

Joint HIV Assessment Mission of Conflict-affected Populations in Nepal



Nepalgunj border crossing point with India

20th November to 1st of December 2006

Participating agencies: UNHCR, UNAIDS, UNFPA, OCHA, WFP, UNDP,
UNESCO, AMDA and the National Centre for AIDS and STI Control

Acknowledgements

The success of this mission would not have been possible without the support of the National Centre for AIDS and STI Control, the offices of UNHCR and UNAIDS in Kathmandu and the support of other UN agencies in the field sites, especially UNDP and UNOCHA in Banke and UNHCR in Damak. Much gratitude is also expressed for the non-government organisation staff who gave their time freely to participate in this mission and whose input was invaluable; in particular, the Lutheran World Federation, AMDA, General Welfare Pratishtan and the British Nepal Medical Trust.

The mission is also indebted to the many government officers of a number of ministries who readily gave their time and insights especially at such a crucial time in Nepal's history and the non-government organisations and community-based organisations who willingly participated. Finally, great appreciation to the people of Banke, Ilam and Kathmandu who so readily participated in this assessment and provided their insights and experiences in often sensitive and personal areas. Though there is no guarantee that they themselves will benefit from the assessment it is anticipated that conflict-affected populations in Nepal and elsewhere will benefit from the insights gained and actions arising out of this assessment.

Table of Contents

List of acronyms	4
Executive summary.....	5
1 Background.....	7
1.1 Context.....	7
1.2 Objectives	7
1.3 History and manifestations of the conflict in Nepal	8
1.4 HIV situation in Nepal	9
1.5 Defining HIV vulnerability, risk and exposure.....	11
2 Methodology	11
3 Findings.....	12
3.1 Ilam	12
3.1.1 General situation	12
3.1.2 Overview of HIV and Sexually Transmitted Infections (STIs).....	13
3.1.3 Protection	13
3.1.4 Vulnerabilities relating to HIV infection	14
3.1.5 Risks relating to HIV infection	15
3.1.6 HIV Prevention	17
3.2 Banke	18
3.2.1 General situation	18
3.2.2 Overview of HIV and STIs	19
3.2.3 Protection	19
3.2.4 Vulnerabilities relating to HIV infection	20
3.2.5 Risks relating to HIV infection	21
3.2.6 HIV Prevention	22
3.2.7 Care, Support and Treatment	23
3.2.8 Surveillance, monitoring and evaluation	24
3.3 Kathmandu Valley	24
3.3.1 General situation	24
3.3.2 Overview of HIV	25
3.3.3 Vulnerabilities relating to HIV infection	26
3.3.4 Risks relating to HIV infection	28
3.3.5 HIV Prevention	29
3.3.6 Care, Support and Treatment	29
3.3.7 Surveillance, Monitoring and Evaluation	29
4 Discussion.....	30
5 Conclusion and Recommendations.....	32
5.1 Overall Recommendations.....	32
5.2 Ilam	34
5.3 Banke	34
5.4 Kathmandu Valley	35
Annex 1: Tables	36
Annex 2: Team Members.....	37
Annex 3: Background Information	38

List of acronyms

AIDS	Acquired Immunodeficiency Syndrome
AMDA	Association of Medical Doctors of Asia
ANC	Antenatal Care
ARV	Antiretroviral
CAP	Consolidated Appeals Process
CDO	Chief District Officer
CHAP	Common Humanitarian Action Plan
CPN	Communist Party of Nepal
DACC	District AIDS Coordinating Committee
FHI	Family Health International
FPAN	Family Planning Association of Nepal
FSW	Female Sex Worker
GFATM	Global Fund for AIDS, TB and Malaria
GWP	General Welfare Pratishtan
HIV	Human Immunodeficiency Virus
OCHA	Office for the Coordination of Humanitarian Affairs
IBBS	Integrated Bio-behavioural Survey
IDP	Internally Displaced Person
IDU	Injecting Drug User
IEC	Information, Education and Communication
INF	International Nepal Fellowship
INSEC	Informal Sector Service Centre
LWF	Lutheran World Federation
MARP	Most-at-risk Population
MSM	Men who have Sex with Men
MSW	Male Sex Worker
NCASC	National Centre for AIDS and STI Control
NFCC	National Fertility Care Centre
NGO	Non-Governmental Organisation
NRCS	Nepal Red Cross Society
NSARC	Nepal STI and AIDS Research Centre
PLWH	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
SOVAA	Social Volunteers Against AIDS
SPA	Seven Party Alliance
STI	Sexually Transmitted Infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Social and Cultural Organisation
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
VCT	Voluntary Counseling and Testing
VDC	Village Development Committee
WFP	United Nations World Food Programme

Executive summary

In November 2006, a joint mission led by UNHCR and the UNAIDS Secretariat, was undertaken to assess the measures to prevent and respond to HIV among conflict-affected populations in Nepal. Participants were from seven UN agencies, national NGOs and the National Centre for AIDS and STI Control.

The assessment was undertaken in three sites in Nepal - Ilam, Banke and Kathmandu districts - that have all been differentially affected by the conflict, are at different stages of the HIV epidemic and have quite different socio-economic profiles. The conflict has had a profound impact on the three selected districts - triggering displacement and migration, disrupting schooling and, occasionally, access to and provision of health services. It has also hampered HIV prevention efforts and impeded efforts to coordinate and improve HIV services at District level. However, the impact of conflict on HIV vulnerability and risk varies considerably from site to site.

In Nepalgunj, the district headquarters of Banke, the conflict was manifest by fragmentation of families and creation of resultant vulnerable household structures whose needs were not addressed due to the lack of protection mechanisms in place. This heightened vulnerability contributed to the increase in male and female sex workers in Nepalgunj and increased number of children and women in potentially abusive and exploitative situations. New entrants to sex work were less likely to be reached by HIV prevention programs and thus, were at greater risk. Of great importance to the humanitarian community is that the lack of protection mechanisms in place clearly exacerbated vulnerability amongst women and children, including HIV-related vulnerability.

Also of significance in Banke was the large increase in uniformed forces as large numbers of army and armed police moved into the district. This resulted in increased civil-military interaction due to the greater demand for sex work and mixing of populations with different levels of risk of HIV transmission (military with civilians). Furthermore, there was disruption of some HIV prevention programs such as outreach of critical HIV prevention services to sex workers. Though impossible to quantify there were reports of increased sexual violence including rape associated with the conflict. In addition to being an abhorrent crime rape carries a higher risk of HIV transmission. It is imperative that programming in conflict addresses prevention and response to sexual and gender-based violence.

Conversely, some factors may have reduced vulnerability to HIV in Nepalgunj. Reduced mobility of transport workers may have meant that fewer transport workers were visiting sex workers. The rural-urban migration may have meant increased availability and utilization of reproductive health and other health services and improved access to education services – all of which would have afforded a degree of protection against HIV.

In Ilam, a more prosperous rural area, there was some fragmentation of families leading to greater vulnerability but not to the extent experienced in Banke. This may have left more women and girls vulnerable to engaging in sex work but this may have been offset by reduced demand due to Maoist condemnation of sex work and curfews - both of which reduced the client base. The conflict most likely precipitated increased rural-urban migration, particularly for young people, and greater migration - mostly of males - to India and elsewhere. The rural-urban migration may have resulted in sexual mixing of these populations but as the level of HIV infection is purportedly very low in both urban and rural areas of Ilam the impact of this on HIV transmission is likely to be negligible.

The biggest armed force presence in Ilam was that of the Maoists. As the Maoist ethos was one of abstinence before marriage and use of sex workers was condemned the usual civil-military sexual interactions associated with a large military presence may not have taken place. Another factor that may have reduced vulnerability was the reduced mobility of transport workers.

Child labour increased dramatically in Kathmandu; though not specifically examined by this assessment large numbers of children, sent to Kathmandu from the districts, would have been placed in situations that rendered them vulnerable to exploitation and abuse. In addition to the psychosocial consequences this would have made them more vulnerable to HIV.

IDUs in Kathmandu may have been more vulnerable to HIV as increased security measures meant people were injecting in private and, consequently, were more isolated from the HIV prevention measures of NGOs.

Throughout Nepal the longstanding conflict exacerbated rural-urban migration and migration to India and elsewhere. Many of these are males migrating alone; male migrants are known to frequent sex workers more often than non-migrants thus increasing their risk of HIV infection. In the post-conflict phase as migrants/displaced persons start to return to areas of origin there is a need to ensure that they have access to HIV-related services throughout all stages of the migration process.

The assessment demonstrates the importance of a coordinated and multisectoral response to HIV during conflicts and, in particular, the importance of strengthened protection mechanisms for women and children. Much of the vulnerability would have been reduced if these mechanisms had been in place. Furthermore, there is a pressing need for better coverage of HIV prevention activities in most at-risk populations and in villages where displaced persons and migrants may return as peace is restored. In the post-conflict scenario with return of persons to rural areas and with the increased numbers of young people in Maoist cantonments there is a need to adjust HIV prevention interventions to this new reality; transition programming affords opportunities for renewed HIV prevention efforts. There are signs of a higher burden of HIV in some districts that have been the source of large numbers of migrants. In addition to strengthening prevention in these source districts, there is a need to improve the care, treatment and support of PLWHs and their families.

1 Background

1.1 Context

Nepal's decade-long conflict formally ended on 21 November 2006. The war claimed the lives of over 12,000 people and shattered families and communities with displacement, migration, abductions and other losses. Populations affected by conflict may have an increased vulnerability to HIV arising from, *inter alia*, breakdown of traditional family and community safety nets placing women and children at risk of HIV through exploitative situations and transactional sex and disruption in education, health, and other essential services including HIV prevention programs. However there is no evidence that increased vulnerability results in a higher HIV prevalence in affected communities.

A better understanding of specific risks and vulnerabilities is needed to comprehensively respond to HIV within a humanitarian context. In 2005, UNHCR reviewed the HIV-related needs of internally displaced persons (IDP) in eight priority countries, including Nepal. The findings suggested that HIV interventions for IDPs failed to address their specific needs¹. To address this gap and contribute to the evidence base of HIV and conflict-affected populations, a number of country-specific interagency assessment missions are planned; Nepal was the first of these missions.

The assessment mission to Nepal took place from 20th November to 1st of December 2006. Ilam, Banke and Kathmandu were the three areas selected to represent rural, semi-urban and urban sites in eastern, mid-western and central Nepal respectively. In Banke and Ilam, due to time constraints, the assessment focussed on the more densely populated District Headquarters.

1.2 Objectives

1. Describe the epidemiology (including prevalence, risk behaviours and vulnerabilities) relating to HIV in conflict-affected communities.
2. Describe and assess current HIV-related interventions.
3. Provide quantitative and qualitative information to guide the development of UNAIDS Nepal's HIV programming in the post-conflict phase.
4. Contribute to the evidence base on HIV programming in conflict-affected populations, including lessons learned, on the integration of the response to HIV within the cluster approach² and the relationship, coordination and technical support mechanisms between the cluster approach and the UNAIDS Technical Support Division of Labour Matrix.
5. Develop recommendations to reduce vulnerability and risk of exposure to HIV and respond to the needs of those infected and affected in conflict settings.

¹ Spiegel, P and Haroff-Tavel, H. (2006) *HIV/AIDS and Internally Displaced Persons in Eight Priority Countries*. January

² In Nepal a collaborative approach has been applied where clusters leads may be shared

1.3 History and manifestations of the conflict in Nepal

The Maoist insurgency started in 1996 as a revolt against the power imbalances that oppressed non-Hindus, women, lower castes and linguistic minorities. The movement grew in popularity among the rural poor in western Nepal attracting marginalised ethnic groups, lower castes and women. The insurgency was characterised by attacks on the police, main landowners, members of other political parties, teachers and local government officials. Forced to leave their land and property or threatened because of their association with the monarchist regime, many people targeted by the Maoists started moving to district headquarters where many chose to settle. Using guerrilla tactics and virtually unchallenged by the government during the first five years, the Maoists gradually gained ground in other districts of the country.³ By 2001, the Maoists controlled 22 of Nepal's 75 districts,⁴ but were present in almost every district. A pattern emerged, with the Maoists more or less controlling the rural areas and the government's presence mainly restricted to district headquarters and urban centres.

It was not until the deployment of the Nepalese Army and the declaration of a state of emergency in late 2001 that the conflict escalated; 54,000 soldiers were deployed throughout the country. Particularly after November 2001, when security deteriorated markedly in rural areas, many people started fleeing to urban district centres, large cities like Kathmandu, Biratnagar and Nepalgunj, and across the border to India. By then, displacement had also started to affect other poorer strata of the population who fled fighting between the rebels and the army, alleged widespread and systematic violations of civilians by the Nepalese Army,⁵ forced recruitment into Maoist ranks and also the more general effects of war.

Between 2001 and 2006 three attempts at a peaceful resolution collapsed; in what was a hugely unpopular move King Gyanendra took control of the country's parliament on 1 February 2005. However, in April 2006, the Communist Party of Nepal (CPN) - Maoist and the Seven Party Alliance (SPA) launched a nationwide popular movement against the monarch's autocratic rule, forcing the king to give up power and restore Parliament. CPN-Maoist and the SPA concluded peace talks culminating in the signing of a comprehensive peace agreement on 21 November 2006.

The transition period leading to the elections of a Constituent assembly in mid-June 2007 involves the cantonment of Maoist combatants, the restriction of the Nepal Army to its barracks and storage of arms and munitions.

³ http://www.raonline.ch/pages/story/np_mao_sum01.html

⁴ Human Rights Watch (2004) *Between a rock and a hard place: civilians struggle to survive in Nepal's civil war*. Human Rights Watch: New York. Available online at <<http://www.hrw.org/reports/2004/nepal1004/>> last accessed [19/01/07].

⁵ Draft Final Report Joint Inter Agency Mission to Mid-Western Region 9 – 16 December 2005

Problems with the Definition of Internal Displacement in Nepal

The UN guiding principles on internal displacement define internally displaced persons as “persons ... who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations or generalised violence, violations of human rights or natural or human-made disasters, and who have not crossed an internationally recognised border.” The estimated number of IDPs in Nepal ranges from 100,000 to 250,000. Part of the difficulty in obtaining a more accurate estimate lies in the stigma associated with IDPs in Nepal which has forced most to conceal their identity. Until recently the term IDP was used for a very limited and specific group of displaced persons, namely wealthier land-owners, the politically affiliated or those openly opposed to the CPN Maoists, persons accused of being informants for the Nepalese army as well as persons the CPN Maoists judged to be “bad or anti-revolutionary people” such as ‘exploitative’ employers.⁶ Indeed all of these groups were forced out of their homes by Maoist threats and the first waves of displaced were mostly drawn from these groups. However, this definition excluded the reportedly large numbers that were victims of widespread violations perpetrated by state actors. Furthermore, as the conflict progressed the impact on the general population worsened and as schools were closed, services disrupted, and children abducted whole communities were affected leading to both forced and unforced migration on a larger scale. Due to the stigma associated with the term IDP in Nepal this assessment focussed on conflict-affected communities and individuals, many of whom were displaced.

1.4 HIV situation in Nepal

Nepal’s HIV epidemic is concentrated among groups at higher risk of HIV, with a general population prevalence estimated at 0.55%.⁷ As of 2005, there were an estimated 70,253 HIV-positive adults⁸, almost half of whom live in the southern districts. Three times as many men live with HIV as women. Most recent estimates⁹ show that 46% of HIV cases are among seasonal labour migrants, 19% among clients of sex workers, 10% are among IDUs and 2% among female sex workers (FSW). A remaining 20% represent wives or partners of HIV positive migrant workers – largely rural females and a number of urban females.

While health facility-based surveillance was discontinued in 2002, regular sero-prevalence surveys have been carried out among groups at higher risk (injecting drug users (IDU), female sex workers (FSW), men who have sex with men (MSM) and clients of sex workers) in Nepal since 2003. In 2005 surveys estimated a 2% HIV prevalence among sex workers in the Kathmandu¹⁰ and Pokhara¹¹ valleys. Among

⁶ OCHA Nepal Thematic Report (2006) *The internally displaced persons: current status*. OCHA: Kathmandu, Issue No1, 06/09/06.

⁷ UNAIDS, Kathmandu

⁸ Aged between 15 and 49 years

⁹ FHI/NCASC (2005) *2005 Estimate report*. FHI: Kathmandu

¹⁰ New ERA/SACTS (2005) *Integrated bio-behavioural survey among female sex workers and behavioural surveillance survey among clients in Kathmandu Valley*. FHI: Kathmandu.

sampled IDUs, HIV infection rates are 51.7% in the Kathmandu valley¹², 31.6% in the Eastern *terai*¹³, 21.7% in the Pokhara valley¹⁴ and 11.7% in the Western and Far Western *terai*¹⁵. There are no data on HIV or STIs specific to those who were displaced.

The National Response

A multi-sector National AIDS Coordinating Committee (NACC) chaired by the Minister of Health was established in 1992. It was expected to lead the multi-sector response, and to coordinate active participation of all sectors in the fight against HIV/AIDS. However, it was not functional until December 2005. The National AIDS Council (NAC) was established in 2001 and is meant to determine overall HIV policy and strategy. The NAC is under the Prime Minister's authority, but it has not functioned as envisioned due to frequent leadership changes.

In practice, the Ministry of Health and Population is the leading authority for the national programme and the National Centre for AIDS and STI Control (NCASC) is the technical and coordination focal point. The NCASC has developed a National Strategy on HIV/AIDS a revision of which has just been completed. Each year, an Annual Work Plan is developed; the Annual Work Plan and Budget for 2005-06 was developed in a participatory manner, involving a wide array of key stakeholders and thus it currently provides a common reference point for the national response. At the district level, District AIDS Coordinating Committees (DACC) are charged with implementing and monitoring HIV projects according to national strategies and guidelines.

The needs of conflict-affected populations have not been addressed by either the National HIV Strategic Plan 2002 to 2006 or the Global Fund proposal for HIV in Nepal. There are activities funded by the Global Fund in conflict-affected districts, but no specific activities for conflict-affected populations. The draft revised National Strategic Plan 2007 to 2011 recognises the presence of conflict-affected populations. The operationalisation of this plan needs to ensure that the needs of these various groups are met.

The 2005-2006 Common Humanitarian Action Plan (CHAP) recognised that Nepal, like many other countries in the region, is reporting increasing numbers of persons infected with HIV. It also acknowledged the rise in HIV vulnerability as a result of armed conflict; USD 185,000 was requested in the Consolidated Appeals process (CAP) to address HIV prevention among most-at-risk populations (MARPs) in-conflict affected areas.

¹¹ New ERA/SACTS (2005) *Integrated bio-behavioural survey among female sex workers and behavioural surveillance survey among clients in Pokhara Valley*. FHI: Kathmandu.

¹² New ERA/SACTS (2005) *Integrated bio-behavioural survey among injecting drug users in the Kathmandu Valley*. FHI: Kathmandu.

¹³ New ERA/SACTS (2005) *Integrated bio-behavioural survey among injecting drug users in Eastern Terai*. FHI: Kathmandu.

¹⁴ New ERA/SACTS (2005) *Integrated bio-behavioural survey among injecting drug users in Pokhara*. FHI: Kathmandu.

¹⁵ New ERA/SACTS (2005) *Integrated bio-behavioural survey among injecting drug users in Western and Far Western Terai*. FHI: Kathmandu.

Largely due to the focus on security and overt humanitarian needs HIV has not received adequate attention in the humanitarian response. Coordination of the humanitarian response has been through a collaborative approach. In spite of being a cross cutting issue and fragmented attempts, HIV has not been integrated into this approach. Of the three interagency assessment missions conducted in 2005 and 2006 only one noted the lack of HIV programming for displaced persons.¹⁶ With the emergence of the cluster approach in IDP response in other settings cluster leads must ensure that HIV considerations are incorporated. The IASC guidelines on HIV/AIDS Intervention in Emergency Settings provide guidance on minimum interventions¹⁷.

1.5 Defining HIV vulnerability, risk and exposure

Risk and vulnerability are often incorrectly used interchangeably. An understanding of these terms is essential to the understanding of the dynamics of HIV and conflict.

Risk of HIV is the likelihood that a person will become infected with HIV either due to his or her own actions (knowingly or not) or due to another person's action. Unprotected sex with multiple partners and sharing contaminated needles are risky activities that increase the probability of HIV infection.

Vulnerability to HIV is a person's or a community's inability to control their risk of infection. It may be attributed, *inter alia*, to poverty, disempowering gender roles or migration.¹⁸

Conflict can impact the degree of interaction between communities with differing levels of risk behaviour and HIV prevalence. Depending on the context greater isolation may decrease exposure opportunity to HIV, while increased mobility may increase the likelihood of exposure.¹⁹

2 Methodology

Information was collected in the three districts from a variety of sources using a qualitative approach and standardised tools: (a) a review of existing national and district-specific data on HIV; (b) key informant interviews with, *inter alia*, affected population groups, government and non-governmental organization (NGO) staff, uniformed forces, youth representatives and service providers, such as teachers and health staff; (c) focus group discussions; (d) observations of health facilities.

Three teams, each composed of five investigators, conducted a total of 75 interviews and 18 focus group discussions during six days in Ilam, Banke and Kathmandu city.

¹⁶ Interagency Assessment Mission Eastern Region 18-29th May 2006

¹⁷ IASC Guidelines on HIV/AIDS Interventions in Emergency Settings

¹⁸ UNAIDS (1998) *Expanding the global response to HIV/AIDS through focused action: reducing risk and vulnerability*. Geneva, UNAIDS Best Practice Collection: Geneva.

¹⁹ Mock et al. (2004) Conflict and HIV: a framework for risk assessment to prevent HIV in conflict-affected settings in Africa. *Emerging Themes in Epidemiology*, 1:6.



Limitations

The following limitations of the assessment are recognised. Firstly, qualitative approaches provide in-depth information about individuals and communities but conclusions cannot be generalised to other conflict-affected areas of Nepal. Secondly, respondent selection presented many challenges. In Kathmandu respondents had often been reached by NGOs and therefore were not necessarily the most vulnerable. In Ilam, the local community's denial of the existence of groups at risk made interactions more difficult. In Banke initial respondents were those known to NGOs but more respondents not being reached by NGO programs were identified using a snowball approach. In all three sites, it was difficult initially to identify displaced persons for the reasons outlined above, however, through snowballing a variety of conflict-affected persons were met during the course of the assessment.

In Kathmandu the team did not meet with working children as it was felt that the time available would not allow for a thorough assessment. Moreover, there was a comprehensive assessment in this important area recently.²⁰

3 Findings

3.1 Ilam

3.1.1 General situation

Ilam is a relatively prosperous hill district in the far east of Nepal, along the border with India, set among misty tea plantations that recall neighbouring Darjeeling.

²⁰ Terres Des Hommes, Save the Children Alliance report: Internally Displaced Children in the Worst Forms of Child Labor due to the Armed Conflict in Nepal; July 2006

The Rais compose the district's predominant ethnic group²¹. Literacy rates were higher for women (67%) than men (63%) in 2001²². Less than 2% of the total male population - but at least 5 to 10% of males aged 15 and 24 - go to India (68%) and countries of the Gulf (24%) to work for periods of one to three years.²³

The health indicators in Ilam, though lower than desired, are considerably better than many other rural districts. The infant mortality rate is 50/1000 livebirths and acute malnutrition prevalence in under threes is 9%; measles vaccination coverage remains low at 73% for children under the age of 5.²⁴ Ante-natal care (ANC) is provided by outpatient departments but only reaches an estimated 20-40% of pregnant women in Nepal.

3.1.2 Overview of HIV and Sexually Transmitted Infections (STIs)

HIV prevalence in Ilam is thought to be very low in the general population. Neither of the two hospitals has detected HIV during screening of blood for transfusions though the numbers screened are small (average 8-10 per month). There has not been any HIV surveillance among the general population, pregnant women or most at-risk groups. The district hospital reported only one AIDS case but a case definition is not in place; care, support and treatment for HIV-infected or those with AIDS are not available. Of note is that in neighbouring Darjeeling in India the HIV prevalence in IDUs was found to be 11.8% in 2004²⁵

Ilam's DACC focuses its efforts and budget to organise World AIDS Day activities. As in many other districts, aside from World AIDS Day, the Committee does not have an HIV budget or programme.

3.1.3 Protection

There was a lack of mechanisms in place to protect women and children and other individuals vulnerable due to the conflict. In particular, there were no mechanisms to identify, register and assess the needs of unaccompanied children, and unaccompanied or single females. For example, during the conflict, a number of unaccompanied child labourers, aged 12 to 14, worked in the market or as domestic labourers. Though most of them have since returned, this group was vulnerable to abuse and exploitation. Among IDPs who had described human rights violations to NGOs, some said that the latter had not been able to do anything to help them.

²¹ NGIIP/CBS (2004) *The population and socio-economic atlas of Nepal*. Survey Department and Central Bureau of Statistics: Kathmandu.

²² Nepal Human Development Report/UNDP (2001) In *Collection and compilation of district profiles: baseline data through secondary sources: Ilam*. Available online at <<http://www.un.org.np/health/district-profiles/index.htm>> Last accessed [2/01/07].

²³ *Ibid* 21

²⁴ NGIIP/CBS (2004) *The population and socio-economic atlas of Nepal*. Survey Department and Central Bureau of Statistics: Kathmandu.

²⁵ <http://www.un.org.np/health/district-profiles/index.htm>

²⁵ Kamallesh S., B. Bal, R. Mukherjee, S. Chakraborty, S. Kumar Niyogi, M. Kumar Saha, S. Kumar Bhattacharya (2004) HIV Coupled With Hepatitis C Virus Among Injecting Drug Users of Himalayan West Bengal, Eastern India, Bordering Nepal, Bhutan, and Bangladesh. *National Institute of Cholera & Enteric Diseases*, Kolkata, India

3.1.4 Vulnerabilities relating to HIV infection

Increased vulnerability

Poverty: Poverty was strongly linked to increased vulnerability of displaced persons. The more destitute were less able to cope with their displacement. Their children dropped out of school and were sent to work with its attendant risks of exploitation and abuse. Poverty also meant that males were more likely to leave and go to India in search of work.

Migration and displacement: Migration was cited as the primary source of vulnerability to HIV by key informants. The destinations mentioned ranged from Darjeeling and Sikkim in India for the more impoverished migrants, to Kathmandu and countries of the Gulf or Malaysia for those able to afford the initial outlay. Numbers were not available, but the Chief District Officer (CDO) specified: “Approximately 2700 passports have been distributed each year from 2003-2005, and nearly 3800 in 2006, mostly to men aged between 18 and 32 years”. Since Nepalis do not require a passport to cross the border into India, a large number of these passport holders are likely to have travelled to countries other than India.

Male migrants are recognised as a group at higher risk of HIV because they are more likely to engage in unsafe sexual practices, particularly if they are away for extended periods. Recent Integrated Biological and Behavioural surveys (IBBS) carried out among migrants in 11 districts of Nepal, found that male migrants to India were more likely to visit sex workers than those in Nepal. HIV sero-prevalence among those men who had visited sex workers in India was 8.2%, compared to 0.8% among those who had not visited a sex worker in India.²⁶

Overall, displacement to Ilam town appeared to be minimal. The IDPs interviewed were of all ages and from all sectors of society, including the elite (e.g. businessmen and teachers) and most had moved with their families, which reduces their vulnerability to HIV. However, a large proportion were young males and sometimes females, escaping Maoist recruitment and fleeing alone.

Most IDP families said that they had to take out loans when they reached Ilam and some could no longer afford their children’s education. One had sent two daughters (aged 21 and 18) to work as support staff in an army camp after not being able to afford education. In addition to curtailing young peoples’ prospects, such occupations put them at increased vulnerability to abuse and sexual exploitation with the attendant risks.

Disruption of families: During the conflict, families were broken up as young men and women fled Maoist recruitment, Maoist and army harassment or sought stable education and work. The actual number of conflict-related family break-ups is difficult to estimate. Respondents who had experienced such separations were feeling the strain of supporting multiple households with limited resources and, according to

²⁶ New ERA/SACTS (2006) *Integrated Bio-Behavioral Survey among Male Labor Migrants in 11 Districts in Western, and Mid-Far Western Regions of Nepal*. August

several sources, many youth share accommodation to save on rent with members of the opposite sex. Some students clarified that although the conflict had precipitated their move to Ilam town, eventually they would probably have left, as their villages offered limited education opportunities.

Disruption of social services: The education system has been severely affected by the conflict, resulting in transfers and drop outs (especially for girls); but it is difficult to assess the impact of interrupted schooling on vulnerability to HIV. Overall, hospitals, health posts, sub-health posts and pharmacies have not been greatly affected by the conflict; but at the same time, no improvements were made to buildings or equipment. One health care provider estimated that the conflict had reduced health care utilisation by 25% due to difficulties of movement and insecurity; strong declines were not reported by other informants. With the improvement in security demand for health care is likely to increase.

Decreased vulnerability

In addition to factors that may have increased vulnerability there are also conflict-related factors that potentially reduce vulnerability. For example, mobility restrictions associated with insecurity and curfews may have reduced vulnerability for those in the transport industry as fewer men were travelling away from home. A sex worker confirmed that these restrictions had made it more difficult for her to sustain her income.

3.1.5 Risks relating to HIV infection

Sexual behaviour: Sexual relations were said to begin around the age of 15 to 20 among teenage girls and 16 to 18 among teenage boys. Some young women believed that protected premarital sex is not immoral, but others said: *“To us, premarital sex is not appropriate, but if our friends were engaged in such behaviour, we would try to help them out rather than ostracise them.”* The young women added that their fellow college students engaged in unprotected sex. According to male youth, both village and the towns’ college girls are often sexually active before marriage. Some respondents and informants noticed an increase in sexual activity among young people over the years, but this cannot be attributed to the conflict.

Many male and female respondents stated that the wives of migrants have extramarital contacts while their husbands are away. Similar family situations and resulting practices have been exacerbated by the conflict, constituting potential bridges and entry points for HIV from mobile males to their partners and the general population. While prevention efforts are being strengthened in western and central parts of Nepal, Ilam has received little support for HIV prevention.

The local authorities, the military and health care providers denied the existence of sex workers, while most respondents and NGO informants confirmed the existence of women who practise sex in exchange for money, but not openly. Their small clientele - identified as transport workers, men who had previously joined the British army, businessmen, students and soldiers - seems to be irregular. One “suspected”²⁷ sex worker said that village women who come to town for the weekly market also exchange sex for money without their families’ knowledge. According to

²⁷ The woman interviewed was thought to engage in sex work but never admitted this

the respondents, most sex workers were uneducated. Nevertheless, a 21-year old female who had been identified by an NGO as a sex worker had finished class 10. She said: *“Those in power get jobs. But people like us, even when we are educated, we do not get jobs.”*

Respondents’ views on the impact of the conflict on sex work in Ilam were nuanced. While the demand for commercial sex was said to have decreased because of Maoist condemnation and insecurity, supply may have increased as it was reported that there was an increase in the number of young girls separated from their families entering sex work.

STIs and abortions provide an indication of unsafe sexual practices. The number of STIs reported in the 2005/06 (2062/63) Annual Performance Report was very low. Nevertheless, it is likely that many STI infections are not reported as consultations in the NGO and private sector are not included in the Health Management Information System. In addition, clients may also be seeking care outside the district to ensure their anonymity. Syndromic diagnosis for STIs is only being used by the Family Planning Association of Nepal (FPAN), Marie Stopes and the community hospital. There was no indication that the number of STIs had increased during the conflict.

Many respondents knew someone, including unmarried women, who had had an abortion, suggesting that abortions are not uncommon. One provider in Ilam performs about 15 to 20 abortions per month, approximately half in unmarried girls; most come from outside Ilam to avoid identification. A male youth said he hears of about eight abortions every year and all are undertaken outside the district. Two girls were his friends’ partners and they were aged 16 and 17 at the time.

Condoms are available at hospitals and health posts at no cost, but often these places are insufficiently stocked and not in discrete locations. They are usually intended for family planning; when respondents tried to purchase condoms or obtain them from the community health volunteers, they would be asked *“Are you married?”* In villages, in particular, respondents said obtaining condoms from the public sector is embarrassing, and they are distributed without instructions on their use. FPAN is the only NGO providing easy access to condoms through its clinic and youth information centres. However, not all respondents were aware of this and most thought that they could only buy them in private pharmacies. Condom supply in the private sector was not affected by the insecurity.

Availability does not ensure condom use. Young men stated that despite their access to condoms and their knowledge of the consequences of unprotected sex, including HIV, they opted to not wear a condom. Young women, on the other hand, were more likely to advocate the use of condoms.

Sexual and gender-based violence: Many respondents had heard of conflict-related rape, but none had directly experienced it. Perpetrators were reportedly from both warring parties. More commonly reported was rape within a relationship. A young male respondent explained: *“If both have agreed to have sex, and then the girl refuses, the guy will forcefully have sex with her. This happens a lot.”* There was no

relationship found between these events and the conflict. In addition to being a severe violation of women's rights forced sex carries a higher risk of HIV.

Injecting drug use: The three young male IDUs interviewed said that most of those injecting drugs are part of Ilam's wealthy middle class, and one estimated that there are more than 2000 IDUs in the district. The three respondents started injecting drugs when they were 15-16 years old. They had tried brown sugar (unrefined heroin, injected and sniffed) and tidigesic (injected morphine and advil combination). The drugs were usually brought in from neighbouring India. NGOs, teachers and the IDUs themselves had noticed a rise in the number of IDUs, but did not link it to the conflict. One IDU who had started injecting drugs in Kathmandu explained this increase, saying: "*I will teach somebody [because] I need a partner.*" Only one IDU said that the conflict had hampered the supply of new injecting equipment. The IDUs interviewed all knew the modes of HIV transmission, but one still shared needles as they were very difficult to buy. HIV infections can also be transmitted from an IDU to the general population through sexual contact; one IDU respondent used condoms infrequently and had had five sexual partners during the past 12 months

3.1.6 HIV Prevention

Most male and female respondents had good knowledge of HIV prevention options, but some women knew very little. A number of female respondents explained that although they knew of the benefits of condom use, they did not know how to use one. There were no striking gender differences in sources of HIV information, which comprised the radio, TV, newspapers, and school.

HIV is incorporated in the curriculum from grade 6, but both students and teachers complained that teacher training is poor and sexual education is didactic and sometimes taught in English; this calls into question the effectiveness.

HIV prevention and behavioural change programmes were minimal during the conflict years, as were other preventive health programmes, due to a lack of funding, qualified personnel and interest. Only three NGOs, FPAN, the Nepal Red Cross and Nari Bikash Sangh's Social Volunteers Against AIDS (SOVAA) were involved in HIV prevention activities. SOVAA's peer education scheme has been active throughout the district, but lack of funding is slowing their efforts. Community health volunteers also provide some HIV information but only to those who ask.

Voluntary counselling and testing (VCT) is not offered in the district. However, both hospitals do test the blood of suspected AIDS patients but do not follow the national algorithm; in particular, no confirmatory test is done and counselling is not provided. The laboratory technician was not aware of internationally accepted HIV testing algorithms.

IDUs and FSWs, two of the most at-risk populations, are currently not reached by any government or non-government actors with HIV prevention. IDUs must travel to Jhapa, an adjoining district of Jhapa, where the NGO Lifeline provides psychosocial support, needle exchange and HIV education to IDUs from Ilam in Jhapa. There is a need to bring these services closer to facilitate access.

All blood is reportedly screened for HIV prior to transfusion under the oversight of the Nepal Red Cross Society. The district hospital only screens for HIV (using Tridot) while the community hospital screens for hepatitis B and C and syphilis, as well as HIV. Blood for transfusion is usually donated by patients' relatives. There were no reports of interruptions in testing supplies due to the conflict.

Both hospitals in Ilam conduct routine testing for syphilis (VDRL), and the number of syphilis cases found is very low. There is no HIV sentinel surveillance among pregnant women and no interventions aimed at prevention of mother-to-child transmission (PMTCT). Indeed, the very low levels of HIV infection do not justify such interventions in the district.²⁸

3.2 Banke

3.2.1 General situation

Banke is a poor rural district in the mid-western region with a population of c.385,000. Nepalgunj is the district headquarters. The district is one of four primary crossing points into India, a neighbour with whom it shares an open border and therefore, a long history of migration. The conflict has heavily affected Banke, which has been both a receiving and a source district of displaced persons.

Although estimates place the total number of Nepali migrants at 1 to 1.5 million, accurate data are not available on the flow within and across the district's boundaries. Numbers collected by border posts and human rights organisations are based on a very narrow definition of 'displaced' and largely reflect only those registered with the CDO. For example, the Informal Sector Service Centre (INSEC) recorded 1129 IDPs in Banke between 2002 and 2004, but the NGO does not capture the reportedly much larger numbers that left for India and those who did not register. In fact, most of the displaced people interviewed were not registered. INSEC states that 303 people have returned home from Banke over the last two years. Larger numbers have expressed interest in returning but have no means to do so.

There are little recent data on the health status of the population. As in other parts of the country, the reach of essential health services is limited. The infant mortality rate was reported as 71.2/1000 live births in 2001²⁹, the prevalence of acute malnutrition of under-three year olds in 2004 was 12.5% and measles immunization coverage was reported as 88.9%³⁰. Literacy rates remain low with marked gender differences: only 43% of females aged 15 and over and 63% of males are literate³¹. Hinduism is the dominant religion (95.2% in 2001) with smaller numbers of

²⁸ Other than primary prevention and prevention of unwanted pregnancies in women already infected

²⁹ Human Development Report/UNDP (2001) In *Collection and compilation of district profiles: baseline data through secondary sources: Banke*. Available online at < <http://www.un.org.np/health/district-profiles/index.htm>> Last accessed [2/01/07].

³⁰ Department of Health Services (2004) In *Collection and compilation of district profiles: baseline data through secondary sources: Banke*. Available online at < <http://www.un.org.np/health/district-profiles/index.htm>> Last accessed [2/01/07].

³¹ *Ibid* 29

Buddhists (1.6%) and Muslims (2.8%, although the size of the Muslim population is reportedly much larger than this).

3.2.2 Overview of HIV and STIs

HIV prevalence in the general population appears to be less than 1% based on ANC data from the year-old PMTCT programme; a reported 30% HIV prevalence amongst IDUs³² suggests a concentrated epidemic. Moreover, according to the district HIV/AIDS report, a cumulative total of 830 HIV-positive cases have been reported as of October 2006. Those infected are primarily - but not exclusively - IDUs, FSWs, male sex workers (MSW), and their clients.

A number of NGOs and community-based organisations are working in HIV mostly among all the major risk groups except for the uniformed services. The DACC has only begun meeting regularly since 2006, possibly because the recent conflict demanded the district authorities' full attention. However, coordination is not taking place and there is no matrix of agencies and their areas of operation³³. As a result, many opportunities are not being tapped, referral links and networks are very limited, and there are notable gaps. Moreover, HIV is often seen as a health issue at district level, and not one that demands a multisectoral response and strong political commitment.

Banke's response to HIV is financially supported by both the second round of the Global Fund for AIDS, TB and Malaria (GFATM) as well as USAID. However, NGO contracts are often limited in duration due to GFATM grant restrictions and delays. In many instances this has severely curtailed activities and directly affected continuity and access to beneficiaries.

3.2.3 Protection

As in Ilam there is very little assistance in place for displaced persons. IDPs are not willing to register with the district authorities. There is also no mechanism in place to assess, document and monitor the needs of separated/ unaccompanied children and single women or female-headed households. There are some measures to monitor the specific needs of war-affected children; Save the Children Norway are assisting 453 children in 11 VDCs in Banke of which over 350 are IDPs, orphans due to conflict or children returning from warring parties. There are other vulnerable children not being reached. Significant numbers of children have been sent to stay with host families in Nepalgunj often for reasons relating to the conflict. In return for household duties the children are given lodging and supported to attend school. These children are very vulnerable to exploitation and abuse; however, there is no documentation of their arrival, monitoring of their situation and no mechanisms in place should they have problems. There are no specific measures in place to reduce economic vulnerability of female-headed households and unaccompanied girls. This

³² New ERA/SACTS (2005) Integrated bio-behavioural survey among injecting drug users in Western and Far Western Terai. FHI: Kathmandu.

³³ Though this matrix is reportedly being developed by the NGO Coordination Committee

was identified as one of the reasons that many women resorted to sex work in Nepalgunj.

3.2.4 Vulnerabilities relating to HIV infection

Increased vulnerability

Poverty: The underlying poverty has exacerbated the vulnerability of individuals and as a result their possible exposure to risk and to HIV. This coupled with lack of employment opportunities for young women, girls and widows meant that these groups were more likely to resort to sex work. Poverty was the commonest reason given for women starting sex work. Frequent strikes, bandhs and road blocks disrupted traffic and affected employment for those whose work involved travelling out of Nepalgunj. Thus, people who were previously able to support themselves may have lost their livelihood.

Migration and displacement: Between 900 and 4000 Nepali migrants, mostly male, cross the Nepalgunj border into India every week; the numbers migrating to India increased during the conflict, according to border guards and other respondents. Evidence and observations at border crossings now show that this trend is reversing and increasing numbers of people are returning to Nepal. However, reliable records are unavailable.

Poverty, lack of employment, as well as disrupted health and education services - with frequent school closures and limited access to all but the most basic health services - probably affected migration patterns, especially for rural populations. Migrants, are more likely to have multiple partners and unprotected sex thus raising their risk of HIV infection.

More often, families that were poorer and already struggling were pushed to migrate when the conflict made it harder for them to cope. A number of persons identified as “migrants” had, in fact, been forced out of their homes by the conflict. One woman shared:

“The Maoists started to pressure my husband to join them. [They] started to threaten him, so my husband used to hide in others’ homes. The incidents of rape had also started to increase [...] so to get rid of all these problems, we came to Nepalgunj.”

Among the displaced in Banke were wealthy landowners, rural young people and children who had fled to urban centres and elsewhere to escape the Maoists and/or the army. Occasionally, whole families had left for India. “*We took everything that could be moved*”, said a respondent. The poverty of many displaced persons combined with the lack of education and skills, and the lack of protection mechanisms for unaccompanied children and women heightened their vulnerability to HIV.

Gender-based violence: A focus group of young schoolgirls who had left their homes to come to Banke reported that unmarried women were harassed by the army, the police and the Maoists, and this encouraged marriage. Early age of marriage and subsequent onset of, often unprotected, sexual activity exposes women to HIV earlier.

Disruption of HIV services: Interrupted HIV and related projects could have affected both HIV vulnerability and risk. Depending on the site of activities and the agency, projects were often suspended due to difficulties travelling and thus were unable to reach as many clients. FSW peer educators recalled how during *bandhs*, they could not reach as many women with information and condoms. During the height of the conflict, fewer transport workers attended a drop-in-centre in Nepalgunj as driving at night was less common.

Decreased vulnerability

Despite the reduction in access to and outreach of HIV activities, mobility restrictions may in fact have reduced the vulnerability of men more likely to stay at home, such as those in the transportation industry.

3.2.5 Risks relating to HIV infection

Although it is difficult to ascertain a direct link with the conflict, there are indications that the risk of STI and HIV transmission may have increased as a result of movements of population groups with lower levels of knowledge and greater vulnerability to engage in risky behaviours.

Sexual behaviour: Key informants confirmed that at the height of the conflict the number of MSWs and FSWs increased in Nepalgunj as a result of harassment in the villages of origin. Female sex workers explained: “*Maoists had beaten some of us and had made us walk naked in the village [...]. Due to this, most of us had run to Nepalgunj.*” MSWs also reported being beaten up and their clothes burnt to “condemn inappropriate behaviour”. This would have increased risk if there were more unsafe sexual practices. The displaced MSWs and FSWs who were interviewed stated that they were now using condoms, but had only begun to do so after they had been reached by outreach projects in Nepalgunj less than a year ago. As new entrants to sex work are the least likely to be reached by interventions, it is probable that more of their initial encounters were unsafe. Indeed sex workers reported that newcomers did not use condoms consistently or did not use them at all.

In addition the number of potential clients and hence demand for sex workers increased during this time, with the influx of army and armed police personnel. It is not known if the army or police are more or less likely to practice safe sex, but there was little evidence of appropriate and sufficient access to information and means of protection. It is therefore likely that some of these encounters would have been unprotected.

The number of people migrating to India increased during the conflict and among them many were some of the most vulnerable and least educated. As a result, unsafe sexual practices and behaviours among migrants are very likely to have increased. The recent IBBS demonstrated that among the sampled migrants returning from India, 17.2% in Western districts and 26.9% in Mid- and Far-western districts had ever had sex with sex workers in India³⁴.

³⁴ New ERA/SACTS (2006) *Integrated Bio-Behavioural Survey among Male Labour Migrants in 11 Districts in Western, and Mid-Far Western Regions of Nepal*. August

Sexual violence: There were reports of rape and other forms of gender-based violence, including trafficking, but insufficient data to clearly establish whether there has been an increase with the conflict. One rural village reported that four women had been raped by the Nepalese army. Interviews with women revealed unreported incidents of rape by security personnel. One female respondent from Bardiya was raped by 16 army personnel soon after entering sex work seven years ago. She left for Nepalgunj after the incident, but never reported it. A small number of young MSM, who had also been humiliated and harassed in their district of origin by the Maoists, had come to Nepalgunj and were engaged in paid sex work. Rape and its associated stigma had forced young women and MSM with few skills to leave their homes and enter sex work in Nepalgunj.

Injecting drug use: The number of IDUs in Nepalgunj has reportedly decreased due to the unavailability of buprenorphine following restrictions in India. This is a safer opiate to inject than heroin, is more readily available and is reportedly preferred by IDUs. In 2003, the International Nepal Fellowship (INF) adopted a harm reduction approach with IDUs, which included the provision of free needles and syringes. They report that more than 1000 persons regularly use their drop-in-centre of which 70% are estimated to be IDUs. Risk behaviours among IDUs reached by the program have reportedly decreased since the introduction of some elements of harm reduction.

3.2.6 HIV Prevention

In spite of an often satisfactory level of awareness of HIV, actual knowledge of HIV and AIDS appeared to be lower in the rural areas visited. This echoes the findings of a number of recent studies among youth in Nepal that show 90% awareness of HIV, which drops to 40-50% when specific HIV-related knowledge questions are asked³⁵. As most migrants are from villages, sources of information and HIV prevention services need to be increased in these source districts. Information, education and communication (IEC) is a component of many of the HIV activities in Banke, but they are not usually available in local languages, such as *Tharu*, and in formats appropriate for those with low levels of literacy.

There have been insufficient efforts to promote behaviour change in border town environments such as Nepalgunj. For example, condoms are not freely available in places where risk behaviour is known to take place, such as cabin restaurants and hotel rooms. The approximately 800 hotels in Nepalgunj receive a large majority of migrants and populations in transit, offering an important front in HIV prevention and a unique opportunity to reach mobile individuals before they leave. The role of condoms in the prevention of HIV and other STIs needs to be emphasised, particularly in rural areas where they are seen essentially as a family planning tool.

In Banke, prevention interventions targeting sex workers, IDUs, migrants, transport workers and MSM mainly provide HIV counselling and testing, STI management and peer outreach. However, these interventions are not meeting needs:

³⁵ New ERA (2006) *Knowledge, behaviours and access to services for young people in four urban areas of Nepal*. UNAIDS: Kathmandu.

General Welfare Pratishtan (GWP) had to reduce its coverage from 250 sex workers to 120 due to funding cuts. Sex workers emphasised the need for more peer educators, a wider availability of drop-in centres and expanded access to quality and confidential STI treatment and HIV counselling and testing.

Prevention among uniformed services also requires strengthening, as there was little evidence that the national program reaches the district levels. The army and police represent the largest proportion of clients of sex workers in Nepalgunj, but free condoms were either not available or not available in privacy to them.

Many components of infection prevention in health care settings are in place, but some areas need strengthening, such as the disposal of sharps. Blood for transfusion is consistently screened for HIV, syphilis and hepatitis B and C. Blood safety does not seem to have been affected by the conflict as supplies and staff were said to be always available.

Counselling and testing are now available in five sites in Nepalgunj, but more regular technical supervision is needed to ensure continued quality in service delivery. Referral links also need to be strengthened as providers are often not aware of other related activities or services. The National Fertility Care Centre (NFCC) provided HIV counselling and testing to 60 clients during three outreach visits to Kawalpur (14 kilometres from Nepalgunj) in November because of the strong demand from its residents. Expanding mobile services is particularly necessary in rural areas with larger numbers of would-be or returning migrants.

3.2.7 Care, Support and Treatment

Nepalgunj was one of the first three sites in Nepal to initiate antiretroviral therapy in 2005. So far, 25 patients currently receive antiretroviral (ARV) treatment; but at least 30 more need, but cannot access, treatment. An additional estimated 100 PLWH require various levels of care for advanced HIV infection. During the conflict, PLWHs had limited access to services. They were sometimes delayed in keeping appointments if they were travelling from outside Nepalgunj, and this may have interrupted treatment for those on ARVs.

Most of the HIV counselling and testing sites refer to the Zonal Hospital for assessment of medical needs, but some, like the Nepal STI and AIDS Research Centre (NSARC), were starting cotrimoxazole and providing other basic care. Banke has three support groups for PLWHs that provide psychosocial, financial and other support: Junkiree (mainly targeting MSM), Hope Nepal (mainly targeting IDUs) and SAWA Club (mainly targeting sex workers). However, all three support groups are open to all those infected. Nevertheless, the funds and capacity are limited: Hope Nepal can only support 18 of the 36 PLWHs requiring help. The NGO's GFATM Phase 1 funding ended in October 2006.

Pre-ART adherence counselling is currently insufficient; there is little advice on potential side effects and how to manage them, and inadequate promotion of adherence. As many patients may live in isolated areas and receive minimal or no support between hospital visits, appropriate counselling prior to starting therapy is

critical to ensure adherence and optimal treatment outcomes. Health services and PLWH groups must be better informed that a CD4 count is not a pre-requisite for initiating ART: PLWHs are currently sent on twelve-hour bus rides to Kathmandu for a CD4 count, a costly and unnecessary process that delays the initiation of therapy.

A major service gap is the lack of livelihood support, such as income generating activities or skills training for PLWHs and their families. PLWHs are sometimes ostracized by their families and require the means to support themselves, but have little opportunity to acquire new skills. NGOs need to provide emergency accommodation for PLWHs as they address stigma and discrimination.

3.2.8 Surveillance, monitoring and evaluation

HIV prevalence data and programmatic data are not collected or compiled for use at the district level to inform programme planning. The HIV epidemic in Banke, fluidity of population movements and HIV transmission dynamics require proactive approaches and strategies based on district-level evidence and needs. In the absence of other data, HIV infection among blood donor samples screened, can provide a proxy for general population infection (Table 2), though with recognised limitations. From January to October 2006, 0.2% of samples screened were HIV-positive and 0.1% were positive for syphilis.

The PMTCT programme at Bheri Zonal hospital started just over a year ago, and to date 0.6% of pregnant women have tested positive for HIV (Table 3). This tallies with the national estimated prevalence of 0.55%. Nevertheless, since ANC coverage is low (20-40%) and fewer than 70% of pregnant women undergo HIV testing (PMTCT district-level data), the figures may exclude mobile women or wives of migrants and should be interpreted with caution.

Integrated behavioural and biological surveys have been conducted in a number of at-risk populations in various sites throughout the *terai*, but district specific data are not always available (Table 1). Recent 2006 figures among migrant workers showed a 1.1% HIV prevalence in the Western Development Region³⁶. STI sentinel surveillance was discontinued in 2001 and periodic IBBS surveys have been carried out since then. Neither HIV prevalence nor programmatic data are being compiled to inform district level programme planning. Data on STI syndromes are collected by NGOs, but these are aggregated at the district levels. As a result, separate syndromes cannot be monitored over time.

3.3 Kathmandu Valley

3.3.1 General situation

The Kathmandu Valley consists of three primary cities - Kathmandu itself, Patan (south of the Bagmati River), and Bhaktapur. Kathmandu Metropolitan City, the capital, is the political, commercial and cultural hub of Nepal.

³⁶ New ERA/SACTS (2006) *Integrated Bio-Behavioral Survey among Male Labor Migrants in 11 Districts in Western, and Mid-Far Western Regions of Nepal*. August

The infant mortality rate in Kathmandu valley was estimated at 50 per thousand as compared to 79.3 in rural areas in 2001. Differences in health indices between urban and rural areas are large: The under-5 mortality in Kathmandu valley is less than 100 per 1000, whereas in rural and mountainous regions, it reaches 147 and 201 per 1000 respectively. There are also differences in immunization coverage and in nutrition. The proportion of children immunized against measles aged 12 to 23 months was estimated to be 70% nationally but close to 90% in Kathmandu. In 1998, a study concluded that 81% of pregnant women in Kathmandu had an institutional delivery and 19% delivered at home.

The population of Kathmandu district was estimated at 1,100,000 in 2001 (4.7% of Nepal's population). The population of Kathmandu valley is now estimated to have reached 1.5 million. Kathmandu alone receives thousands of migrants each year. Push and pull factors include internal displacement caused by the Maoist insurgency and search for seasonal or long-term economic opportunities. Most residents not originally from Kathmandu, including migrants and IDPs, do not register with the authorities, making it difficult to accurately estimate the population. The valley embraces most of Nepal's ethnic groups, but Newars are the indigenous inhabitants.

The displaced population has been estimated to be between the 30,000 registered to two million. A survey carried out in 2003 by the National Human Rights Commission, concluded that a reasonable estimate would fall between 150,000 to 200,000 individuals. Another study conducted by the Community Study and Welfare Center in 2004 estimated the total number of IDPs to range from 350,000 to 400,000.

During the conflict, the Nepalese Government kept a stronghold in the district headquarters, regional urban centers and Kathmandu, which meant the direct effects of conflict were minimal. Most IDPs tended first to flee to district centers and then on to larger cities; Kathmandu remained a key magnet because of security and employment opportunities. Some IDPs have been able to join relatives and use their network to re-develop their activities. Many other male and female IDPs survive on a small income from working in the burgeoning informal sector often in low skills requiring jobs where most rural migrants also work, including in brick kilns, construction, dance and cabin restaurants, and garment and carpet factories.

The concentration of IDPs in urban areas has led to a rapid increase of urban population: between 5.2 and 7% between 2001 and 2003. In the previous decade, the urban population growth was only 3.6%. The influx of new populations has exerted tremendous pressure on urban service delivery and has affected the quality of drinking water, education, health services, electricity and other basic services.

3.3.2 Overview of HIV

The Kathmandu Valley houses 17% of the country's PLWHs, which is predominated by IDUs (25%) and clients of sex workers (44%). In 2005, there were 12,000 HIV-positive adults compared to 8,000 in 2003.³⁷

³⁷ FHI/NCASC 2005 estimate report

HIV infection among sex workers is estimated to be 2%; the number of sex workers is estimated to be between 4,000 to 4,500³⁸. Eighty-two percent of sex workers were born outside the Kathmandu valley. About 30% of sex workers are younger than 20 years and almost half female sex workers are new, meaning that they have joined the sector within 12 months. Almost half of them are illiterate and only 56% reported consistent condom use. More than 80% of them are reached by NGOs.

Little information exists on male clients of sex workers. Reportedly three-quarters of the clients are migrants to the Kathmandu Valley with a median age of 26 years and 51% married; their median duration of living in the capital was 40 months.³⁹

In 2005, it was estimated that 5,000-6,500 IDU were living in the Kathmandu Valley, about 50% of them are believed to be HIV positive. Despite the fact that 80% reported knowing the existence of needle exchange programs in Kathmandu 27% reported sharing needles with 2 or more IDUs in the previous week.

There is an estimated 10,000 to 15,000 MSM in the valley, with a prevalence of HIV estimated to be between 3.6% for MSM and 4.8% for MSW. Consistent condom use with male partners is estimated at 57%. Over two thirds of MSM reported sexual relations with female sex partners as well as male partners in the last 12 months.

3.3.3 Vulnerabilities relating to HIV infection

Increased vulnerability

Poverty: Poverty in the districts has worsened with the conflict, as many businesses have closed due to *bandhs*. Most new residents have migrated to Kathmandu, drawn by the perception that there are more economic opportunities in the city than in villages. Often they do not intend to return. Many respondents believed that their situation had improved: families that were not paid in monetary terms for agricultural work were now receiving a wage in Kathmandu which gave them access to more services and better food. The major expenditures of concern to families were school fees, food and rent. Migrants' access to health care and education was not a problem if they could pay. However, some of the interviewees were very poor and access to basic services was difficult.

Young boys perceived poverty as a major cause for crime, migration, and risky behaviour, such as alcohol and drug use. It is also the main driving factor for women entering commercial sex work in Kathmandu. Respondents believed that over the last few years the supply of sex workers has been increasing, especially the number of younger girls, sometimes as young as 13. Females reported migrating from their villages to escape poverty, and lack of education and employment opportunities. Most of the female sex workers interviewed had come to Kathmandu to seek employment or had been thrown out by their in-laws (especially those who

³⁸ New ERA/SACTS (2005) *Integrated bio-behavioural survey among female sex workers and behavioural surveillance survey among clients in Kathmandu Valley*. FHI: Kathmandu.

³⁹ *Ibid*

were widows). A few mentioned that they had first entered sex work to be able to pay the rent. Evidence collected in Kathmandu district shows that some of the girls sent away by their families ended up in bars and restaurants and were economically and sexually exploited.

Migration and Displacement: Respondents reported that larger numbers of people had moved to Kathmandu to escape conflict, forced recruitment by Maoists and violence from Maoists and the military. However, the exact number of IDPs in Kathmandu is not known because most do not settle in specific sites. In addition, many of the IDPs interviewed had already established networks or had relatives in Kathmandu. Most of the displaced respondents were married and had travelled with their families to Kathmandu. This has served as a safety net as either spouse could find work. It also reduces their vulnerability to HIV. The links between these households' displacement and increased HIV vulnerability were not obvious.

All the IDPs interviewed stated that the discrimination they suffered was due to their poor economic status rather than their displaced status. Access to education and health services was mainly dictated by their ability to pay rather than their unregistered status in Kathmandu, and parents were earning suitable wages. In fact, schools were often closer and of better quality. Increased HIV vulnerability was not obvious, but a few respondents reported that increasing numbers of unaccompanied single girls and women displaced by the conflict have entered into sex work, particularly within 'cabin restaurant' establishments.

Disruption of families: Widows, including war widows, were often discarded by their families following the death of their husbands, with no entitlement to any assets. Many had to sell their jewellery to compensate for their late husbands' lost income. Widows, if unable to meet their basic needs, are vulnerable to engaging in sex work and to exploitation. During the conflict, Maoist soldiers left their families for long periods of time, often returning only once or twice a year. The Maoist ethos had been the strict observance of abstinence among its members. Now that the peace agreement has been signed and integration is being promoted, risk behaviour may increase.

Disruption of social services: Kathmandu's education system was not significantly affected in the long-term by the conflict. Schools had to close during *bandhs*, some teachers were abducted and the Maoist took some 9-10 year olds out of school to attend rallies in Kathmandu. All the health service providers reported that direct health services (treatment, supply of medicines) remained stable during the conflict, but the strikes had reduced awareness, advocacy and outreach programmes due to major disruptions in transport services and access to roads. The public health sector did not have contingency measures in place for supply chain management to the districts. At the same time, the government was afraid the health supplies would get into Maoist hands.

Community HIV prevention programmes and advocacy rallies were disrupted during the conflict because large gatherings were banned. The strikes made travelling in and out of Kathmandu difficult for outreach workers and peer educators. There was no report of lack of access to condoms during the conflict.

Violence and harassment: Most interviewees did not report any direct violence related to the conflict, but the increased security measures resulted in sex workers, IDUs and MSMs being more harassed by the police and being taken off the streets. This made it more difficult for outreach workers to reach them with HIV prevention. Sex workers reported that in the post-conflict period, Maoists had harassed them on a weekly basis and would sometimes steal their money. During the conflict, the government tended to protect the perpetrators of human rights violations rather than the victims. The police are still the only channel for reporting human rights violations.

Decreased vulnerability

Most IDPs and migrants interviewed had fled to Kathmandu to seek security, economic opportunities and gain better access to services (e.g., education and health). Most reported an improvement in their security situation and had not experienced any conflict related violence in Kathmandu. Many of the young girls and boys interviewed had received some basic HIV awareness and prevention education while in Kathmandu, which they had not received in the rural areas. Although awareness of reproductive health-related issues was still generally low.

Prevention services, such as condoms and STI treatment, were reported to be easily accessible and at a reasonable cost in Kathmandu. IDPs did not report experiencing more difficulties than other Kathmandu citizens in accessing these services as ability to pay was the determining factor.

3.3.4 Risks relating to HIV infection

Sexual and reproductive behaviour: The young men interviewed were likely to be accepting of premarital sex but women are not expected to have sex before marriage and tend to stay monogamous. Married couples commonly practiced contraception, including the use of condoms for family planning purposes.

Sexual risk: Young male respondents said they knew of friends who visited sex workers and that they used condoms. Young males who had migrated or moved to Kathmandu alone reported visiting sex workers.

During the conflict the number of recruits into the Nepalese Army increased significantly. Army representatives reported that they did not provide condoms in the barracks even though they stated that both married and unmarried soldiers visited sex workers. This was confirmed by both MSWs and FSWs who reported that their largest clients were army and police personnel.

All the sex workers interviewed said they now used condoms consistently with clients, ever since they had been in contact with peer educators. They added that most of their clients also bring their own condoms, but that some would not insist on using condoms when they were drunk. However, before talking to either peer educators or outreach workers, the sex workers had not used condoms consistently, particularly if the clients offered them more money. Most of the sex workers charged 300-500 NRPs on average per client (approximately USD 4-7).

Injecting drug use: Most IDUs came from a wealthier background as it costs around 200-300 NRps per day to maintain their habit. All the drug users interviewed stated that they had at one point shared injecting equipment but this was not directly linked to the conflict. Although, it was perceived that young unemployed migrants or IDPs were entering into drug use, there was no evidence to support this.

Increased security in Kathmandu has led to changes in injecting sites from previously more public areas which are heavily patrolled (particularly along the river banks) to indoor locations. This has made it more difficult to identify IDUs and reach them with prevention activities.

3.3.5 HIV Prevention

The youth interviewed reported that sex education in urban schools was either inadequate or not taught properly; in rural ones, it was even poorer or non-existent. The media, especially TV and radio, was the major source of HIV and STI information.

HIV prevention knowledge was high among the respondents who had been selected by NGOs for this assessment. However, those who had not had a long history with these programmes had minimal knowledge.

3.3.6 Care, Support and Treatment

ARV treatment services were not affected by the conflict in Kathmandu. However, during the strikes, people coming to Kathmandu for treatment could not enter or easily move around Kathmandu to receive treatment, and outreach workers could not leave.

3.3.7 Surveillance, Monitoring and Evaluation

The existing HIV and AIDS sentinel surveillance was initiated in 1991. Five sub-populations were initially included: female sex workers, STI patients, IDUs, ANC attendees, and TB patients. Seven HIV surveillance sites were identified. However, after a few rounds, sites and periodicity were changed in 1995. Various groups were surveyed over the years using various methodologies.

Surveillance activities currently target MARPs; IBBSs have been carried out since 2003. This covers IDU in four sites, FSW and clients in three sites and MSM in Kathmandu. Numbers of HIV, AIDS and STI cases are monitored. Blood donations are screened for HIV and other blood borne infections. In 2003/4, the HIV prevalence in blood donors was 0.37%. HIV is also tested among TB patients. PMTCT programs have started in three hospitals.

4 Discussion

Conflict is often associated with an increased vulnerability to and risk of HIV. However, there is also evidence that conflict can reduce vulnerability by, for example, deterring mobility and improved access to services. The relative importance of these factors varies from context to context and each context must be examined in detail to determine the likely outcome and the most crucial interventions. There is no evidence that increased vulnerability associated with conflict is associated with an increase in HIV prevalence in affected populations.

This assessment has examined three sites in Nepal that have all been differentially affected by the conflict, are at different stages in the HIV epidemic and have quite different socio-economic profiles. As a result the impact of conflict on HIV vulnerability and risk varies considerably from site to site.

In Nepalgunj the conflict led to fragmentation of families and creation of resultant vulnerable household structures whose needs were not met due to the lack of protection mechanisms in place. Banke was both a receiving district and a source district for these disrupted families. As a result of this heightened vulnerability there was an increase in male and female sex workers in Nepalgunj and increased numbers of children and women in potentially abusive and exploitative situations. New entrants to sex work were less likely to be reached by HIV prevention programs and thus were at greater risk. Of great importance to the humanitarian community and to the response is that the lack of protection mechanisms in place has clearly exacerbated vulnerability amongst women and children including HIV-related vulnerability.

Also of significance in Banke was the large increase in uniformed forces as large numbers of army and armed police moved into the district. This resulted in increased civil-military interaction due to the greater demand for sex work and, in addition to transactional networks, mixing of populations of different HIV risk profiles (military with civilians) in casual and sometimes more formal relationships. Furthermore, there was disruption of some HIV prevention programs such as outreach - including condom distribution - to sex workers and fewer transport workers were reached by drop-in-centres. Though impossible to quantify there were reports of increased sexual violence including rape associated with the conflict. In addition to being an abhorrent crime rape carries a higher risk of HIV transmission. Programming in conflict needs to address prevention and response to sexual and gender-based violence. Lastly, the conflict resulted in an increase in rural-urban population interaction which may have resulted in sexual mixing of populations with different levels of exposure to and levels of HIV. In this situation, unlike in many other contexts, the levels of HIV infection in urban areas may be lower than many of the rural areas of origin. This is because of the strong association of HIV with migration in Nepal; the majority of migrants are from rural areas. Conversely, some factors may have reduced vulnerability to HIV in Nepalgunj. Firstly, reduced mobility of transport workers may have meant that fewer transport workers were visiting sex workers. The rural-urban migration may have meant increased availability and utilization of reproductive health and other health services and improved access to education services – all of which would have been protective against HIV.

Lastly, the conflict did not take place in isolation. During the last three to four years the HIV services in Nepalgunj considerably increased unrelated to, and in spite of, the conflict. This would have considerably offset many of the factors outlined above that have heightened vulnerability to HIV.

In Ilam, a more prosperous rural area, there was some fragmentation of families and creation of resultant vulnerable household structures but not to the extent experienced in Banke. As a result there may have been an increase in supply of sex workers. This may have conversely been associated with reduced demand due to Maoist condemnation of sex work and curfews both of which reduced the client base. The conflict most likely precipitated increased rural-urban migration, particularly for young people, and greater migration - mostly of males - to India and elsewhere. The rural-urban migration may have resulted in sexual mixing of these populations but as the level of HIV infection is purportedly very low in both urban and rural areas of Ilam, the impact of this on HIV transmission is likely to be negligible.

The biggest armed force presence in Ilam was that of the Maoists. As the Maoist ethos was one of abstinence before marriage and use of sex workers was condemned the usual civil-military sexual interactions associated with a large military presence may not have taken place. This may have afforded the population some measure of protection against HIV – at least with regards the military presence. Other factors that may have reduced vulnerability were the reduced mobility of transport workers as noted in Banke. The extent of rape associated with the conflict, though impossible to quantify using a qualitative approach, was reportedly less than in Banke. However, any act of sexual violence places the individual at significantly greater risk of HIV.

Child labour increased dramatically in Kathmandu; though not specifically examined by this assessment large numbers of children would have been placed in situation that rendered them vulnerable to exploitation and abuse. In addition to the psychosocial consequences this would have made them more vulnerable to HIV.

IDUs in Kathmandu may have been more vulnerable to HIV as increased security measures meant people were injecting in private and consequently, were less likely to be reached with critical HIV prevention interventions. However, the conflict seemingly did not influence IDU numbers and only one said he could not access clean injecting equipment because of the conflict.

In all three sites the vulnerability of displaced persons to HIV varied with gender, age and socio-economic resources. Unaccompanied female IDPs, IDP widows and children displaced alone were identified as some of the most vulnerable. During humanitarian emergencies these are the groups that need to be targeted by protection interventions. In the post-conflict phase many of these needs remain and need to be addressed in transition programming.

Throughout Nepal the longstanding conflict has exacerbated rural-urban migration and migration to India and elsewhere. In all three districts, respondents asserted that migration had increased due to the conflict, but there are no figures to evaluate the scope of migration or displacement. Some migrants and their relatives

were certain that their migration had been triggered by the conflict rather than economic hardship; for others it is possible that limited employment opportunities in villages would have eventually pushed them to migrate irrespective of the conflict. It should also be recognized that the economy of Nepal was badly affected by the 10-year conflict and that conflict and economic pressure to move or migrate are linked. As many of these are males migrating alone this will have resulted in an increased vulnerability to HIV. In the post-conflict phase as migrants/displaced persons start to return to areas of origin there is a need to ensure that they have access to HIV-related services throughout all phases of the migration cycle.

Since the signing of the peace treaty transport workers have regained their mobility, and the Nepal army is returning to their barracks. The increase in these sex worker client groups may boost demand and heighten the possibility of exposure to HIV and other STIs with greater client turnover. Therefore, the needs of these most-at-risk groups must be addressed. In the post-conflict scenario with return of persons to rural areas and with the increased numbers of young people in Maoist cantonments there is a need to adjust HIV prevention interventions to this new reality. Transition programming affords opportunities for renewed HIV prevention efforts.

5 Conclusion and Recommendations

The assessment has not been able to demonstrate that the conflict has led to an increase in HIV prevalence in affected populations. However, HIV related vulnerability has increased in all three sites to varying extents. The assessment demonstrates the importance of a multisectoral response and in particular the importance of strengthened protection mechanisms for women and children. Much of the vulnerability would have been reduced if these had been in place. Furthermore, there is a pressing need for better coverage of HIV prevention activities in most at-risk populations and in villages where displaced persons and migrants may return as peace is restored. In sites with a higher burden of HIV there is a need to improve the care, treatment and support of PLWHs and their families.

5.1 Overall Recommendations

A) Strategy and policy

- Ensure the vulnerability of conflict-affected populations (including displaced persons and returnees) is recognised and specific activities are taken to address this in the National HIV Strategic Plan and in the annual action plans.
- Include HIV and AIDS awareness and prevention services within a broader health programme for cantonments that should be coordinated under the larger UN plan.
- Given the porous border with India and the large numbers of people moving back and forth between these two countries cross border programming is essential to adequately address HIV
- Within humanitarian emergencies involving IDPs cluster leads must ensure that HIV considerations are incorporated into the response. The IASC guidelines on HIV/AIDS Intervention in Emergency Settings provide guidance on minimum interventions.

B) Coordination

- Strengthen the capacity of the DACCs to coordinate and operationalise a multi-sectoral response to HIV at the district level through clear terms of reference, adequate funding, training of key DACC members and consistent supportive supervision.
- Improve availability and use by DACCs of district level strategic HIV data for decision-making

C) Protection

- Stronger protection mechanisms (such as *inter alia* registration of unaccompanied women/children, reporting and response mechanisms for protection concerns and monitoring of protection needs) are needed for the most vulnerable in conflict-affected settings; in the Nepal context these include young girls, child domestic labourers, street children and unaccompanied or single women.
- Advocate for the establishment and institution of a code of conduct for the military including ensuring that soldiers are aware of their obligations under international law
- All agencies working in a humanitarian context should have a code of conduct established which prohibits sexual exploitation; affected communities need to be aware of their rights to assistance and protection and how to confidentially report breaches
- Further assessment is needed to reduce vulnerability to sex work in the post-conflict phase in particular identifying alternative livelihoods for sex workers or those considering sex work

D) HIV Prevention

- Increase coverage of population groups at highest risk with targeted prevention interventions; especially for sex workers in Nepalgunj and IDUs in Ilam
- Strengthen HIV prevention among migrants using a multi-staged approach: before migration, during transit, at destination points and on return. This includes access to HIV-related information, condoms, confidential STI management and HIV counselling and testing services. As the main destination is India this entails bi-country programming; lessons can be learnt from agencies with the relevant experience.
- Improve instruction on, availability of, and access to condoms; these should be available confidentially and in privacy to those that need them; this includes in hotels, cabin restaurants, tea shops, police posts, cinemas, border crossing points, outreach workers, NGOs and health posts.
- Strengthen the availability and appropriateness of HIV-related IEC materials and media; in particular ensuring the needs of linguistic minorities and low literacy audiences are met (appropriate languages, radio programmes, street drama)
- Expand mobile HIV counselling and testing which will contribute towards meeting the needs of Nepal's rural and more isolated communities; this is particularly important to meet the needs of potential and returning migrants and displaced persons.
- HIV prevention for the following groups needs to be integrated into the post-conflict HIV planning: rural youth, returnees, those applying for passports, demobilized soldiers from both warring parties, those in Maoist cantonments;

support from high levels within the Maoist leadership is needed to determine how HIV and AIDS issues can be integrated into the health and other services for cantonments.

- Strengthen prevention and care services in the government sector (including the integration of HIV prevention and STI management into reproductive health services, such as family planning and pregnancy related care).
- HIV prevention in the uniformed services needs to be strengthened at the district level; this includes training of senior officers to garner support, adequate funding for HIV-related awareness and condom provision, and removal of institutional barriers to HIV-related services e.g. lack of confidentiality of treatment of STIs

E) Surveillance, monitoring and evaluation

- Promote the collection and generation of HIV-related data by the NCASC for district-level planning and programming.
- Prioritise a district-level strategic information/monitoring and evaluation strategy using the national Monitoring & Evaluation Framework.
- Reinforce data systems and sentinel surveillance in locations where population movements and risk behaviours are high and where there has been evidence of displacement, pending a review of the surveillance system in Nepal.
- Improve surveillance and reporting of STIs (*i.e.* by disaggregating according to sex and age, and syndrome).

F) Capacity building

- Provide regular support supervision in technical and managerial areas to NGOs and CBOs implementing HIV-related projects; local NGOs could be partnered with a technically sound international NGO for a defined period to provide essential technical backstopping, oversight and coaching in crucial phases.
- Strengthen capacity of community-based development NGOs that serve impoverished and/or marginalised populations to deliver HIV services.

5.2 Ilam

- Establish HIV counselling and testing using the national HIV testing algorithm and rapid testing at Ilam district hospital; ensure appropriate algorithms are followed for other testing such as screening of blood for transfusion
- Encourage local authorities and health officials to recognise the existence of MARPs (without stigmatisation) and develop HIV prevention programmes with the support of NGOs.
- Initiate HIV prevention services for IDUs as a priority using a harm reduction approach
- Provide training of service providers on the national protocols for STI syndromic management.
- Provide incinerators in hospitals, primary health care facilities, health posts and sub-health posts

5.3 Banke

- Increase coverage and quality of prevention interventions for MARPs (especially sex workers and clients of sex workers, including migrants).

- Include the numerous hotels and similar establishments in HIV prevention programming through engaging hotel owners and workers and making condoms and IEC materials freely available.
- Expand access to interventions which improve the economic security of women and girls such as microfinance, vocational training, literacy programs and income generation , recognition of property and inheritance rights
- Increase the ARV quota for Banke District; this may entail a national review of ARV allocations by district to ensure they are distributed to the more affected districts.
- Increase availability of ART in districts where significant numbers of HIV positive migrants or spouses have been detected by developing strategies for referral and follow-up
- Include pilot projects to improve the livelihoods of PLWH in the HIV response in the district; ensure these are monitored and evaluated and successful projects expanded.

5.4 Kathmandu Valley

- Prioritise young girls and women, especially widows, in HIV prevention initiatives in Kathmandu; in particular, expand targeted interventions in establishments where young girls are working such as bars, teashops and cabin restaurants.
- Expand access to interventions which improve the economic security of women and girls (as above)

Annex 1: Tables

Table 1: HIV and Syphilis Prevalence from Integrated Behavioural and Biological Surveys in selected *terai* Districts

	1999	2003	2005
FSW (HIV)		0.00%	1.50%
FSW Syphilis)		3.00%	4.00%
IDU (HIV)*		-	30.00%
Labour migrants (HIV)		-	1.10%
Truck drivers (HIV)	1.50%	1.75%	1.00%
Truck drivers (Syphilis)		2.25%	1.75%

* IDU data are for Banke only; Source: New Era/ Family Health International

Table 2: Prevalence of HIV, hepatitis C and syphilis in blood donors, Nepalgunj, 2003 to 2005

	Samples screened	HIV	HepC	Syphilis
2003	4003	0.2%	0.3%	0.0%
2004	4569	0.2%	0.3%	0.1%
2005	4591	0.1%	0.2%	0.1%

Source: Nepal Red Cross Society, 2006

Table 3: Prevention of Mother to Child transmission data, Bherizonal Hospital, November 2005 to October 2006*

No. attending ANC	No. accepting testing	% accepting testing	No. positive	HIV % positive	HIV % positive
2644	1809	68.4	11	0.61%	

*estimated ANC coverage 20-40%

Annex 2: Team Members

Ilam

Michel Carael, UNAIDS Consultant
Sara Dang, UNAIDS Consultant
Manju Karki, UNFPA Kathmandu
Nirmal Rimal, AMDA Nepal
Paul Spiegel, UNHCR Geneva
Bharati Limbu,, AMDA
G. Adhikari, AMDA

Banke

Ann Burton, UNHCR Bangkok
Sushant Murkherjee, WFP Nepal
Sarita Rai, UNHCR Nepal
Pragya Shah, UNDP Nepal
Isabel Tavitian-Exley, UNAIDS Nepal
Geeta Pradhan, LWF
Pradeep Paudel LWF

Kathmandu

Naramada Acharya, UNAIDS Nepal
Taona Kuo, UNAIDS Bangkok
Hanne Melfold, OCHA Nepal
Aurorita Mendoza UNAIDS Nepal
James Mutharia, UNHCR Nepal
Bina Pokharel NCASC
Suresh Pradhan UNESCO Nepal
Nabina Rajbhandari, UNAIDS Geneva
Bimala Pokahrel, AMDA
Sudesh Regmi, AMDA

Annex 3: Background Information

1. Conflict overview⁴⁰

Historical Outline

- CPN-Maoist insurgency started in 1996
- Today, more than 12,000 persons have died in Nepal
- Three peace processes have collapsed
- King Gyanendra took control on 1 February 2005
- In April 2006, the CPN-Maoist and the Seven Party Alliance (SPA) launched a nationwide popular movement against the monarch's autocratic rule, which forced the king to give up power and restore Parliament. CPN-Maoist and the SPA have now concluded peace talks, agreed to hold elections for a Constituent Assembly and the mutually agreed ceasefire remains in place since April.
- Nevertheless, the CPN-Maoist still effectively controls most of the countryside, refusing access to many government service providers and interfering in humanitarian and development programmes.
- Reports of abductions, extortion and recruitment by the CPN-Maoist have increased.

2. Conflict-affected populations

Internally Displaced People (IDP)⁴¹:

- Numbers could be anywhere between 100,000 and 250,000
- IDPs comprise landowners, political party workers, village elites, potential CPN-Maoist recruits or those suspected by the Security Forces, and those forced to leave because of school closures, disruption of local commerce and the lack of basic services.
- IDPs either go to India or settle in the district headquarters where the most conceal their identity.
- Differentiating between conflict-related displacement and traditional seasonal and economic migration is difficult.
- Most are reluctant to return because of security concerns or financial restrictions. Nevertheless, many IDPs and migrants did return to Nepal from India during the Dashain festival this October.

Widows⁴²

- Although there are no statistics on the exact number of conflict widows, the Single Women's Group NGO estimates that it was working with almost 6,000 widows.
- High caste Hindu widows are subject to societal rules and stigma (they are assigned a special dress code to mark them as bearers of ill tidings) but lower caste widows can remarry

⁴⁰ OCHA Nepal Situation Overview, Issue No.7/Sep and OCHA Nepal Thematic Report

⁴¹ OCHA Nepal Situation Overview, Issue No.7/Sep and OCHA Nepal Thematic Report

⁴² Dang, S. (no date) HIV vulnerabilities and conflict dynamics. Unpublished.

- Nepali widows and their children are at risk of sexual violence from their in-laws

Badis

- One of the lowest Dalit castes that served as entertainers and courtesans for the hill kings in the late 18th century
- Today, sex work is a gendered norm among the Badis and in contrast to other Nepali communities, the girl-child is preferred. Therefore Badis may avoid using condoms in the hope of producing as many daughters as possible
- Their traditional income as stone and sand collectors has been reduced as displaced people turn to this trade

Girls and women⁴³

- 40% of 53 vulnerable girls and women surveyed knew of conflict victims who had been pushed into the sex trade
- 71% of 55 female sex workers said their numbers had increased because of the conflict
- 19% of 55 said they became sex workers as a result of displacement and conflict-related threats
- 37 out of 39 sex workers had been displaced without family members
- The study confirms that females from *dalit* and backward communities are more likely to enter the sex trade
- Education does not spare conflict victims from sex work

Civilians

- Affected by *bandhs* (shutdowns) and curfews
- Young women have been having unprotected sexual relations with security officers

Villages outside the district headquarters:

- Nearly total absence of government officials
- Lack of basic services and protective mechanisms for returnees

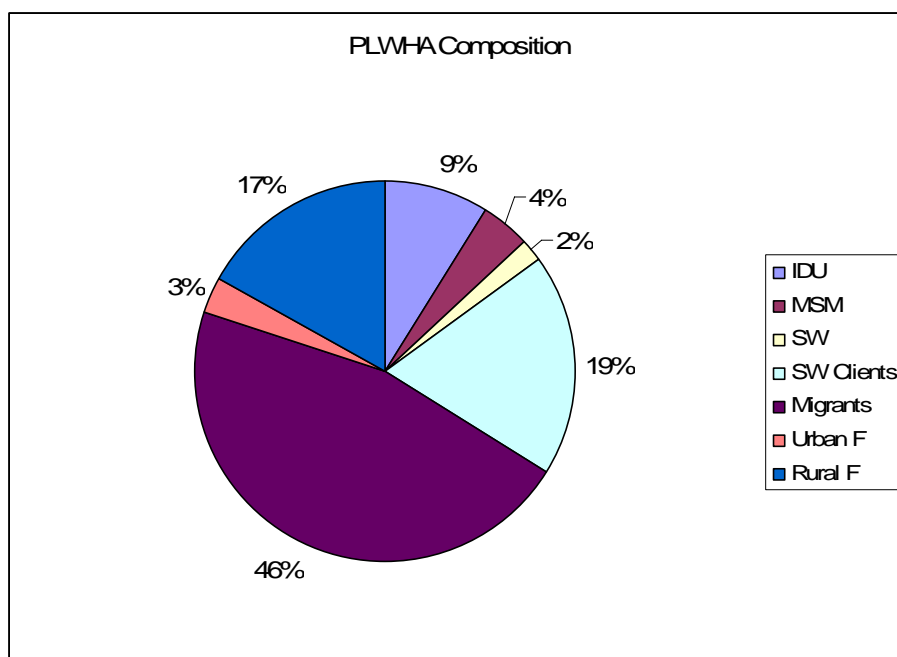
3. HIV overview⁴⁴

- 70,000 HIV-positive adults⁴⁵ (figures range from 32,000-119,000) estimated in 2005
- 60,000 estimated in 2003
- 0.55 percent of general adult population is infected with HIV
- Four times as many men are living with HIV/AIDS than women

⁴³ Save the Children Norway (no date) A study on impacts of armed conflict pushing girls and women into sexual abuse and sex trade. Save the Children Norway: Lalitpur.

⁴⁴ FHI/NCASC 2005 estimate report

⁴⁵ Aged between 15 and 49 years



Sampling area	%	Details
Kathmandu valley	17%	<ul style="list-style-type: none"> 12,000 adults HIV-positive (range: 5,000-20,000) in 2005 8,000 in 2003 PLWH composition: clients of sex workers (44%) and IDUs (25%)
26 highway districts	43%	<ul style="list-style-type: none"> 30,000 adult HIV-positive in 2005 (range: 11,000-56,000) Same number in 2003 PLWH composition: seasonal labour migrants (37%), clients of FSW (22%) and rural women (21%)
7 far-western hill districts	22%	<ul style="list-style-type: none"> 15,000 adults HIV-positive in 2005 (range 4,000-23,000) 14,000 in 2003 PLWH composition: seasonal labour migrants (80%) and rural women (14%)
Remaining districts	18%	<ul style="list-style-type: none"> 13,000 adults HIV-positive in 2005 (7,000-20,000) 10,000 in 2003 PLWH composition: seasonal labour migrants (60%) and rural women (25%)

Data Limitations:

- MSM outside the KTM valley: size estimates and HIV prevalence
- Seasonal migrants: actual size and HIV prevalence
- IDUs, FSW, MSM and seasonal labour migrants: size estimates in the remaining districts

4. Population Profiles

a. Sex workers

- Nepal's sex workers are grouped into
 - those who solicit clients from the streets
 - those operating from establishments such as dance restaurants, cabin restaurants, bhatti pasals (traditional taverns), massage parlours, residential settlements (private houses) and discos.
- Their numbers are estimated to be
 - between 4,000- 4,500 in the Kathmandu Valley
 - 400 in the Pokhara valley
 - Data is not available for rural locations.

Survey:

- Those who participated in the IBBS surveys were aged 15 to 59 years and represented a range of ethnic groups and castes.
- First sexual relation:
 - In the Kathmandu valley, more than half before the age of 15
 - In the Pokhara valley, nearly a third when they were 9.
- Average weekly incomes:
 - Rs.50 to Rs. 8,000 in the Kathmandu valley
 - Rs. 300 to Rs. 18,000 in the Pokhara valley.
- Duration in sex work:
 - Pokhara valley: 29 months on average
 - Kathmandu valley: 19 months among those based in establishments and 33 months for those based in the streets.
- HIV infection:
 - 2% among the 500 SW in Kathmandu
 - 2% among the 200 SW in Pokhara.
- Protective measures:
 - Abstinence and being faithful were identified by less than 40% of the participants
 - Vast majority of sex workers knew that condoms could protect them from HIV.
- Condom use in the Kathmandu valley:
 - 56% with clients over the past year
 - less than 20% with other partners.
- Condom use in the Pokhara valley
 - a third with clients over the past year
 - less than 15% with other partners.

b. The clients of sex workers

Survey

- 400 clients of sex workers surveyed in both the Pokhara⁴⁶ and Kathmandu⁴⁷ valleys

Profile

- Aged between 14 and 55 years
- Sexual experience at 17 on average
- Approximately three-quarters of the respondents had migrated to Kathmandu from other districts
- Vast majority was literate and working in the service and business industry, as wage labourers and drivers. Some were students
- All identified condoms as a means of protecting themselves from HIV
- More than 80% said they had used them consistently with sex workers over the past year
- Less than 10% used them consistently with wives.
- Less than a fifth of the clients identified abstinence as a means of protecting themselves from HIV
- Less than half identified being faithful as another
- Two thirds of those surveyed had had sexual relations with more than two FSWs

c. Injecting Drug Users

Survey:

- 1,245 IDUs participated in four surveys in the Kathmandu⁴⁸ and Pokhara⁴⁹ valleys, and in the western, far-western⁵⁰ and eastern⁵¹ Terai districts in 2005
- Profile
 - Belonged to a range of ethnic groups
 - Median ages ranged from 21 years in Western and Far Western districts to 26 years in the Kathmandu valley
 - Pokhara valley: majority were unmarried
 - Kathmandu valley and Western and Far Western districts: majority were married
 - Eastern Terai: equal number of married and single respondents
- The majority were either literate or had formal schooling

Risky behaviour:

- Tidigesic or a combination of drugs

⁴⁶ New ERA/SACTS (2005) *Integrated bio-behavioural survey among female sex workers and behavioural surveillance survey among clients in Pokhara Valley*. FHI: Kathmandu.

⁴⁷ New ERA/SACTS (2005) *Integrated bio-behavioural survey among female sex workers and behavioural surveillance survey among clients in Kathmandu Valley*. FHI: Kathmandu.

⁴⁸ New ERA/SACTS (2005) *Integrated bio-behavioural survey among injecting drug users in the Kathmandu Valley*. FHI: Kathmandu.

⁴⁹ New ERA/SACTS (2005) *Integrated bio-behavioural survey among injecting drug users in Pokhara*. FHI: Kathmandu.

⁵⁰ New ERA/SACTS (2005) *Integrated bio-behavioural survey among injecting drug users in Western and Far Western Terai*. FHI: Kathmandu.

⁵¹ New ERA/SACTS (2005) *Integrated bio-behavioural survey among injecting drug users in Eastern Terai*. FHI: Kathmandu.

- At least half were under 21 when they began injecting drugs (except for the Western and Far Western Terai respondents)
- At least half had started the habit in other parts of Nepal or in another country (except for those from the Kathmandu valley).
- Needle sharing is highest in Eastern Terai, but at least one fifth of all the surveyed participants admitted to this risky practice
- Respondents reported improper cleaning procedures
- A significant majority of the participants were also sexually active and at least a third had had more than one partner
- At least a third used condoms consistently with sex workers and less than 15% used condoms with consistently with their regular partners
- More than 90% of the participants knew that condoms could protect them from HIV and that sharing needles could transmit the virus
- Most common sources of information were the radio and television, followed by NGO workers, friends and relatives
- HIV infection in the sampled population:
 - 51.7% in the Kathmandu valley
 - 31.6% in the Eastern Terai
 - 21.7% in the Pokhara valley
 - 11.7% in the Western and Far Western Terai

d. Young people

Survey

- Based on a 2005 survey⁵² conducted among 2,401 young people aged 15-29 years (almost a third of Nepal's population falls within this age group⁵³)
- Four major urban centres: Kathmandu, Dharan and Biratnagar in eastern Nepal, and Nepalgunj in the west
- Both married and unmarried youth participated

Knowledge of HIV/AIDS

- Most of the young people interviewed had heard of HIV/AIDS
- But only half answered questions on transmission pathways and protective methods correctly
- Virus pathways identified: sharing infected needles, sexual intercourse, blood transfusions, unprotected sex, multiple sexual partners and mother-to-child
- Main sources of information: television and radio
 - Respondents in Nepalgunj were less informed
 - Women's knowledge was generally poorer

First sexual experience:

- Premarital sex: 45% of the young men and less than 2% of the young women

⁵² New ERA (2006) *Knowledge, behaviours and access to services for young people in four urban areas of Nepal*. UNAIDS: Kathmandu.

⁵³ His Majesty's Government of Nepal, National Planning Commission Secretariat, Central Bureau of Statistics. *Population census 2001: National report*. UNFPA: Lalitpur.

- Age: 20 for men; 18 for women
- Almost a quarter had used condoms

Sexual relations in the last 12 months

- One third of the sexually active respondents had had sexual relations in the last 12 months
 - 21% used condoms with their spouse
 - 77% used condoms with their boy/girlfriend
- 28 respondents said they had had multiple sex partners
- 18 said they had had anal sex
- 3 had injected drugs

Condoms:

- Availability: pharmacies, grocery stores, health posts or sub health posts, *paan*⁵⁴ shops, government hospitals, private clinics, primary health centres and family planning clinics
- Barriers to access: distance for most, as well as the fear of being seen by others obtaining condoms
- Men who did not use a condom:
 - felt it was unnecessary
 - partners had objected
 - reduced their sexual satisfaction
 - did not like using them
- With sex workers:
 - 19 of the 22 male respondents who had had sexual relations with a sex worker in the previous year said they had used a condom during their last encounter
 - Two thirds did so consistently over the past year

Accessing sexual and reproductive health services

- Only 12% felt that young people faced difficulties in access
- Women formed a larger fraction
- Reasons stated by women:
 - Primary: behaviour of health staff, shyness in using services, confidentiality concerns
 - Secondary: financial cost of services and discomfort with staff of the opposite sex
- Some male respondents also pointed to the inconvenient location of the facilities and the perceived lack of experience of health staff

e. Migrants

Survey⁵⁵

- 1,620 migrants surveyed in Jhapa, Chitwan, Rupandehi, Banke, Doti and Achham

⁵⁴ 'Paan' shops are small informal street vending stores, typically selling tobacco products.

⁵⁵ New ERA (2006) *A final report on baseline survey of HIV/AIDS program among adolescents, young adults and migrant laborers in six districts in Nepal*. HIV/AIDS Program Management Support Agency, UNDP: Lalitpur.

Knowledge of HIV/AIDS

- Had heard of HIV/AIDS from radio and television as well as friends and relatives
- One third knew someone who had been infected
- Most knew that condoms could protect them from the virus

First sexual experience

- Two thirds had had their first sexual relation between the ages of 16 and 20
- 13% said their first sexual acts had taken place before they had turned 15
- First sexual partner was a female friend for a quarter of the respondents (and wives for 74%)
- 9% used condoms

Sexual relations during the last 12 months:

- Less than 7% had had sexual relations with a sex worker
- Another 10% had had sexual partners with whom they were not married
- The men had had 2.2 commercial and 2.62 non-commercial partners on average
- More than half of those who had had sexual relations with sex workers during the last month had not used a condom
- Of the nine migrants who had had male sexual partners over the last 12 months, six said they had not used condoms, either because they were not available or because they did not like using them

5. Gender issues

- Women cannot return to their natal homes
- Women cannot apply for citizenship when they reach the age of 16⁵⁶ without their fathers' or husbands' permission and legally are thus non-persons
- Domestic Violence:
 - A study⁵⁷ found that two thirds of the 625 respondents experienced domestic violence daily
 - Data on marital rape is not available

6. Stigma and discrimination

Majority of the youth survey⁵⁸ participants said:

- they would take care of an HIV-positive family member
- an HIV-positive teacher should be allowed to teach
- they would buy food products from an HIV positive shopkeeper (mean score of 4.2)
- felt HIV-positive persons should not get married
- HIV/AIDS was due to immoral sexual behaviour

⁵⁶ Nepali girls are sometimes married before the age of 16.

⁵⁷ Saathi (1997) *A situational analysis of violence against women and girls in Nepal*. Saathi and The Asia Foundation: Kathmandu.

⁵⁸ New ERA (2006) *Knowledge, behaviours and access to services for young people in four urban areas of Nepal*. UNAIDS: Kathmandu.

- feared losing honour/respect and social standing if they had family members who were HIV-positive

Only half or less

- would share a meal with an HIV-positive person
- would share information about an HIV-positive family member being HIV-positive outside of the family

7. General health status of conflict affected populations

Internally Displaced People⁵⁹

- Data is not collected by district health offices
- No special programme or funds for IDPs (many take out loans to cover health expenses; others can afford health services)

IDP Children⁶⁰ (in Banke)

- 59% of children under the age of 3 are underweight
- 73% of children in Rajhena IDP camp and 63% of those in Simalghari IDP camp are malnourished
- At least 55% are suffering from common illnesses like diarrhoea, fever, skin ailments, etc.
- Malnutrition rates and prevalence of common illness among 82% of small children is worrying (especially in Rajhena camp)
- Most are from female-headed households whose husbands are away in India

8. Assessment districts

Facts for the Kathmandu Valley

PLWH

- 17% of Nepal's PLWH population
 - 12,000 adult HIV-positive in 2005 and 8,000 in 2003
 - PLWH composition: clients of sex workers (44%) and IDUs (25%)

Sex workers

- Population range: 4,000 – 4,500
- More than half of 500 SW surveyed had had sexual relations before the age of 15
- Average weekly incomes: Rs.50 - Rs. 8,000
- Duration in sex work:
 - 19 months for establishment-based SW
 - 33 months for street-based SW
- HIV infection: 2% among the 500 SW
- Condom use:
 - 56% with clients over the past year

⁵⁹ UNHCR et al. (2006) *Inter-agency IDP mission report mid-western region, 9-16 Dec. 2005*. UNHCR, UNICEF, UNOCHA, OHCHR and NRC.

⁶⁰ Terre des Hommes (2005) *Nutritional status of children victims of armed conflict in Nepal: a survey report of IDP children in Banke district*. Terre des Hommes: Lalitpur.

- less than 20% with other partners.

Clients of sex workers

- Age range: 14-55 years (median: 26)
- Median age of first sexual intercourse: 17
- Average number of sex workers visited over the past year: 5
- 64% visited more than two sex workers
- Three quarters of the clients surveyed had migrated to Kathmandu from other districts
- 18% had had sexual relations with sex workers in other parts of the country and 1% had been to India

Injecting Drug Users

- Profile:
 - Median age: 26
 - Majority were married
 - Majority were literate
- Drug injection
 - Tidigesic or a combination of drugs
 - Average duration: 6 years
 - 53% began before the age of 20
 - 20% share needles
 - 25% injected drugs in other parts of the country
- Sexual activity
 - Almost 87% sexually active
 - Average age of first sexual experience: 17 years
 - In the last twelve months, 58% had been sexually active and 40.8% of these had had two or more partners
- Condoms
 - Consistent use with sex workers: 34%
 - With regular partners: 13%
- Knowledge
 - 91% knew that condoms could protect them from HIV
 - 98.7% knew that sharing needles could transmit the virus
- Most common sources of information: radio and television
- HIV infection in the sampled population:
 - First round (2002): 68%
 - Second round (2005): 51.7%

Street Children⁶¹

- Only 91.6% of boys (N=359) and 78.1% of girls (N=41) surveyed in Kathmandu had migrated to the capital
- 6.6% (of 243 boys living in the streets) were no longer attending school because of the present conflict and 6.2% left their home because of the conflict
- 32.3% of boys (sexually active boys: 341) and 26.8% of girls (sexually active girls: 40) had had either anal or vaginal intercourse

⁶¹ UNESCO, SathSath and Child Welfare Scheme (2006) *A study on knowledge, attitudes, practices and beliefs in the context of HIV/AIDS among out-of-school street-based children in Kathmandu and Pokhara*. UNESCO: Lalitpur.

- Condom use among sexually active respondents (and 11 girls)
 - Among 115 boys: 25.9% (first sexual act); 35.3% (last sexual act)
 - Among 11 girls: 9.1% (first sexual act); 27.3% (last sexual act)

Facts for Banke

Sex workers⁶²

- Estimated number of sex workers: 294-390 (urban) and 249-313 (rural)
- Banke jungle is a popular place for female sex workers to solicit their clients

Migrants⁶³

- 83.3% of 225 respondents were married (age range: 16-59)
- Majority (65.6%) worked as wage labourers
- Destination in India
 - 59.3% to U.P/Bihar
 - 18.9% to South India
- Types of sexual partners in the last 12 months: spouse (90.2%), sex worker (4.6%) and other (13.2%)
- Migrants aged 15-24:
 - 42.9% of them did not use condoms while having sex with non-commercial and non-regular sexual partners during the last 12 months
 - 37.5% had complete knowledge of HIV/AIDS

Facts for Ilam

IDP office⁶⁴

- The Seven Party Alliance has opened an office to facilitate the return of IDPs (they received two applications by 22 September 2006)
- A returnee reported that the CPN/M had forbidden her from harvesting cardamom in her own field.

⁶² CREHPA (2004) Estimations of sex workers and potential client sub-population in select major towns in *terai* and along the east-west highway districts: a rapid assessment and update. FHI: Kathmandu.

⁶³ New ERA (2006) A final report on baseline survey of HIV/AIDS program among adolescents, young adults and migrant laborers in six districts in Nepal. HIV/AIDS Program Management Support Agency, UNDP: Lalitpur.

⁶⁴ OCHA Nepal Situation Overview, Issue No.7/Sep and OCHA Nepal Thematic Report