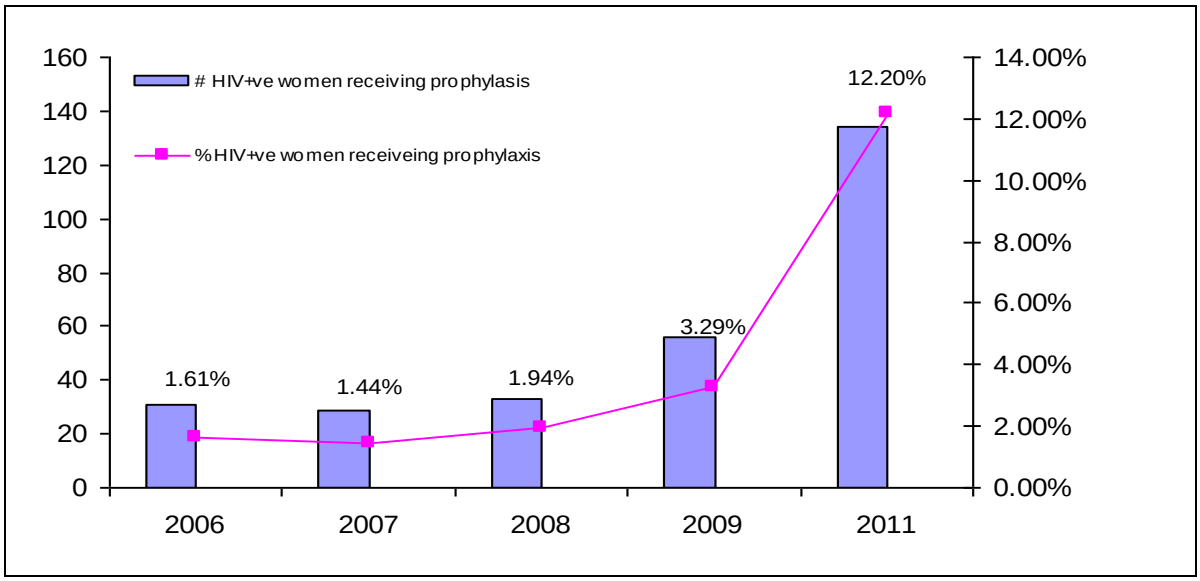
Regarding PMTCT, the coverage is slowly increasing (Figure 7). It is estimated that there are 1,097 HIV-positive pregnant women, of which 933 pregnant women require antiretroviral (ARV) prophylaxis for the prevention of MTCT. In 2011, only 130 of 933 (13.9%) mothers received ARV prophylaxis from 22 PMTCT and community based-prevention to mother-to-child transmission (CB-PMTCT) sites. After the adoption of option B (triple ARV prophylaxis) in 2011, single dose Nevirapine (sdNVP) and expanded regimen with ZDV prophylaxis are gradually getting phased out. Considering the disaggregation by regimen, 31 people received sdNVP, 39 people received expanded regimens, 18 people received Triple ARV prophylaxis, and 46 people were on ART. The coverage of PMTCT is very low and needs to be increased considering the universal coverage targets.

Based on the experiences of CB-PMTCT services in Achham district, NCASC has expanded the services in Sunsari and Kailali Districts. The Female Community Health Volunteers (FCHV) are mobilized in these two districts for CB-PMTCT in order to raise awareness and refer pregnant women for HIV testing and counselling. A plan has been drawn to expand CB-PMTCT efforts to four new districts in the Far-Western region and to provide HIV testing facilities and ARV prophylaxis treatment at the community level. Facility-based PMTCT will be expanded to hospitals and public health centres (PHCs) in 39 HIV high burden districts within the next three years with support from the GFATM. Progress has been made to initiate coordination among the Family Health Division (FHD), Child Health Division (CHD) and NCASC to integrate and establish strong linkages among HIV, child health and reproductive health services focusing on all four prongs. This coordination provides

a platform for expanding the services to the PHC and the birthing centres (at the community level) in the above-mentioned 39 districts to increase the access of the PMTCT services and achieve the PMTCT goal.

Thus far, the Early Infant Diagnosis (EID) services, which enable the confirmation of HIV infection in infants through a virological test, have not been established in Nepal; however, the process for establishing these services has been initiated, and the preparation of the National Early Infant Diagnosis Guidelines is in the final stage. Currently, the EID service is being provided by fhi 360 in five sites, and the dried blood spot (DBS) samples are sent to Bangkok.

Figure 7: Scaling-up of PMTCT Services in Nepal: 2006-2011



Positive prevention

The National Strategy (2011–2016) includes positive prevention, which mainly focuses on beneficial and voluntary disclosure of HIV-positive people's access to treatment and care through engagement of positive people, counselling for PLHIV on safer sex interventions to prevent HIV transmission to others, including family planning (FP) and STI, and behavioural counselling and psychosocial support to HIV-discordant couples through couples counselling. Positive prevention has increased the access of PLHIV to various services and has evoked stigma reduction in the communities. PLHIV themselves are highly effective outreach educators and community mobilizers. By using interpersonal approaches and ensuring confidentiality, they encourage changes in individual behaviours, and are able to reach out more easily to those PLHIV who do not wish to disclose their status.

Between January and December 2011 (data from both ASHA Project and Saath-Saath Project), 1,215 PLHIV (611 males and 604 females) were reached by the project, of which 172 PLHIV were discordant couples and 595 PLHIV (371 males and 274 females) were enrolled for ARV. Furthermore, 145 PLHIV (64 males and 81 females) were trained and mobilized as positive speakers. During this period, 1,469 PLHIV (611 males and 843 females) were trained on HIV-related stigma and discrimination reduction.

Positive prevention under the ASHA[3] Project has led to considerable reduction in HIV-related stigma and discrimination; PLHIV have become more confident and practice and promote safer and healthier lifestyles. After the successful conclusion of ASHA Project on September 30, 2011, positive prevention activities are being continued under the latest HIV and FP intervention by USAID, the Saath-Saath Project, which was initiated in October 2011, and have been scaled up to thirteen districts of Nepal.

Treatment, care and support

The national guidelines on Pediatric ART have been updated in order to adapt the new WHO guidelines. Moreover, the new ART guidelines have been finalized and are in the process of being approved. The community and home-based care guidelines were updated and SOP for Community Care Centres (CCCs) were established in 2011 for standardizing the care and support services in the country.

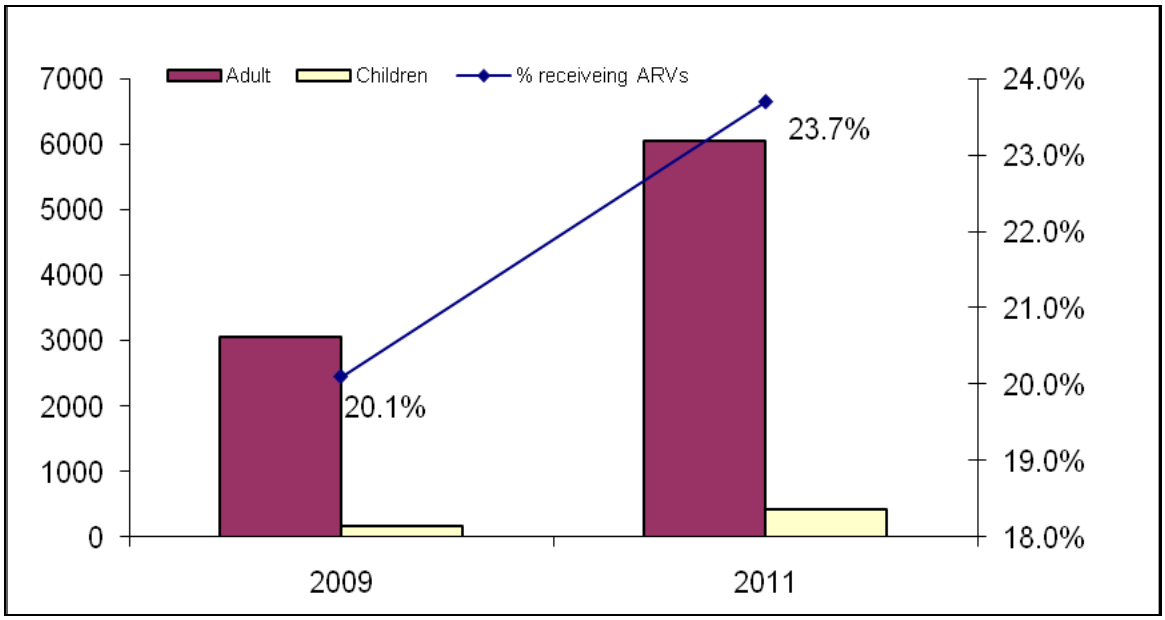
Antiretroviral Therapy

Overall, the estimated number of adults and children falling below the cluster of differentiation 4 (CD4) 350 criteria and thereby requiring ART are 25,244 and 2,112 respectively. Until December 2011, 23.7 per cent (6,051 adults, 432 children) were accessing ART from 26 ART sites and 10 sub-ART sites throughout the country. In 2009, only 20.1 per cent had accessed ART services through 23 ART sites. There has been an increment in ART enrolment during the last one year owing to the country's adaptation of the new WHO criterion for initiating ART. Efforts to align the CCCs, community home-based care (CHBC) sites and ART sites to facilitate the quality of ART services, especially in ensuring adherence and follow up of PLHIV on ART and HIV-positive mothers and infected and exposed babies, have shown good progress.

Although achieving the 80 per cent universal access target for the actual number of people receiving ART versus the total number of people who require ART in the next few years appears challenging, Nepal has been able to enrol and provide ART to all those PLHIV who are ineligible and require ART. The identification rate and coverage of the testing and counselling services need to be increased in order to minimize the gap between the estimated and the identified number of PLHIV, which will assist in increasing the coverage of ART and PMTCT in the country.

[3] Advancing Surveillance, Policies, Prevention, Care & Support to Fight HIV/AIDS (ASHA) Project

Figure 8: Scaling-up of ART services: 2009-2011



The data shows that as of December 2011, 980 of those on ART had died, and 718 have been lost to follow-up. Furthermore, 12 people have stopped treatment and 43 people have switched to the second line treatment of ART. However, owing to a lack of national identification number system and given the high frequency of patient transfers between sites, the verification of these numbers is difficult. Among 36 sites that provide both ART and sub-ART around Nepal, 34 are operated by public hospitals, with the remaining 2 being operated by national NGOs. Thirteen of these sites are equipped for providing the CD4 count service. Initiations and plans to provide integrated counselling testing, PMTCT, adult and paediatric ART services at these 36 sites have already been instituted.

TB and HIV

Coordination linkages between NCASC and National Tuberculosis Programme (NTP) for the TB/HIV have strengthened during the last few years. The development of the TB/HIV protocols, training curriculum and coordination between the two GFTAM grants (TB National Strategy Application (TB-NSA) and SSF HIV) for complementing the TB/HIV initiatives in the country are some of the initiatives that have shown positive results. The TB/HIV coordination team has formulated with the involvement of the officials from the Department of Health Services (DoHS), National TB Center, NCASC, technical partners and other stakeholders. The establishment of the isoniazid preventive therapy (IPT) in the country has also shown progress.

Community and home-based care and services by CCCs have established for providing care support and treatment in a few districts. These CCCs have been able to bridge the gap between the community and the ART centres. Community and home-based care has been instrumental in providing follow-up care at home for PLHIVs.

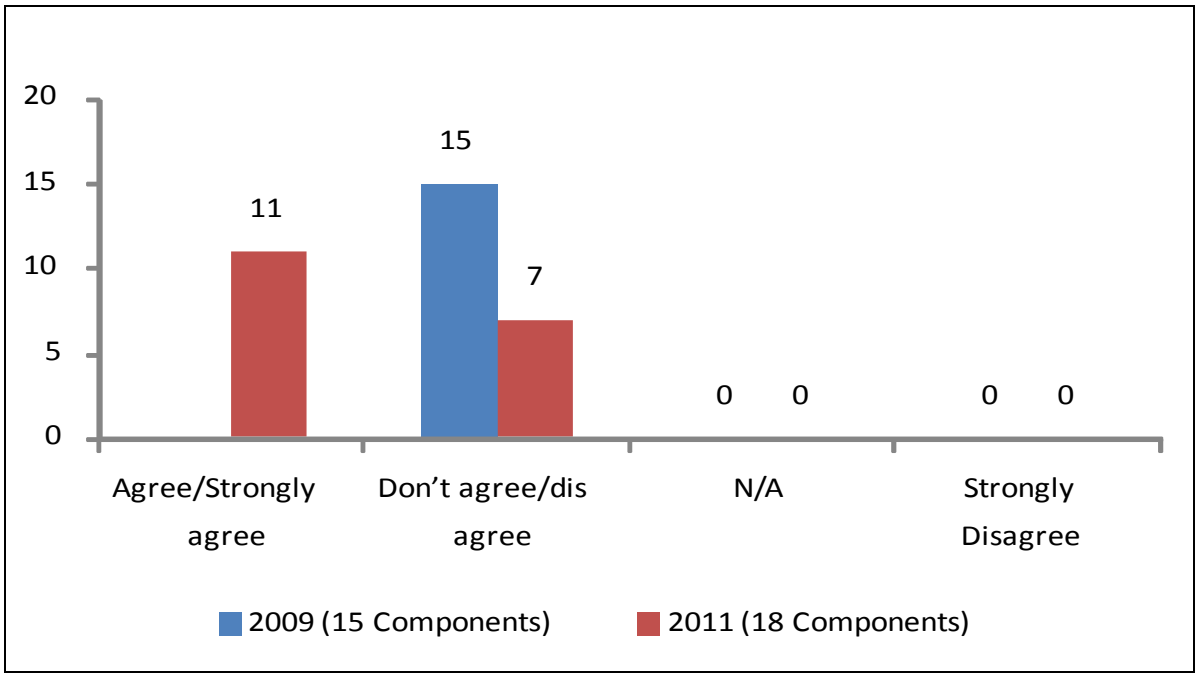
C. Support for creating an enabling environment

An analysis of the trend of NCPI findings over the course of three previous reports yielded a mixed result. The trend analysis of some of the main questions/components of NCPI is described below[4].

To what extent has HIV prevention been implemented?

A majority of the people who require services have access to the following services (this part had 14 components in 2009, whereas there were 16 components in 2011).

Figure 9: To what extent HIV treatment, care and support services implemented?

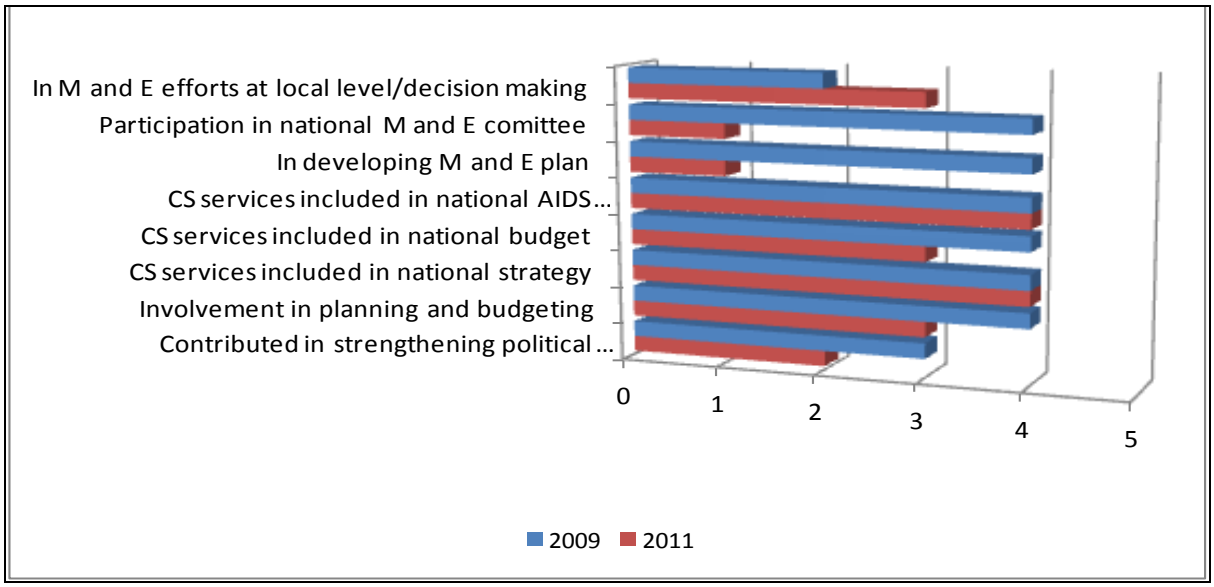


The analysis clearly shows that as compared to 2009, a greater number of participants in 2011 "Agree/Strongly Agree" that more people are now accessing preventions services. This is a reflection of the perception of improved coverage of prevention services.

Part B. To what extent are CS representatives involved in M&E

[4] Please note that there has been a change in the design of the NCPI tool in this round and hence, these trends have to be considered in this context and limitation in mind. Moreover, although in the previous rounds, the NCPI tool was administered at a regional level, it was administered only at National level in 2012.

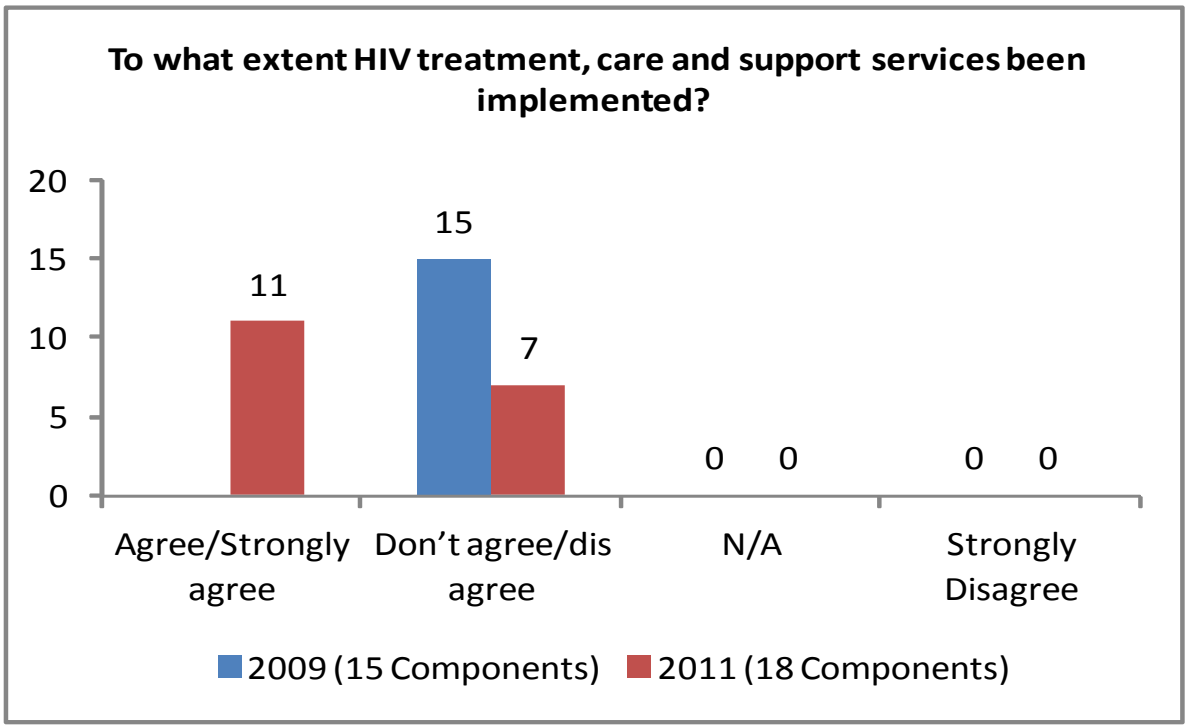
Figure 10: To what extend civil society representative involved (rating at 0-5 scale)



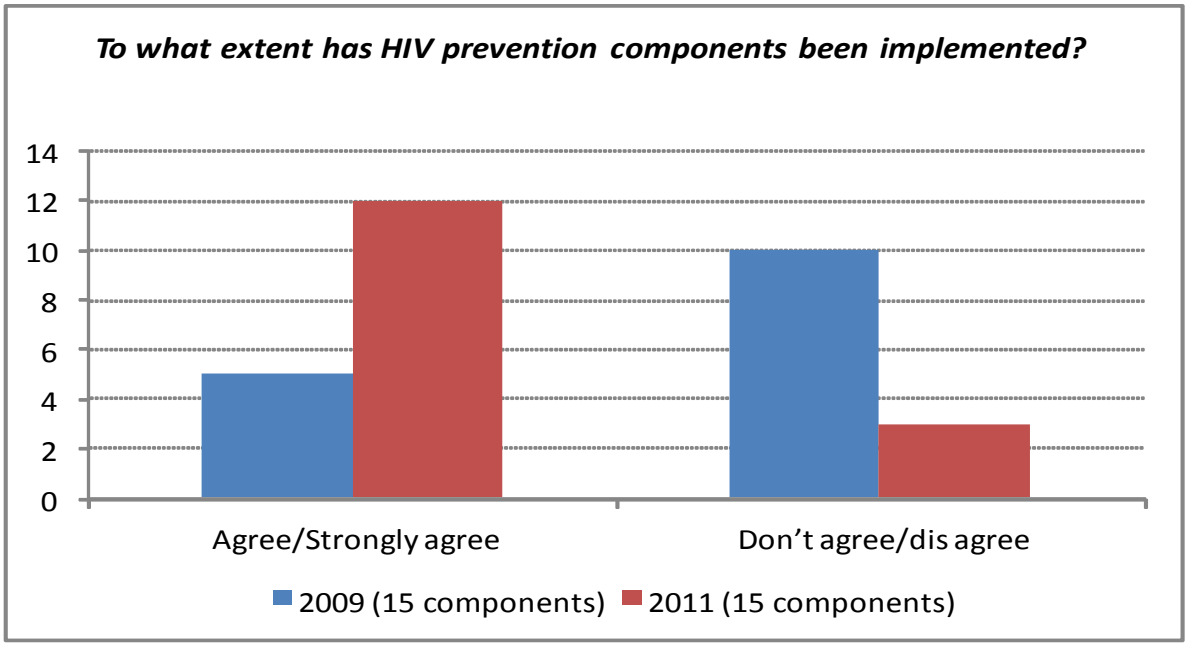
In general, the involvement of the civil society in M&E in 2011 was lesser than that in 2009; however, in some particular aspects, the involvement of the civil society in M&E is higher than that in 2009. This emphasizes the need to institutionalize the linkages and re-activates the Strategic Information Technical Working Group (SI-TWG), which is the forum for involving all stakeholders, including civil society representatives, in the M&E-related work.

1.1. To what extent have the following HIV treatment, care and support services been implemented?

Figure 11: To what extent has HIV prevention components been implemented?



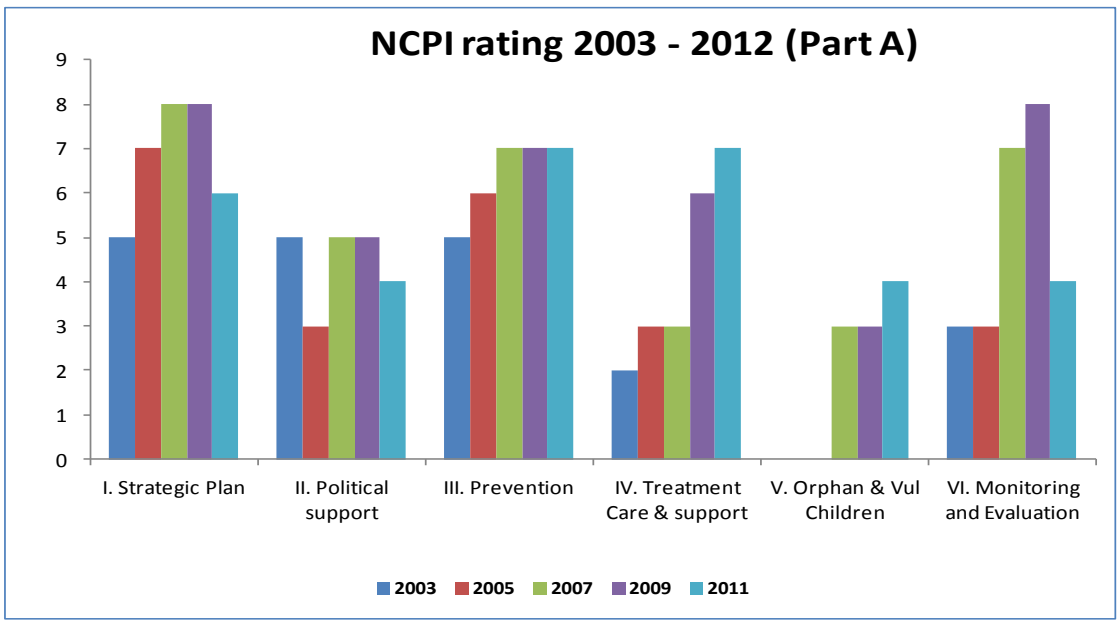
The implementation of treatment, care and support services appeared to be better than that in the previous year.



As compared to 2009, a greater number of the participants in 2011 agreed that many components of the HIV prevention programme had been implemented.

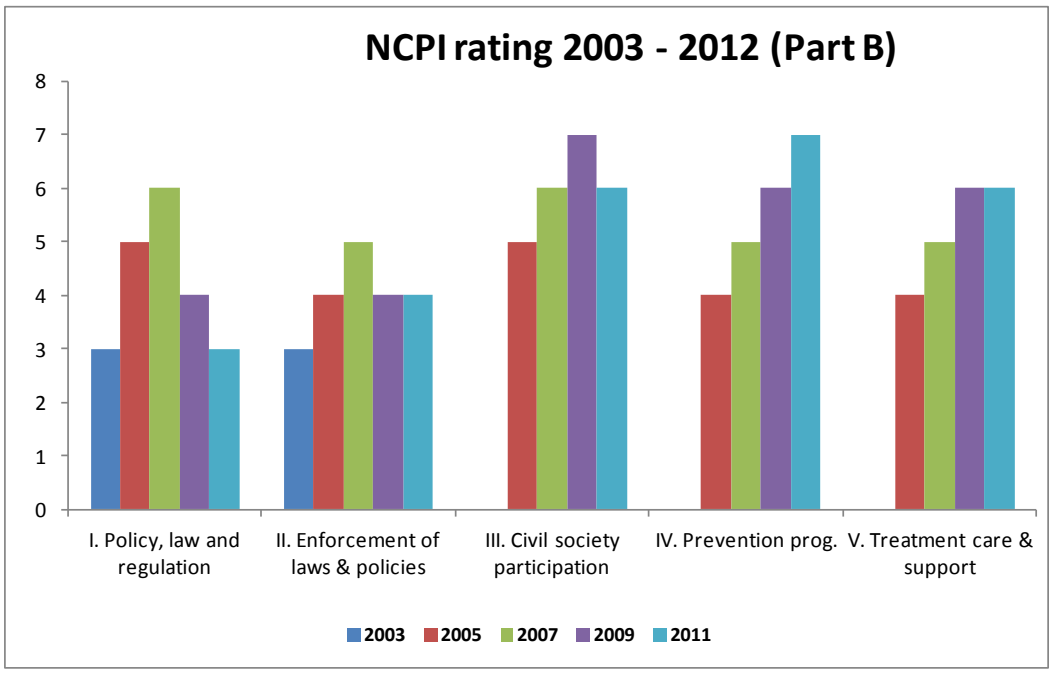
Overall rating part A and part B

Figure 12: : NCPI Rating 2003-2012 (Part A)



As compared to 2009, there was a decline in three areas (effort in strategic plan, political support and M&E) and a marked improvement in treatment care and support in 2011.

Figure 13: NCPI Rating 2003-2012 (Part B)



As compared to 2009, there was a decline in policy, law and regulation and civil society participation, and improvement in prevention programme in 2011.

D. National Programme and Achievements

Some progress has been observed with respect to the national commitment and strengthening of the national response during this reporting period (2010–2011). The major achievements during this period are as follows:

- Recognition of HIV and AIDS as a priority in the country's latest development plan (National Interim Plan, National Health Sector Program Phase II (NHSP II) 2010–2015, National HIV/AIDS Strategy, 2011–2016, National HIV and STI Policy, 2011).
- Inclusion of HIV and AIDS as one of the key programme areas in NHSP II for the period 2010–2015.
- Significant progress has been made towards adopting the "Three Ones" principles:
    - One strategic plan: National HIV/AIDS Strategy 2011–2016
    - One coordinating authority: Establishment of the HSCB under the leadership of the Ministry of Health and Population, with representation from civil society and other vulnerable communities
    - National AIDS Council
    - One M&E framework: The development of a national M&E framework for ensuring the harmonization of national and global indicators (i.e. United Nations General Assembly Special Session (UNGASS) and Health Sector indicators) is underway. A system and

institutional arrangement has established to collect, collate and disseminate information. The above-mentioned points highlight the initial steps that have been taken to establish the country's M&E system, which will enable the use of strategic information to support decision-making, planning and implementation

- Strengthening of institutional arrangements to support the national HIV and AIDS response such as SI-TWG, CHBC, etc. Additional technical working groups or thematic groups (MSM, FSWs and PWIDs) were formed in the areas of treatment and care such as for the management of logistics and supplies, ART working group, etc.
- Securing increased financial resources for HIV and AIDS:
    - Commitment by the government for increased budget
    - Successful application to the Global Fund, SSF (Rounds 7 and 10) and covering the gaps identified for the response
    - Commitment by USAID to continue its funding through the Saath-Saath Project managed by fhi 360
    - From 2010 onwards, World Bank (WB), DFID, Australian Agency for International Development (AusAid) and Kreditanstalt für Wiederaufbau (KfW) have now agreed to fund HIV and AIDS through a pooled funding mechanism
- Progress has been made in terms of strengthening capacity on HIV of national leaders, policy makers, women and youth leaders.
- Formation and registration of networks of key populations at higher risk (e.g. sex worker organizations, network of positive persons, organizations of women living with HIV, networks for MSM, etc).
- Implementation of a comprehensive legal framework on HIV and AIDS to promote human rights and establish HIV and AIDS as a development agenda.

Chapter IV Best practices

A. Legal and constitutional campaign

The LGBTI community has been marginalized and stigmatized, and has been living as a hidden population group for centuries in Nepal; they are harassed, abused, blackmailed, excluded from homes and schools and denied basic healthcare by healthcare centres. A lack of protection from discrimination and violence has driven the LGBTI community further underground, thereby exposing them to further risk of acquiring HIV or contracting STIs.

First, self-help groups of MSM/LGBTI were established in Kathmandu (the first one being Blue Diamond Society (BDS) in Kathmandu) and in other districts of Nepal. Initially, BDS and other MSM/LGBTI CBOs worked on HIV prevention programs that also served as a platform for addressing human rights issues of MSM/LGBTI. Different advocacy, sensitization and awareness raising programs were organized, such as meeting the press, continuous lobbying, delegations and sit-in programs at the central to local levels. Sunil Babu Pant, who is an openly gay and leading LGBT rights activist, took the government to court demanding to end all kinds of discrimination and violence against LGBTI by the state party and to ensure equality. On December 21, 2007, the Supreme Court of Nepal ruled in favour of the LGBTI community ordering the Nepal government to (1) issue citizenship ID to third genders, (2) amend or scrap all discriminatory laws against LGBTI in Nepal and (3) introduce same sex marriage law in Nepal.

The following positive outcomes have resulted from this historic decision of the Supreme Court:

(1) Violence against MSM/LGBTI from the state party has reduced dramatically.

(2) More MSM/LGBTI are openly disclosing their sexual orientation to their families and to the public.

(3) The attitudes of social groups, political parties, government, and media toward LBGTI have become supportive.

Sunil Babu Pant became a member of the Constitution Assembly and Parliament of Nepal. Bishnu Adhikary and Badri Pun were granted citizenship IDs in their own gender identities, as ruled by the Supreme Court. This encouraged other community people to demand their own identities in their own genders. The mainstream political parties acknowledge the problems of the LBGTI community and put them in their manifestos. Moreover, the print media positively highlights the issues of this community and the government has begun allocating funds for enabling the planning and implementation of programs for benefitting this community. Nepal's Country Coordination Mechanism (CCM) has MSM/TG representation. Local district governments also support small-scale MSM/LGBTI programs. Healthcare centres and healthcare providers have become friendlier to LGBTI/MSM. MSM/TG now hold a positive self-image and engage in responsible sexual behaviours.

Merely distributing condoms and providing VCT services cannot be effective in isolation. Human rights must be an integral part of any HIV intervention. The attitudes of the people who have rights

and who are respected are more positive towards themselves and their societies; such people accept and feel proud about their true identities and behave in a responsible manner.

B. Community based-prevention of mother-to-child transmission (CB-PMTCT)

Due to distance, rugged geographical terrain and having the PMTCT services in the district hospital leads to inequity depriving majority of pregnant women from HTC and to know their HIV status. UNICEF and FHI (USAID funded ASHA project) supported GoN to implement a decentralized, community based PMTCT service integrated with MNCH services. The CB-PMTCT model was implemented in Achham, one of the HIV high burden districts.

The community level volunteers were trained to educate, generate demand and refer for PMTCT services. HIV testing and counselling, ARV medicine integrated with the MNCH services at PHCs/HPs, During ANC visits pregnant women are encouraged to take HTC services. If the pregnant woman is tested positive she is referred for CD4 count and eligibility of ART. During pregnancy period she is provided with continuous counselling on nutrition, drugs that she needs to take during and after delivery. Community workers also encourage and support the positive women to have delivery at the health institution.

Based on the Achham CB-PMTCT study report the ANC coverage increased from 78.7% in 2009 to 82.2% in 2011. HTC uptake increased from 8% in 2008 to 40% in 2011 in the intervention area. In the same period 82% positive pregnant women received ARV prophylaxis compared to 50% in 2008, and infant ARV coverage was 57% in 2008 and reached 85% in 2011.

EID result from all HIV exposed babies from Achham is also very promising as all of these children have tested negative. All HIV positive women interviewed had exclusively breastfed their babies for six months. However, the study highlights the need to have birthing facilities at sub health post to increase institutional delivery, andto address stigma and discrimination and changing social norms to ensure equitable access to services.

Realizing the efficacy of this approach that uses the existing human resources and structures available in the community level to improve the PMTCT service utilization, the country has proposed scaling up this service to four additional districts this year. This model can be replicated in countries with similar HIV situation and community health structure.

C. Effective coordination by SI-TWG to harmonize different studies on stigma and discrimination

Three different studies having the component of assessment of stigma and discrimination amongst PLHIV were planned by various agencies.

1. National Federation of Women Living with HIV/AIDS (NFWLHA) in collaboration with Joint United Nations Programme on HIV and AIDS (UNAIDS) and National Association of People Living with HIV/AIDS in Nepal (NAP+N) has conducted a study on women living with HIV/AIDS for profiling their socio-economic status.
2. Likewise, Family Planning Association of Nepal (FPAN), in partnership with UNAIDS, International Planned Parenthood Foundation (IPPF), and NAP+N has conducted a PLHIV Stigma Index study using a globally recommended tool, which allows comparability and aims to track trend on stigma among PLHIV.
3. United Nations Development Program (UNDP) has conducted the end-line survey of DFID/UNDP multiyear HIV/AIDS programme where patient satisfaction was assessed, which also consisted of stigma as a component at the service delivery level. For the stigma-related portion of the study, UNDP collaborated with Center for Molecular Dynamics Nepal (CMDN), UNAIDS, WHO, NAP+N and Nava Kiran Plus.

Since all of the studies focused on stigma and discrimination among PLHIV by assessing the same parameters, there was an obvious overlap. The SI-TWG was the apex technical advisory body that led and coordinated the M&E, research and surveillance activities in the country and played an active role in harmonizing these studies and avoiding an overlap.

In its meeting on 17 January 2011, SI-TWG called a special meeting to examine the stigma index studies and therein requested UNAIDS to coordinate among these three studies to avoid obvious overlap. As requested, UNAIDS, through a series of meetings with all stakeholders, studied the design and operational plans of these studies, ensured that there were no overlaps and synergized the resources available for the studies. This was done by identifying complementarities and capitalizing on them.

Every agency agreed to use the same sample frame (10 districts representing 5 zones). Furthermore, NFWLHA agreed to eliminate the stigma-related questions and focus on reproductive rights issues emphasized by FPAN, and focused on conducting some case studies. FPAN ensured that 50 per cent of the sample size represented women, which made the report more comprehensive and provided data to NFWLHA.

UNDP and FPAN agreed to collaborate on the training of the investigators/interviewers who belonged to the PLHIV community by sharing the cost of travel and other training costs. FPAN agreed to provide a dataset of 27 questions of UNDP interest.

Moreover, it was agreed that all the agencies would clearly acknowledge the use of partnerships in conducting the studies in publications. The experience of conducting these studies by effectively using platforms like SI-TWG and prompt coordination among agencies indicates that studies can be conducted in a timely and cost-effective manner, can save the opportunity cost of respondents, and

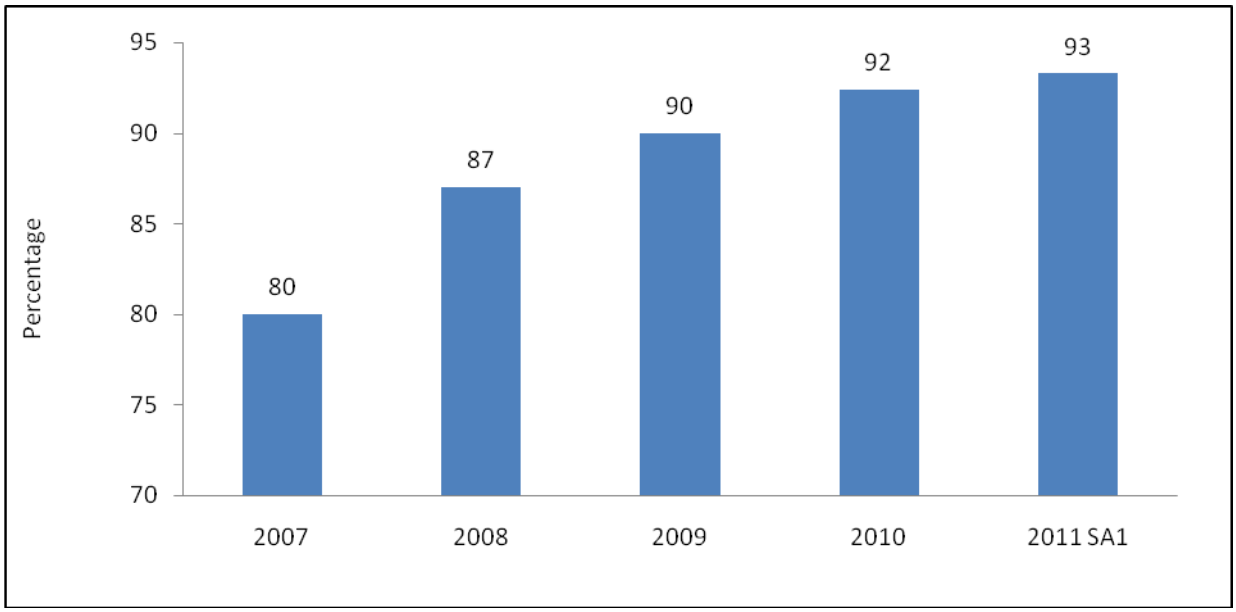
can add to the ownership and quality of the studies.

D. Supporting program through quality data: An example of systematic Data Quality Audit practice from the ASHA Project

Data quality audit (DQA) was integral to routine data monitoring and quality assurance in the USAID-funded ASHA Project, which was managed by FHI 360 Nepal. Quality data are integral for accurate accounting for measuring progress on interventions, evidence-informed decision making and for national/donor reporting. Under ASHA Project, a systematic implementation of DQA was first initiated in 2007 and repeated annually until the end of the project in September 2011. The DQAs involved ASHA Project NGO staff members who generated, monitored, reported and used the data.

The DQA rounds used a standard tool with six dimensions, that is, M&E administration and management, data and system integrity, validity, reliability, accuracy and data use and feedback. Methods used for information collection included management and staff interviews, record reviews and observations. The overall composite score was calculated and expressed in terms of percentage. Based on the recommendations of each DQA exercise, necessary updates were made in the recording, reporting mechanism and database system, additional training was planned and a regular internal DQA was planned at each NGO. As a result, the average composite score increased from 80 per cent in the first year (2007) to 87 per cent in 2008 and 90 per cent in 2009, that is, an increase of 10 per cent. This score was maintained above 90 per cent in all subsequent years.

Figure 14: Composite Scores of DQAs of ASHA Project Implementing Agencies: FYs 2007 - 2011



Building upon this experience, in 2010, the ASHA Project extended support to NCASC in developing and piloting the DQA of HIV data reported by selected government service sites from all five regions. The objective of this mini-pilot project was to utilize the findings to plan the DQA for NCASC and its partners in order to institutionalize a collaborative system for ensuring better quality data for national response. Findings of the mini-piloting were utilized to publish a DQA plan in 2011 using a

refined DQA tool that is suitable for a national data reporting system. This plan is being institutionalized by NCASC.

Overall, the DQA process ensures the quality of collected and reported data by service sites to strengthen the M&E system and establish the credibility of the information being reported for the National HIV Program. It enables the government, donor communities and other stakeholders to have access to reliable evidence for making informed decisions for instituting an effective national HIV response.

Chapter V Major Challenges and remedial actions

Policy and structural response

- Although the revised policy was released in 2011, the directives/executive instructions to implement the provisions are yet to be issued by MoHP. These directives are required for clarifying a few ambiguities and the roles of the following two government entities: HSCB and NCASC.

- Although the policy and strategy envisages the multisectoral nature of response to HIV, there is a need to institutionalize linkages of other related sectors/ministries and develop a truly multisectoral and coherent response.

- Regarding the expanded mandate of NCASC to lead the implementation of targeted interventions, a mechanism is required for ensuring that NCASC regularly consults key populations at higher riskand the PLHIV community to enable effective implementation of the programs.

- Financing the establishment expenses of HSCB, including essential staff, as envisaged in the policy, especially through assured government support, is necessary for HSCB to function as a national multisectoral HIV response coordinating authority.

Programmatic response-prevention treatment care and support

- With the adaptation of the new WHO guidelines of CD4 350 and below and Option B as ARV prophylaxis, maintaining the adherence of the PLHIV, including HIV-positive pregnant mothers during pregnancy and breastfeeding, is challenging. Strong coordination between the existing community health systems, CHBC, CCCs and ART sites needs to be established in order to maintain the optimal adherence level. The existing systems of follow up for monitoring maternal and child health can also be utilized for addressing the challenge. The coordination and inter-referral linkages among the service centres also need to be strengthened. Regular use of the transfer forms initiating individual unique ID for HIV-positive people needs to be ensured.

- The duplication of services such as counselling and testing including STI, needle syringe exchange, CHBC, community mobilization services availability in a defined geographical area needs to be addressed for ensuring optimal resource utilization. This will also prevent the underutilization of these services. Services using the Geographical Information System (GIS) must be mapped in detail and re-location of the services needs to be conducted. The new National HIV/AIDS Strategy, 2011–2016 also focuses on this area.

- Another major area that will require attention in the future is avoiding duplication in reporting. Provision of an individual unique ID, especially for the PLHIV, can be initiated to minimize duplication. This can also assist in ensuring the establishment of adequate follow up monitoring mechanisms for PLHIVs including HIV-positive pregnant mothers.

- A lack of physical access to services owing to difficult terrains and/or limited services in focused districts is a challenge. A focused approach is necessary for ensuring the provision of continuum of care especially for PLHIV. More community involvement and utilization of the existing facilities for availing the services can help in increasing the coverage.

- Defining a minimum comprehensive package for prevention services for key populations at higher risk continues to be a challenge; however, the new national strategy and the progress made in developing the SOP will enable the programs to minimize this gap.

- Determining an appropriate strategy for continuum of care for the people moving across the open border between India and Nepal and displaying high-risk behaviours still requires a clear protocol and strong linkages between the service providers of the two countries need to be developed.

- There are some evidences of the overlapping risk among the key populations at higher riskin the country. A definite approach needs to be designed for groups with overlying risks. Linkage and coordination can be strengthened for providing integrated and comprehensive services among the different implementing partners.

- Retention of pregnant mother on ARV prophylaxis following option B.

- CD4 testing services are available at 13 sites. Innovative approaches have been used by some of the programs for ensuring regular CD4 testing of the PLHIV. The learning from these approaches need to be documented and scaled up for better management of care and support for HIV-positive people. Similarly, viral load testing is limited only to Kathmandu. Systems must be established for better utilization of this service by the service providers and the beneficiaries.

- Establishment and expansion of EID sites for early diagnosis and treatment for infants born to HIV-positive mothers in the country needs to be conducted in the immediate future based on the learning from the existing, though limited, EID services in the country.

Support for creating an enabling environment

- Discriminatory laws continue to affect negatively the prevention efforts; therefore, there is an urgent need to push the HIV bill, which will create an enabling environment.

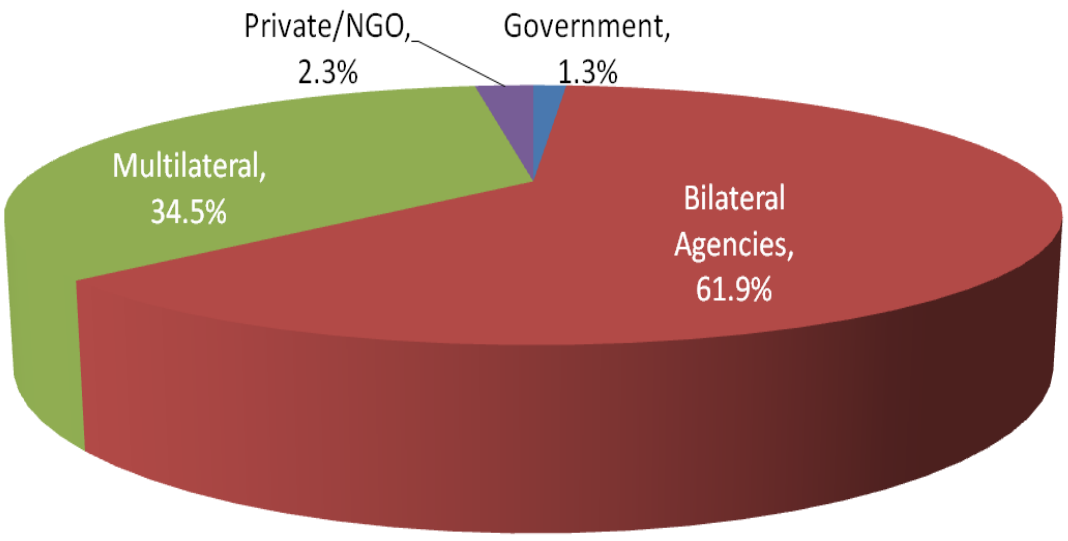
- CBOs need to be strengthened to take up advocacy and legal literacy programmes.

Chapter VI Support from the country's development partners

Nepal used an innovative cost and time effective tool—resource tracking tool—in order to analyse the resource inflow in the AIDS programming in the country. Although the tool uses the same scheme of budget classification as that of the National AIDS Spending Assessment (NASA), it has the advantage that instead of focusing only on the expenditure at the national level, it also analyses the past year expenditure, present year's budget and obligation for the next year up to the district levels. In a response that is heavily dependent upon external support, this permits the policy makers and program managers to have clarity on the sustainability of the present funding, while it can also be potentially used as a tool for donor coordination that will avoid overlaps and duplication. The first published report that used this tool was entitled "Resource Inflow for the HIV and AIDS Programmes in Nepal-2010" and is the latest information source that describes the financing of the HIV response in the country. Information from this study has been used in this Nepal Country Progress Report,2012.

The study[5] revealed that in 2009, 20.45 million USD was spent on HIV programmes in the country, with bilateral and multilateral agencies contributing 61.9 per cent and 34.5 per cent of the total spending, respectively and the Government funding only 1.3 per cent of the overall spending on the programs .

Figure 15: Total Expenditure on AIDS: US $ 20.45 million (2009)



Source: Resource Inflow for the HIV AIDS Programmes in Nepal-2009

[5] For the detailed study design, assumptions and limitations, please refer to the following study: "Resource Inflow for the HIV and AIDS Programmes in Nepal-2010" HSCB/2011

Table 3: Total Expenditure on AIDS: US $ 20.45 million (2009

1. Prevention	11,014,846	10,617	10,631,071	373,158
2. Care and Treatment	1,257,258	0	1,257,258	0
3. Orphans and Vulnerable Children (OVC)	276,880	0	276,880	0
4. Program Management and Administration Strengthening	5,433,132	155,268	5,174,776	103,088
5. Incentives for Human Resources	279,312	99,531	179,781	0
6. Social Protection and Social Services excluding OVC	0	0	0	0
7. Enabling Environment	2,152,711	0	2,152,711	0
8. Research	40,662	0	40,662	0
Total	**20,454,800**	**265,416**	**19,713,138**	**476,246**

Amongst the bilateral agencies, DFID was the largest contributor and supported 30.93 per cent of national response and USAID supported 26.78 per cent of the national response (mainly through the ASHA project, which was implemented through FHI 360). Amongst the multilaterals, GFATM supported 31.3 per cent of the national response and UN agencies contributed 3.19 per cent of national response in 2009.

Bilateral Agencies

Amongst the bilateral agencies, the five-year support by DFID began in 2005; most of its HIV and AIDS funding was channelled through the UNDP and the remainder was directed through NCASC for strengthening DACC at the district level. The four major areas of DFID support have been as follows: (1) supporting NGOs in order to enable them to provide HIV prevention, treatment, care and support services to key populations at higher risk; supporting national NGO networks; (2) supporting project M&E, capacity building and research; (3) enabling the capacity development of GoN structures—primarily, the NCASC and the HSCB and (4) directing the operational cost of the UNDP HIV/AIDS Project Management Unit. By December 2010, over USD 25,146,417 had been expended across these broad areas. In addition, DFID has supplied USD 2.4 million as “bridging fund” to prevent the disruption of services provided to key populations at higher riskby NGOs, whereas MoHP is establishing its system by directly contracting NGOs. An end-of-support period independent

evaluation conducted in 2011 revealed important learning, apart from highlighting a high rate of HIV and Hepatitis B and Hepatitis C co-infections.

USAID assistance is guided by the US Government Nepal Country Assistance Strategy that was developed in 2009 and the Nepal Global Health Initiative Country Strategy that was developed in 2010. The program by USAID aims to reduce the transmission and impact of HIV and AIDS and improve the reproductive health of selected key populations at higher risk in a manner that supports the GoN. This includes support to GoN-led surveillance of the concentrated epidemic, policy development, expansion of prevention, care, support and treatment, and improving the capacity of local NGOs, private sector and GoN to deliver high-quality HIV-related services. The Saath-Saath Project has been planned for a duration of five years from October 2011–September 2016 and has been allocated a total budget of USD 27.5 million. This project is being implemented by a team led by FHI 360 Nepal with Association of Medical Doctors of Asia, Jhpiego, over 40 local NGO partners and in close collaboration with GoN authorities at the national and local levels. The goal of the project has been described as follows: "To reduce the transmission and impact of HIV and AIDS and improve reproductive health among selected most-at-risk populations in a manner that supports the Government of Nepal." USAID also provides approximately USD 2 million per year to support the marketing of condoms and STI kits through the commercial sector through the Ghar Ghar Maa Swasthya Social Marketing Program. This program is specially designed to increase awareness and sustained availability and accessibility of condoms and STI kits to the vulnerable groups.

Saath-Saath Project has seen a few major developments since 2011 with USAID, DFID, WB, AusAID and KfW supporting the national program through pooled funding mechanism as a part of NHSP II.

The Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) supports the scaling up the National OST program in Nepal. The initiative focuses on the capacity development of governmental and non-governmental institutions, including development and institutionalization of training in the field of OST and combined HIV treatment for the staff of relevant services (medical and social support), and builds a reference and referral system with relevant health and support services.

Pooled Funders in the Health Sector-wide Approach (The World Bank, DFID and AusAID, GAVI and KfW)

As a part of NHSP II, USD 19 million has been committed for a period of five years by the pooled funding partners and the activities range from supporting the implementation of the targeted intervention programs to strengthening the national surveillance system. The contracts for implementing the targeted interventions have just being signed and the implementation has just begun.

Global Fund

Nepal has successfully secured an additional USD 57 million for the national response on HIV and AIDS for the period 2011–2016 from GFATM, Round 10. This is in addition to the ongoing Round 7 Phase 2 HIV grant implementation. The purpose of Round 10 HIV grant is to strengthen the capacities of the government and key organizations, including civil society organizations, and to mobilize a sectoral response that enhances and contributes to the achievement of the NHSP II

implementation for increased access to prevention and care services for key populations at higher risk, migrants and women belonging to the reproductive age group in priority districts.

The NCASC, FPAN, Save the Children and UNDP are the principal recipients (PRs) for this grant. Nepal is also one of the recipient countries of the approved Regional MSM proposal of Global Fund Round 9; for this grant, Population Services International (PSI) is the PR.

UN agencies and UNAIDS secretariat

The UN system has supported numerous activities for combating the HIV and AIDS epidemic in the country. The nature and scope of UN support ranges from policy development and capacity building at the national and regional levels, to service delivery and social mobilization at the grass roots level. The main activities supported by UN agencies include supporting the review of the NSP and development of the NSP 2011–16, supporting the strengthening of the national M&E system, Universal Access Review 2010, mapping and size estimation of key populations at higher risk, development of the national surveillance guidelines, expanding PMTCT services and strengthening community-based care programs. The overarching framework of the UN support has been the formulation of national HIV strategies and United Nations Development Assistance Framework (UNDAF), and conducting the Common Country Assessment. Most importantly, the UN system has fully recognized the impact of both the decade long conflict and the new opportunity that it has created for development and social transformation. UNAIDS, as the secretariat of the joint UN programme, supports the GoN and works with all stakeholders to coordinate a variety of activities with the NCASC and the HSCB. UNAIDS is coordinating the development of the national M&E plan along with NCASC in partnership with FHI 360/USAID and is also supporting the development of the NAP.

Other stakeholders

There are number of other funding partners such as Big Lottery Fund and Elton John Foundation that channel their funds through INGOs and NGOs, and some private sector organizations that contribute funds as a part of their corporate social responsibility initiatives.

Challenges and Remedial Actions

- Coordination amongst External Development Partners (EDPs) supporting HIV response in the country has been one of the major challenges for the Government, because many programs remain vertically designed and implemented, thereby resulting in many potential overlaps, as indicated by the resource inflow study. In a few of the districts, over five EDPs are supporting different components of HIV response, thereby adding to the management and overhead costs and also incurring a high coordination cost.
- In absence of a scientific evaluation of the programs supported by EDPs, its impact on the HIV epidemic cannot be understood fully. There is an urgent need to make an impact assessment or conduct an evaluation of the programs using a scientific methodology, on a nation-wide scale, to assess the efficacy of current intervention packages and undertake course correction.

- For effective implementation of a national M&E system, EDPs must agree to migrate to one national system and contribute to strengthening the national M&E system in a phased manner in order to enable the national government to coordinate the national response efficiently.
- The contribution of GoN in funding the response is very low and in order to ensure sustainability and continuation of programs and to play a stronger role in the national response, the Government needs to increase their budget allocation for this disease prevention treatment and care.
- During the transition period, when the national response was to support from pooled funds, the country witnessed disrupted services, especially in terms of the prevention services for key populations at higher risk, and this could have undermined the progress made during the previous years. A well thought-out and carefully implemented transitional plan is strongly recommended to avoid a repetition of such disruption in the future.
- It is recommended that EDPs develop a joint plan to strengthen the national government and gradually move to budget support as against project-based funding to ensure sustainability and effective implementation.
- The legal environment is still non-conducive and discourages key populations at higher riskto access services; there is a need to continue providing advocacy for introducing enabling provisions in law.
- Many EDPs support the national response by directly funding NGOs and in the absence of a system to share this information, its coordination becomes difficult and its alignment with NSP cannot be ensured.

Chapter VII Monitoring and evaluation environment

Overview of the National M&E system

The NAC chaired by the Rt. Hon'ble Prime Minister of Nepal is responsible for the overall monitoring and accountability of national response to HIV in Nepal. The NCASC under the MoHP is established to function as the coordinating department to support the implementation, monitoring and oversight of HIV/AIDS activities for the overall activities under the MoHP. NCASC with its units manages and monitors the relevant activities from the central to peripheral implementing levels and reports relevant national and international committed indicators; its units include Policy, Planning, Advocacy; Prevention; Treatment, Care and Support; Strategic Information (surveillance, monitoring & evaluation and research); Administration and Finance; and Procurement

Strategic Information (SI) unit within the NCASC is responsible for collecting all the information related to HIV in order to substantiate well-informed evidence-based decisions. Being the focal unit for M&E, the SI unit leads all the M&E activities including coordination among various stakeholders and capacity building activities under the NCASC mandates.

At the regional level, regional health offices have been established to monitor and manage health activities. In order to enhance the monitoring of HIV response at the regional level, regional field officers are being recruited to strengthen the current system. At the district level, DACCs, a multisectoral task force, have been established to coordinate and monitor HIV prevention and care activities among the implementing partners and different community stakeholders.

Under the existing national M&E guideline, NCASC has initiated the development of an integrated M&E system of data collection, management, and analysis, at the district, regional and central levels. Furthermore, national M&E training was conducted at the regional and district levels to strengthen the national recording and reporting systems. NCASC has been coordinating and collaborating with various development partners in strengthening and mainstreaming the current M&E system.

Over the last two years, considerable progress has been made in establishing coordination among M&E and surveillance to strengthen national systems. With support from UNAIDS, USAID/FHI 360, DFID, Global Fund, WHO and other development partners, the major activities and achievements are listed as follows:

a) HIV surveillance

- Size estimation of key populations at higher risk (PWIDs, FSWs, MSW/TG/Clients) was conducted by HSCB and NCASC in 2010 with the support from the WB, UNODC, UNAIDS, UNDP and UNAIDS.
- With the support of USAID/FHI 360, NCASC conducted IBBS among FSWs and PWIDs in Kathmandu and Pokhara Valleys in 2011 and among male labour migrants (to India) in Mid-Western and Far-Western districts in 2010
- Nepal has produced national estimates of HIV infections annually (2010 and 2011).

- Nepal has produced EPI factsheets annually since 2009 (three rounds: 2009, 2010 and 2011).
- Prevalence survey of Hepatitis B and C coinfection with HIV was conducted in 2011 by UNDP, UNAIDS and WHO.
- Size estimation of Children Affected by AIDS (CABA) was conducted in 2010 by NCASC, UNICEF and UNAIDS.
- Mode of transmission (MOT) tool was piloted in Nepal as a part of the regional MOT project in partnership with the East-West Center and UNAIDS Regional Support Team (RST), Bangkok.
- Drafted the national guidelines on HIV and STI surveillance in Nepal.

b) M&E

- Nepal has now adopted a new result framework under National HIV/AIDS Strategy, 2011–2016
- A national database has been developed at NCASC and is being rolled out at the regional and district levels in a phased manner. This database will enable the management of the information being received by various implementing agencies and service delivery points. Regular training programmes have been planned to strengthen the capacity of field-level functionaries to improve the quality of reporting.
- The M&E sections of key national guidelines such as STI, HIV testing and counselling, ART and PMTCT have been updated.
- Most of the recording and reporting tools on HTC, ART/OI, PMTCT, STI and targeted prevention interventions in Nepal have been updated.
- End-line evaluation of the five-year programme supported by DFID was conducted in 2011.

c) Research

- A national-level workshop, which was attended by a wide range of stakeholders, was conducted by NCASC with support from WHO in November 2010 to develop the National HIV Research Agenda. The workshop was very consultative and the workshop proceeding outlined the key research priorities in Nepal.
- The National Stigma Index study among PLHIV was conducted using the PLHIV Stigma Index User Guide in 2011 by FPAN, UNAIDS and NAP+N.
- Migrant Risk Index study in Nepal was conducted by UNAIDS in 2011.
- Knowledge, Attitude, Behaviour and Practice surveys amongst street vendors in Nepal were conducted by International Labour Organisation (ILO) and UNAIDS in 2011.
- Study on the behaviour of returnee sex workers from India was conducted by ILO and UNAIDS in 2011.
- Analysis of the socio-economic situation of women living with HIV in Nepal was conducted by UNAIDS and NFWLHA in 2011.
- Risk and vulnerability assessment of transgender people was conducted by BDS, Technical Support Facility (TSF) and UNAIDS.

Challenges and Remedial Actions

- Vertically structured, donor-driven M&E systems are still in existence. Therefore, a common national M&E framework and systems for capturing the details of the national response to HIV and AIDS in Nepal (including those implemented by non-state actors) need to be defined.
- Although M&E has shown substantial achievements over the last two years, it appears that many weaknesses in the system, primarily in terms of quality and timeliness of reporting, persist. The capacities of field-level functionaries in M&E need to be developed; this will improve the quality of data collection, thereby enabling better understanding through more rigorous analysis.
- Currently, the human resources required to implement all the components of national M&E systems at the national and sub-national levels are inadequate. A major portion of the national M&E systems (including human resources) is funded and supported by Global Fund/Pooled fund. In order to ensure its sustainability, a plan for building national capacity with knowledge transfer in a phased manner is required and a plan for integrating M&E of HIV management information system (MIS) into health management information system (HMIS) in the long run also needs to be developed.
- Manual compilation of monthly reports for generating results is time consuming and is unable to provide disaggregated data for further analysis. Considering that the number of served delivery sites has increased by approximately over 500 sites, it is necessary to convert the paper-based recording and reporting system into an electronic system for ensuring efficiency.
- Giving necessary technical updates to all the staff members, especially at the district level (DACCs), poses a big challenge. It is essential to update various M&E training modules and provide refresher training to the staff.
- The problem of developing an inventory of all service delivery points (including that from non-state actors) and updating them persists. Therefore, the service delivery mapping tools to track this information need to be reconstructed and made available for a larger number of stakeholders, especially through the electronic portal (NCASC).
- Various research activities related to HIV and AIDS are planned and conducted by various partners and academic institutions in Nepal. However, in the absence of a clearly defined national HIV research agenda, the studies that are being conducted are not addressing the knowledge gaps and the results are not being effectively used for policy making and improving programmes. Therefore, there is an urgent need to finalize the National HIV Research Agenda (most importantly, the operational research agenda) and concretely define a roadmap with a national plan for conducting HIV research in order to enable the knowledge gained from research to be used for programme efficiency, quality and coverage.

The Need for M&E Technical Assistance and Capacity Building for the year 2012–2013

As an integral part of the national M&E guidelines and plan, the technical assistance and capacity building on HIV-related strategic information (HIV surveillance, programme M&E and research) are

critical aspects of the national M&E systems that require to be well planned, coordinated and streamlined through the development of the national M&E capacity building framework. In early 2011, the third round of the national M&E system was assessed using the 12-component monitoring and evaluation system strengthening (MESS) tools. Based on the findings of the 2011 MESS Assessment, experience from the field, newly updated M&E systems, mechanism and components as envisioned in the new National HIV/AIDS Strategy 2011–2016, the key areas that require national and/or international technical assistance and capacity building/upgrading efforts are as follows:

a) Surveillance

- Develop training curricula for conducting HIV and STI surveillance activities: HSS, IBBS, HIV drug resistance surveillance, and size estimation of key populations at higher risk
- Quality implementation of planned IBBS surveys
- Size estimation of key populations at higher riskto HIV and update this data every 2–3 years
- Advanced HIV epidemic analysis and modelling to better understand the epidemic and informing improved planning of response, such as Asian Epidemic Model, estimation and projection package (EPP)/SPECTRUM, etc.
- Design an implementation framework and plan to conduct HIV drug resistance surveillance, and train adequate human resources
- Design, implementation and reporting of sentinel surveillance for HIV and STI among ANC attendees, STI patients and key populations at higher risk
- Conduct trainings on HIV surveillance including HIV drug resistance
- Improved use of programme monitoring data for surveillance

b) M&E

- Use of programme monitoring data (by adequate and appropriate analysis) for improving programme outcomes at various levels, especially at sub-national levels, by the government and non-state actors
- Design and conduct evaluations of key interventions, preferably prevention interventions among key populations at higher risk to HIV in Nepal
- Use of GIS to best fit the M&E and Surveillance MIS systems to better understand progress and gaps, and take steps for improving the system. This demands the understanding of the basics of GIS application on HIV M&E, getting staff trained by NCASC, and arranging necessary GIS-related infrastructure
- Develop and update national M&E calendar, including surveillance and research activities
- Upgrade the M&E training curricula at various levels for key interventions
- Advanced M&E training for key HIV M&E staff at the national level (including M&E personnel from key partners of national response)
- M&E of M&E is necessary for reviewing and updating the M&E systems and its requirements, including data quality assessment and improvement plans

c) Research

- Finalize the national research agenda and plan with a clearly defined roadmap, and update the research priorities every two to three years
- Design, conduct and report priority operational research through service sites
- Develop a national-level HIV- and STI-related research repository (preferably electronically) at NCASC
- Develop a capacity building framework and conduct training on HIV- and STI-related research, including research communication efforts, such as publishing in peer-reviewed journals

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ANNEXES

ANNEX 1: Country Consultation Process

Date	Activities
19 September 2011	UNAIDS Geneva formally sent a letter to GoN regarding the progress report on AIDS
23 September 2011	UNAIDS Country Office shared the GARPR Reporting Guideline to NCASC and requested NCASC to initiate the process of reporting
12 October 2011	UNAIDS Country Office formally sent a letter to Secretary of MoHP requesting the initiation of the progress report on AIDS and assigned the organization and focal person for liaising and communicating with UNAIDS for the reporting
16 November 2011	MoHP assigned NCASC for the preparation of GARPR Report
1–11 December 2011	The focal person collected background materials, developed a draft road map, prepared matrix of indicators and data needs in consultation with the SI unit of NCASC and UNAIDS Nepal.
12 December 2012	First Preparatory Meeting for initiating GARPR process held and roadmap drafted.
1 week of January 2012	Concept Note and roadmap for GARPR reporting prepared.
3 January 2012	First informal TWT meeting held; roadmap and report chapters finalized; responsibility of drafting the chapters assigned
10 January 2012	Meeting with new ERA for re-analysis of IBBS indicators required for global reporting held
19 January 2012	Formation of Advisory Group (AG) and Technical Working Team (TWT) with clear TORs and concept note of GARPR
6 February 2012	Advisory Committee Meeting held and the roadmap and status of reporting shared
February 2012	Resource inflow for HIV/AIDS Programme data reanalyzed as per GARPR requirement for indicator 6.1
13–14 Feb 2012	National Consultations on National Commitments and Policy Instrument held with Government Agencies and CSO organization including Multilateral and Bilateral Organizations
1–12 March 2012	Data by TWT was reviewed
13 March 2012	Data Validation workshop held
14–15 March 2012	Workshop to draft narrative section of the report held
16 March 2012	Draft report shared through online process with stakeholder for comments and feedback
23–24 March 2012	TWT addressed genuine comments and suggestions received from stakeholders
25 March 2012	Forwarded to MoHP for final endorsement
29 March 2012	GARPR Report submitted to UNAIDS Headquarters

ANNEX 2: Terms of References for Technical Working Team and Advisory Group

TOR of Technical Working Team (TWT)

- Identify the data needs (including sources and collection tools) as required by the indicators to be reported
- Develop a road map for the timely completion of the preparation of the National AIDS Response Progress Report 2012-Nepal
- Collect and collate data
- Analyze data, obtain final result values (findings) and complete the data forms
- Prepare draft results of the National AIDS Response Progress Report 2012-Nepal
- Conduct data validation workshop with relevant stakeholders
- Share the draft report to the Advisory Group (AG) and other experts for their technical inputs;
- Conduct final dissemination workshop of the National AIDS Response Progress Report 2012-Nepal
- Submit the final narrative report and indicator data to the director of NCASC

Members of TWT

1. Dilli Raman Adhikari, SI focal point, NCASC
2. Dr Hemant Ojha, Senior Medical Officer, NCASC
3. Mahesh Shrestha, M&E Officer, NCASC. Also focal point for GARP Reporting 2012
4. Deepak Kumar Karki, Surveillance Officer, NCASC
5. Alankar Malviya, M&E Advisor, UNAIDS, Country Office, Nepal
6. Dr Atul Dahal, National Profession Officer, WHO, Country Office, Nepal
7. Birendra Pradhan, UNICEF, Country Office, Nepal
8. Komal Badal, UNAIDS

TOR of Advisory Group (AG)

- Provide technical advice to TWT to ensure the timely preparation of National AIDS Response Progress Report 2012-Nepal
- Specifically, provide technical advice to TWT in terms of identifying data requirements, sources of data and data collection tools required for indicators, as well as to document the limitations of the data available
- Provide timely and constructive feedback to TWT for finalizing the National AIDS Response Progress Report 2012-Nepal

Member of Advisory Group (AG)

1. Dr. Yesho Bardhan Pradhan, Director General, Department of Health Services
2. Dr. Bal Krishna Suvedi, Chief PPICD Division, MoHP
3. Dr. Ramesh Kumar Kharel, Director, National Centre for AIDS and STD Control
4. Mr. Bishnu Sharma, Executive member, HSCB

5. M&E Officer, Ministry of Health and Population (MoHP)
6. M&E Officer, National Tuberculosis Centre
7. Senior Officer (Statistician/Demographer), HMIS, Management Division
8. Senior Officer (Statistician/Demographer), Center Bureau of Statistics (CBS)
9. Representative, Institute of Medicine, Tribhuvan University
10. Ms. Tara Chettry, Chief of Party, Save the Children
11. Dr. Pulkit Chaudhary, Project Director, Global Fund Program, Family Planning Association of Nepal (FPAN)
12. Mr. Satish Raj Pandey, Country Director, FHI 360
13. Dr. George Ionita, Programme Manager, HIV-PMU, UNDP
14. Ms. Nafisa, Chief, HIV Unit, UNICEF
15. Ms. Shanta Gurung, USAID
16. Mr. Goma Rai, President, NAP+N
17. Mr. Sunil Babu Pant, President, LGBTI
18. Mr. Anan Pun, President, Recovering Nepal
19. Ms. Bijaya Dhakal, President, Jagriti Mahila Maha Sangh
20. Mr. Jagadish Chandra Bhatta, President, National NGOs Network Group Against AIDS, Nepal (NANGAN)
21. Mr. Rishi Ojha, President, Nepal HIV/AIDS Alliance (NEHA)
22. Ms. Tsering Sherpa, President, NFWLHA
23. Representative, Nepal Red Cross Society (NRCS)
24. Mr. Rajan Bhattrai, Programme Co-ordinator, NCASC
25. Dr. Bhesh Raj Pokharel, Senior Integrated Medical Officer, NCASC
26. Ms. Usha Bhatta, Public Health Officer, NCASC

ANNEX 3: National Commitments and Policy Instrument (NCPI)

Uploaded on http://aidsreportingtool.unaids.org