An Assessment of the Legal and Policy Environment in Response to HIV in Nepal

December 2015

National Centre for AIDS and STD Control
Ministry of Health and Population
Teku, Kathmandu, Nepal
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<thead>
<tr>
<th>ACRONYMS</th>
<th>Description</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immunodeficiency Syndrome</td>
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<tr>
<td>ART</td>
<td>Anti-Retroviral Therapy</td>
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<td>CABA</td>
<td>Children Affected by AIDS</td>
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<tr>
<td>CBOs</td>
<td>Community Based Organizations</td>
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<tr>
<td>CHBC</td>
<td>Community and Home Based Care</td>
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<tr>
<td>CSO</td>
<td>Civil Society Organization</td>
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<tr>
<td>DDC</td>
<td>District Development Committee</td>
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<tr>
<td>DOTS</td>
<td>Directly Observed Treatment Short course</td>
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<tr>
<td>EDPs</td>
<td>External Development Partners</td>
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<tr>
<td>EQAS</td>
<td>External Quality Assurance System</td>
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<tr>
<td>FSW</td>
<td>Female Sex Workers</td>
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<tr>
<td>GFATM</td>
<td>Global Fund to Fight against AIDS, Tuberculosis and Malaria</td>
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<tr>
<td>HNIS</td>
<td>Health Management Information System</td>
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<tr>
<td>HSS</td>
<td>Health System Strengthening</td>
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<tr>
<td>HTC</td>
<td>HIV Testing and Counselling</td>
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<tr>
<td>IBBS</td>
<td>Integrated Bio-Behavioural Survey</td>
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<tr>
<td>ICPD</td>
<td>International Conference on Population and Development</td>
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<td>INGOs</td>
<td>International Non-Governmental Organizations</td>
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<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
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<tr>
<td>MACC</td>
<td>Municipal AIDS Coordination Committee</td>
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<tr>
<td>MARPs</td>
<td>Most At Risk Populations (gradually replaced by the terminology KAPs)</td>
</tr>
<tr>
<td>MCH</td>
<td>Maternal and Child Health</td>
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<tr>
<td>MDG</td>
<td>Millennium Development Goal</td>
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<tr>
<td>MoHP</td>
<td>Ministry of Health and Population</td>
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<tr>
<td>MSM</td>
<td>Men having Sex with Men</td>
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<tr>
<td>MSW</td>
<td>Male Sex Workers</td>
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<tr>
<td>NAC</td>
<td>National AIDS Council</td>
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<tr>
<td>NACC</td>
<td>National AIDS Coordination Committee</td>
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<td>NCASC</td>
<td>National Centre for AIDS and STD Control</td>
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<tr>
<td>NGOs</td>
<td>Non-Government Organizations</td>
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<td>NHIP</td>
<td>Nepal HIV Investment Plan</td>
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<td>NHSP</td>
<td>Nepal Health Sector Programme</td>
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<td>NHRC</td>
<td>National Human Rights Commission</td>
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<td>NPHL</td>
<td>National Public Health Laboratory</td>
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<td>NSEP</td>
<td>Needle Syringe Exchange Programme</td>
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<td>NSP</td>
<td>National Strategic Plan</td>
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<tr>
<td>OIs</td>
<td>Opportunistic Infections</td>
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<td>OST</td>
<td>Oral Substitution Therapy</td>
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<td>PWID</td>
<td>People who Injecting Drug</td>
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<td>PEP</td>
<td>Post Exposure Prophylaxis</td>
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<tr>
<td>PLHIV</td>
<td>People Living with HIV</td>
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<td>PPP</td>
<td>Public Private Partnership</td>
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<tr>
<td>PrEP</td>
<td>Pre-Exposure Prophylaxis</td>
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<tr>
<td>SRH</td>
<td>Sexual and Reproductive Health</td>
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<tr>
<td>STI/STD</td>
<td>Sexually Transmitted Infection/Disease</td>
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<tr>
<td>SWAP</td>
<td>Sector Wide Approach to Programme</td>
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<tr>
<td>TG</td>
<td>Third Gender</td>
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<td>UNAIDS</td>
<td>United Nations Joint Programme on HIV AIDS</td>
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<td>UNDP</td>
<td>United Nations Development Program</td>
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<td>UNICEF</td>
<td>United Nations Children Fund</td>
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<tr>
<td>UNGASS</td>
<td>United Nations General Assembly Special Session on HIV AIDS</td>
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<td>WHO</td>
<td>World Health Organization</td>
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<tr>
<td>YKAP</td>
<td>Young Key Affected Populations</td>
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As a signatory to the Political Declaration on HIV/AIDS 2011, following the recommendation of the Global Commission on HIV and the Law (2010-2012), and in line with the ESCAP resolutions 66/10 and 67/9, this Assessment of Legal and Policy Environment in Response to HIV in Nepal was undertaken at the leadership of the National Centre for AIDS and STD Control, under the joint collaboration with the key partners including governments key ministries, National Human Rights Commission, People living with HIV, Key Populations (Female sex workers, People who Inject Drugs, Men who have sex with men and transgender people etc.), UN agencies and External Development Partners. This review is also in line with the “Nepal HIV Implementation Plan (NHIP) 2014-2016, which states that “Punitive laws must be revoked and the interpretation of vague laws used to target certain populations must be scrutinized”.

This review of HIV-related laws and policies identifies the legal and policy barriers to accessing health and HIV services for key populations and presents a set of recommendations that can save lives, save money, help ending AIDS in Nepal and advance Nepal’s efforts to implement its human rights commitments and lead the region in protecting and promoting the rights of those most vulnerable. This report also captures the recent development in the country, specifically the new Constitution of Nepal 2015 and suggests a way forward for its effective implementation in protecting and promoting the rights of PLHIV and KPs.

I am very much convinced that the findings and recommendations of this report will guide the new National HIV Strategic Plan (2016-2021), ensuring that evidence-based laws and practices firmly grounded in human rights exist; challenging the discrimination, promoting public health and protecting human rights, ultimately leading to ending AIDS by 2030. Lastly, I thank the Steering Committee members for their guidance and support in conducting this assessment, UNAIDS for their financial and technical support and all the Government, EDPs and NGO partners and KP members for their inputs through the small consultative meetings and the validation workshop.

Dr. Dipendra Raman Singh
Director
National Centre for AIDS and STD Control
EXECUTIVE SUMMARY

This report follows on the recommendation of the Global Commission on HIV and Law in undertaking national reviews and multi-stakeholder consultations by 2015, relating to the legal and policy barriers towards the elimination of HIV-related stigma, discrimination, and violence. The assessment was carried on from November 2014 to January 2015, under the leadership of the National Centre for AIDS and STD Control (NCASC), of the Ministry of Health and Population, which convened a Steering Committee to oversee the whole process. Recommendations from the Global Commission on HIV and Law were used as a key reference throughout the reviewing process and suggestions and inputs from the validation meeting held on 26 January 2015 have also been incorporated into the final recommendations in this Assessment report.

The Review aims to (1) analyse the laws, policies, law enforcement practices and access to justice based on data from a desk review and thematic group consultations with people living with HIV and other key populations; (2) make concrete recommendations for creating an enabling environment for the National HIV response to be successful.

Nepal has been found to have a history of providing protective laws and policies towards the vulnerable and marginalised groups in society. Efforts at the international, regional, national, and local levels are improving the lives of people living with HIV and other key populations. However, important recommendations from this review include the clarifications of ambiguous laws to prevent further prejudice against people living with HIV/AIDS and other key populations based on human rights instruments.

This report was finalized in December 2015, updated with the new data/information available by July 2015 and also with the context of the Constitution of Nepal 2015 in place.
A. INTRODUCTION

1. Background
During the Asia-Pacific High-Level Intergovernmental Meeting, held between 6-8 February, 2012 in Bangkok, countries in the Asia-Pacific region have adopted a regional framework for action called the “ESCAP Roadmap to 2015”. This report follows on the recommendation of the Global Commission on HIV and Law\(^1\) in undertaking national reviews and multi-stakeholder consultations by 2015, relating to the legal and policy barriers towards the elimination of HIV-related stigma, discrimination, and violence.

Punitive laws, policies and practices, including discrimination against people living with HIV (PLHIV) and Key Populations, obstruct HIV prevention efforts by discouraging HIV testing and limiting access to HIV prevention, treatment, care, and support services. Following Nepal’s signature to the ESCAP Resolutions 66/10 and 67/9 pertaining to the removal of legal and political barriers to universal access, this study will assess the country’s Legal and Policy environment in response to HIV.

2. Objectives
The review on the legal and policy environment in response to HIV in Nepal aims to:
- Analyse the legal environment, including the laws, policies, law enforcement practices and access to justice based on the available literature/documents
- Make concrete recommendations for removing any legal or policy barriers to accessing HIV services (i.e. create an enabling environment for HIV responses to be successful).

3. Methodologies
Led by the National Centre for AIDS and STD Control (NCASC) from the Ministry of Health and Population (MoHP), following the recommendations from the Global Commission on HIV and the Law and in line with the Guidance Document for conducting the national reviews and consultation meetings\(^2\). This assessment was carried out from November 2014 to February 2015 and involved the following processes:
- The NCASC convened a Steering Committee (SC) to guide, support, and oversee the legal environment assessment and the national consultation. The members came from sectors including the relevant Ministries; Health and Population, Home Affairs, Law and Justice, from National association of People living with HIV in Nepal and Blue diamond Society representing key affected communities, UNAIDS and UNDP from UN agencies and the National Human Rights Commission (NHRC) in Nepal.
- A desk review was conducted on the national constitution, laws, acts, policies, strategies, plans, guidelines, and the draft Civil and Penal codes, in line with the ESCAP Regional Roadmap to 2015 and informed by the recommendations of the Global Commission on HIV and the Law (2012) and

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\(^1\) UNDP, Global Commission on HIV and the Law: Risks, Rights, and Health, July 2010.
\(^2\) Creating Enabling Legal Environments: Conducting National Reviews and Multi-Sector Consultations on Legal and Policy Barriers to HIV services; Guidance Document for Asia and the Pacific Region 2013.
Several one and one and group consultation meetings with PLHIV and key population networks and other partners were conducted to collect further information on the practical implications of existing laws, policies, and guidelines and the impact they have on the access to HIV services.

A validation meeting was organized on 26 January, 2015 with the key line ministries, NGOs, NHRC, development partners, law enforcement authorities, parliamentarians, PLHIV, and other key affected populations, to validate and refine the draft findings, and the recommendations. (Validation meeting report with the list of the participants attached - Annex II).

The recommendations included in this report reflect the inputs and suggestions provided at the validation meeting hosted by the NCASC on 26 January 2015.

This report was finalized in December 2015, incorporating the new context regarding the fundamental rights as mentioned in the newly endorsed Constitution of Nepal 2015.

### B. LITERATURE REVIEW AND ANALYSIS

#### 1. The Situation of HIV in Nepal

HIV epidemic in Nepal is largely driven by sexual transmission that accounts for more than 85% of the total new HIV infections. The epidemic remains concentrated among the key affected populations notably; people who inject drugs (PWID), men who have sex with men (MSM), transgender people (TG), male sex workers (MSW), female sex workers (FSW) and male labour migrants (MLM) as well as their spouses. With an overall national HIV prevalence of 0.20 % (adult male 0.28%, adult female 0.13%) in the year 2014, currently there are an estimated total of 39,249 people living with HIV. As shown in Figure 1, the estimated HIV prevalence among adult aged 15-49 years has dropped from a peak (0.35%) in 2005, and is likely to remain around 0.13 % in 2020. The new infection estimates also suggest that the trend of annual new infection is declining and will continue to drop further if the same level of intervention is maintained. The annual new infection in 2014 is estimated at 1,493 and is expected to decline to 899 by 2020. An estimated number of 2,576 deaths were caused by AIDS in 2014, lower compared to estimated 3,362 deaths in 2013, which is largely due to increased access to treatment. The estimates also indicate that 26% of total infections are distributed among PWID (8%), MSWs & TGSW (3%), Clients (6%), MSM (8%), and FSWs (1%). These apart, low risk males including MLM account for 40% and low risk females account for 34% of the remaining infections.

As of July 2015, 26,702 HIV-positive cases have been recorded, of which 11,089 cases are on anti-retroviral therapy (ART).

Poverty and the lack of livelihood opportunities contribute to the rise of HIV, with risk factors including sex work, the sharing of unclean needles, and migration to India and other countries for work opportunities. In addition to economic, and possibly health challenges, key affected populations also face social challenges that include prejudice, discrimination, and marginalization. As a result, these key populations are at an increased risk of HIV and have lower access to prevention, testing and treatment services.

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3 NCASC, HIV Factsheets Summary-2015
2. The Legal Environment

2.1 International Human Rights Instruments
Nepal is a party to a large number of international human rights instruments. The country is a signatory to a total of 21 human rights related international conventions, 11 ILO related conventions, and 4 Geneva Conventions. The treaties that Nepal agreed to include the International Covenant on Civil and Political Rights (1966), the International convention on Economic, Social and Cultural Rights (1966), the Convention on the Rights of the Child (1989), and the Convention on the Elimination of All Forms of Discrimination against Women (1979). Obligations in these conventions establish the accountability of the government of Nepal to ensure that rights to lead free and healthy lives, in dignity, liberty, and security are enjoyed equally by all in Nepal.

2.2 National Constitution
Recently endorsed Constitution of Nepal (2015), the main law of the land, with 35 Parts and 308 Articles, guarantees that every person, regardless of their situation or condition have the fundamental rights which include Right to live with dignity, Rights to freedom, Right to equality, Right to communication: Rights relating to justice Right of victim of crime, Right against torture, Right against preventive detention, Right against untouchability and discrimination, Right relating to property Right to freedom of religion, Right to information Right to privacy, Right against exploitation Right relating to education, Right to language and culture Right to labour, Right relating to health Right relating to food Right to housing, Rights of women, Rights of the child, Rights of Dalit Rights of senior citizens, Right to social justice Right to social security, Right against exile, Right to constitutional remedies. No person shall be deprived of his or her personal liberty except in accordance with law. Rights to freedom includes the freedom of opinion and expression; freedom to assemble peacefully and without arms; freedom to form unions and associations; freedom to move and reside in any part of Nepal; freedom to practice any profession, carry on any occupation; and establish and operate any industry, trade and business in any part of the country

Article 18 (2) under Right to Equality states that no discrimination shall be made in the application of general laws on grounds of origin, religion, race, caste, tribe, sex, physical condition, condition of health, marital status, pregnancy, economic condition, language or region, ideology or on similar other grounds. The Constitution also contains a specific right to health care, including information on one’s health condition, access to emergency health care and equal access to healthcare. Women specifically have the right to safe motherhood and reproductive health and to freedom from any kind of violence.

Nepal has become the first Asian country to identify the existence of ‘gender and sexual minorities’ in its constitution. Although the Art 18 (3) mentions about making of special provisions by law for the protection, empowerment or development of the citizens including gender and sexual minorities; and as per Art. 42 (1), under the rights to social justice, gender and sexual minorities along with several other groups, shall have the right to participate in the state bodies on the basis of inclusive principle, further dialogue with stakeholders is required to determine implications of Article 18 and next steps in terms of implementation.

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4 Constitution of Nepal 2015
5 Constitution of Nepal, Article 35.
6 http://www.deccanherald.com/content/505993/a-ray-light-south-asia.html
The legislative audit conducted in 2004\(^7\) to identify the gap between international obligations and national practices as implemented in the country clearly showed the need for law reform so that the legal system makes a more positive contribution in controlling the further spread of HIV and to protect the rights of people infected and affected by HIV/AIDS. Based on the recommendation drafting of HIV Bill to protect the rights of infected and key populations was started which is still in draft form with the MoHP.

In Nepal, the Supreme Court has the jurisdiction to remedy for violations of fundamental rights based on the Constitution\(^8\). On numerous occasions, the Supreme Court of Nepal has handed down judgments protecting the rights of oppressed and marginalised populations, particularly for PLHIV and affected populations, and sexual and gender minorities.

The National Human Rights Commission (NHRC) established in 2000 by the statutory act has been upgraded as a constitutional body by the Interim Constitution 2007 with the mandate of protection, promotion and effective enforcement of human rights which continues in the new Constitution of Nepal 2015\(^9\). Collective Rights Division of NHRC has identified HIV and AIDS as a priority issue to deal with, in the context of human rights in Nepal.

NOTE: At the time of literature review for drafting this report and the validation workshop in January 2015, the draft constitution was not ready for the discussion. However the Penal Code and Civil Code drafts were ready and being discussed. So the draft report at the time of validation meeting was focussing more on the Penal and Civil codes provisions. One of the major recommendations received was to advocate for the constitution under draft to recognise the rights of PLHIV and KPs. Accordingly wide advocacy efforts were made jointly by the Governments, civil societies and the EDPs to influence the draft constitution. As a result the Constitution of Nepal, endorsed in September 2015, shows significant progress in terms of making of special provisions by law for the protection, empowerment or development of the citizens including gender and sexual minorities and also their right to participate and non-discrimination for all based on health condition. This final report is updated in the context of the new Constitution of Nepal 2015 in place.

**a. Right to Equality and Non-discrimination**

Fundamental Rights and Duties, Right to equality, Article 18 (1 to 3) of Constitution of Nepal 2015 states that all are equal before the law and are entitled without any discrimination to equal protection of the law; no discrimination shall be made against any citizen in the application of general laws on grounds of religion, colour, sex, caste, tribe, origin, language or ideological conviction or any of these. It further confers the right of non-discrimination on various grounds clearly including ‘gender and sexual orientation’ and ‘health status’. It bans any kind of discrimination based on gender and sexual orientation and grants SOGI people with right to participation in state machinery.

**b. Right to Health**

The Constitution state “every citizen shall have the right to free basic health services from the State and no one shall be deprived of emergency health services; every person shall have the right to get information about his or her medical treatment; every citizen shall have equal access to health

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\(^{6}\) NCASC/Policy Project/FWLD (March 2004), HIV AIDS and Human Rights: A Legislative Audit, National Centre for AIDS and STD Control/Policy Project/Forum for Women, Law and Development.

\(^{7}\) Part 11, Article 128 of the Constitution of Nepal 2015

\(^{8}\) Part 25, Article 248, The Constitution of Nepal 2015
services. (Constitution of Nepal 2015, Article 35 Part 3). However, in practice, people living with HIV (PLHIV) have not had access to proper and sufficient care, treatment, and support. Even the proposed draft of the Penal Code under Article 103, Chapter 5; Offense against Public Interest, Health and Safety, Convenience and Morals; criminalizes people who “purposefully or knowingly commit acts that would transmit Hepatitis B or HIV, give blood or coerce to give blood or come into sexual contact without precautionary measures in place, or cause entry of blood, semen, saliva, or other bodily fluids into the body of another. Charged with attempt to murder, this could result in imprisonment for up to 10 years and a fine of NRs. 100,000. If the transmission occurs from negligence or recklessness, it is proposed to punish the HIV positive person with three years-imprisons and a fine of NRs. 30,000”10.

This kind of punitive law criminalizing HIV or Hep B transmission will be counterproductive in bringing infected and affected people to the preventive, treatment and care services. Any criminal charge for HIV non-disclosure, exposure or transmission should take into account the current reality of HIV infection, including the benefits of HIV treatment. HIV infection is a serious health condition that has become chronic and manageable with treatment. As a result, a person with HIV can now live a near normal lifespan11.

The Infectious Diseases Control Act 2020 (1963) confers special powers to the government to take the necessary actions to root out any infectious diseases likely to spread out. It may designate any official entity to make the necessary arrangements to prevent further spread of any infectious diseases among populations. Under this act, infected people may be kept in insolation and their freedom of movement may be upheld for broader public health benefit.

HIV can be differentiated from other infectious diseases in that it cannot be transmitted by normal contact such as talking, handshaking, etc. etc. Unfortunately, this provision, which aims to prevent transmissions and cure infectious diseases, does not explicitly differentiate between different types of infectious diseases and which would justify for segregation or not. Accordingly, this presents a risk that people living with HIV could be segregated despite this having no justifiable public health benefit. It is likely that such laws as described above violate the prohibition on discrimination on grounds of health status in the new Constitution.

The Constitution of Nepal also lays out provisions to eliminate discrimination against women in accessing health care as women have been found to face significantly more discrimination than men do: “(1) No discrimination of any kind shall be made against the women by virtue of sex. (2) Every woman shall have the right to reproductive health and reproduction. (3) No woman shall be subjected to physical, mental or any other kind of violence; and such act shall be punishable by law.”12 However, due to the prevailing prejudice against PLHIV and key affected populations (female sex workers, people who inject drugs, men who have sex with men, or transgender people) it has been found that they were often denied access to health care services. Women spoke of their experience of discrimination from health care workers if they disclose their HIV status, particularly


11 UNAIDS: Guidance Note 2013, Ending overly broad criminalization of HIV, non-disclosure, exposure and transmission: Critical scientific, medical and legal considerations.

12 Constitution of Nepal 2015, Article 38.
from nursing staff, obstetricians and gynaecologists. They complained of health care workers breaching confidentiality with negative consequences\textsuperscript{13}.

Studies have found that women have been denied of family planning and SRH services and even been coerced into sterilization and into pregnancy termination by health personnel because of their HIV status\textsuperscript{14}. Considerable efforts are now required to ensure the provisions of the Constitution are implemented and enforced. The law must also enforce that every woman, regardless of HIV status, has the right to choose to continue a pregnancy or to have an abortion, without being pressured or coerced into it.

In Nepal, the legal age of consent is 18 years. Anyone 18 years or older requesting HIV Testing and Counselling (HTC) is deemed able to give full informed consent. Children (below 14 years) and minors (Under 16 years) cannot legally provide consent. HIV testing may be undertaken without parental consent on a case-by-case basis, if the counsellor determines that the minor has sufficient maturity to understand the testing procedures and results. Adolescents can be designated as ‘mature’ or ‘emancipated’ minors if they are married, pregnant, sexually active or are already parents\textsuperscript{15}.

Thus, the legal age for informed consent for an HIV test is unclear as the definition of the age range for childhood is inconsistent. The need to provide parental/guardian consent for the age group below 18 can present a barrier to young people accessing HIV testing and other services, undermining their right to health as recent IBBS studies have shown more than 10% of the respondents were children below the age of 19 with risk behaviours of injecting drug, sex work and same sex practice.\textsuperscript{16}

c. Right to Free Movement

Nepal and India have an ‘open border’ policy adopted through the 1950 bilateral Peace and Friendship Treaty. It states that, “the nationals of either country share the same privileges in the matter of residence, ownership of property, participation in trade and commerce, movement and other privileges of a similar nature in the territories of the other”.

The Immigration Regulation Act 2051 (1994) mandates for every foreigner entering Nepal to submit an International Medical Certificate. In the absence of such certificate or in the case of an infectious disease, the visa of the said person may be revoked. This immigration regulation needs to clarify that HIV status is not required to be included in the medical certificate or otherwise disclosed.

The Constitution of Nepal 2015 provides the right of equality and free movement to all Nepali citizens and right to non-discrimination on grounds of health condition in the application of general laws, but the existing Infectious Diseases (Control) Act challenge this right through quarantine and segregation of people with infectious diseases and presents a threat to the civil liberties of people living with HIV/AIDS.

\textsuperscript{13} Positive and Pregnant, How Dare You: A study on access to reproductive and maternal health care for women living with HIV in Asia; Findings from six countries: Bangladesh, Cambodia, India, Indonesia, Nepal and Vietnam
\textsuperscript{14} FPAN (2011), Report of People Living with HIV Stigma Index Nepal
\textsuperscript{15} NCASC, National Guidelines for HIV Testing and Counselling, September 2011
\textsuperscript{16} NCASC, IBBS among Men who have Sex with Men (MSM & Transgender (TG) People in Kathmandu Valley, 2015; IBBS among Sex workers in Kathmandu Valley 2015; IBBS among people who inject drugs in Kathmandu Valley, 2015; IBBS among Sex workers in Kathmandu Valley 2015
d. Right to Privacy and Confidentiality
According to the Constitution, the privacy of any person, his or her residence, property, document, data, correspondence and matters relating to his or her character shall, except in accordance with law, be inviolable. In the case of Advocate Sapana Pradhan Malla v. Government of Nepal, Office of the Prime Minister and Council of Ministers, the Supreme Court delivered a critical decision regarding the protection of the rights of people living with HIV. The Court confirmed the right to privacy in respect to a person’s HIV status. The Court further prohibited a person from obtaining knowledge of another person’s status and restricted any form of publication. Any person in violation of this declaration may be found in contempt of court and subject to penalty. The Court identified women, children and PLHIV as vulnerable groups prone to exploitation and noted their specific need for the right to privacy.

Although there are no specific legal provisions made regarding the right to privacy and HIV information so far, the Code of Conduct of the Nepal Medical Council and the Regulation of Nepal Nursing Council provide for the privacy of patients and professional responsibility prohibiting doctors and nurses from disclosing any matters about their patients, except as prescribed by law. In practice the situation is different as shown by the Stigma Index study, where 7% of women, 33% of TG, and 8% of men reported forceful testing of their HIV status during a medical examination.

e. Rights in the Work Place
The Constitution of Nepal 2015 prohibits discrimination in the application of general laws on the grounds of health condition. National Policy on HIV/AIDS in the Workplace clearly states “To ensure that HIV testing will not be performed in any process including appointment, training and promotion, etc.” NSP 2011-2016 also has emphasised the implementation of the work place policy and programme. But the implementation of the workplace policy and program is very limited. It was found that medical screenings, which include HIV tests, were conducted by uniformed services during the recruitment process (Nepal Police, Armed Police, and Nepalese Army) and that HIV positive people were disqualified for the job following test results.

f. Right to Information
The Constitution of Nepal 2015 guarantees the right to information in that every citizen shall have the right to obtain or demand information on any matters of concern to themselves or to the public. While documents such as the NSP and documents from the UN, government agencies and NGOs talk of rights-based approaches, stakeholders consulted from among FSWs, IDUs, sexual minorities, WLHIV and others claimed not to be aware of their rights. Indeed, it is important to be aware of one’s rights in order to be able to assert the same.

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17 UNAIDS, Gender Audit of the Response to HIV in Nepal 2011.

18 Ministry of Labour and Transport Management; National Policy on HIV/AIDS in the Workplace 2007


20 UNAIDS, Gender Audit of the Response to HIV in Nepal 2011
2.3 Narcotic Drugs (Control) Act, 2033 (1976)

In Nepal, drug control initiatives began with a Liquor Control Act in 1960, which allowed license holders to produce and sell cannabis. In 1976, the government made the Narcotics Drug Control Act-1976 which banned the production, storage, selling, consumption and trade of all types of narcotics and psychotropic substances listed in the Act. So far the Act has been amended three times (1981, 1987 and 1992). In 1991 Nepal became the party to the UN Single Convention on Narcotic Drugs 1961 as amended by the protocol of 1972. In the same year Nepal became the party to United Nations (UN) against illicit trafficking of narcotic drugs and psychotropic substances of 1988. The Act was basically focused on punitive approach in the beginning, however, in its amendment in 1993, it incorporated the principles of major international instruments and widens the scope of the Act beyond criminal justice system.

3. Policies, Strategies, and Guidelines related to HIV and AIDS

3.1 Response to Global and Regional Commitments

Nepal is one of the 189 signatories to the United Nations General Assembly Special Session of HIV AIDS Declaration of commitment on HIV AIDS (UNGASS), which was held in June 2001. As per the UNGASS commitments, Nepal had submitted four UNGASS reports every two years from 2004. Moreover, Nepal submitted two National AIDS Response Progress Reports to contribute to the Global AIDS Response Progress Reports, 2012 and 2013 as part of country’s commitment to the UN General Assembly Political declaration of 2011. The reports highlighted the efforts and achievements in the areas of prevention, treatment, care and support, human right issues, civil Society Organization (CSO) involvement, policy and strategy status in the country.

At the regional level, the South Asia Association of Regional Cooperation (SAARC) – consisting of Afghanistan, Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan, and Sri Lanka – has signed in 2004 a Memorandum of Understanding (MoU) with UNAIDS to help member states work towards the goals of HIV prevention and care for PLHIV. The SAARC Secretariat, with assistance from UNAIDS, developed the first SAARC Strategy on HIV and AIDS for 2006-2010 (and extended until 2012), aiming at containing the epidemic and mitigating the socio-economic impact of the disease in the region.

The current SAARC Regional Strategy on HIV and AIDS (2013-2017) is implemented with the aim of advancing human rights for under-served, marginalized, and vulnerable groups in the response to HIV. Principally, it also emphasizes on regional dialogue for cross-border issues relevant to HIV but the implementation wise much needs to be done on cross boarder issues for the prevention of HIV infection among the Nepalese migrants to India.

\[21\text{ Narcotic Drug Control Act 1976}\]
\[22\text{ The Health, Policy initiatives for drug control in Nepal, 2011}\]

3.2 National Response to HIV and AIDS

The response to HIV AIDS at the legislative and national policy levels have facilitated to create an enabling environment for PLHIV. Ever since the first case of HIV was reported in 1988 in Nepal, the government has worked together with international organizations and stakeholders to formulate policies, strategies and guidelines [see annex 1 for a chronological list of the policies, plans, strategies, and guidelines] to combat HIV.

3.2.1 National Policy Environment

a. National Health Policy, 2070 (2014 AD)
A new policy named the “National Health Policy 2071 BS (2014 AD)” has been issued by the Ministry of Health and Population to ensure the rights of every citizen to quality health services. It has well emphasized the importance of effective prevention of HIV.

The National Centre for AIDS and STD Control (NCASC) was formed in 1988, under the Ministry of Health and Population, and adopted the National AIDS and STD Control Policy, 1995 which was revised in 2011 and named as the National Policy on HIV and STI, 2011. The policy has stipulated seven guiding principles in line with international policy environment, such as the “Three Ones” principle. The revised policy of 2011 determines linkages among The National AIDS Council (NAC) which was formed in 2002, HIV AIDS and STI Control Board (HSCB) formed in 2007 by the cabinet order for a multi-sector engagement of different ministries, the private sector, and civil society including PLHIV, to broadly respond to the HIV epidemic. However, NAC and HSCB have been found inactive.

In terms of risk reduction, a “National Guideline on Universal Precautions, Waste Disposal and Post Exposure Management” was developed in 2007 by NCASC to standardise procedures among health service providers and minimize the risks of infections for health service providers and their patients. However, it was found that in practice, the mandatory Universal Precaution was often compromised, depending on the setting of the service sites. For instance, confidentiality measures are not always respected in public health service sites (one incident of TU Teaching Hospital has been documented in a report that a Medical Officer had openly marked the Emergency Ticket revealing the “HIV+ve” status. The guideline does not include the new approaches of preventing HIV transmission as the pre and post-exposure prophylaxis.

The Ministry of Labour and Transport Management of Nepal endorsed the “National Policy on HIV AIDS in the Workplace, 2007” (Cabinet decision of 8 October 2007), based on the ILO Code of Practice on HIV AIDS and the World of Work. At the initiation of Federation of Nepalese Chambers of Commerce and Industry (FNCCI) with the support of UNAIDS and ILO; Business Coalition on AIDS in

24 Three Ones refers to one agreed HIV AIDS action framework, one national AIDS coordinating authority, with a multi-sector mandate; and one agreed country-level monitoring and evaluation system
26 CDC (2012), Fact Sheet: PrEP a new tool for HIV Prevention, Centre for Disease Control
Nepal (BCAN) was established in 2011 to expand the workplace programs to protect workforce from HIV infection and creating supporting environment for the care and treatment of the infected and affected people as a part of the corporate social responsibility of the business sector. BCAN’s work is limited only doing awareness-raising programmes that only to the few workplaces/industries in Kathmandu Valley.

Although the National Policy on HIV/AIDS in the workplace prohibits HIV testing during the recruitment process as guided by the International Convention of 1958 in relation to discrimination in the work place, uniformed services and foreign employment agencies have been found to exclude candidates for employment after a positive HIV result.

Other countries (e.g. in the Gulf area) also demand HIV tests within a week following entry and return HIV positive people to their home country.

Replacing the Narcotic Control National Policy of 2052 (1995 AD), a comprehensive National Drug Control Policy was endorsed by MoHA in 2063 BS (2006 AD), with the vision of “Attainment of Healthy and prosperous Society Free from Drugs Addiction”.

e. Nepal Narcotic Drugs Control Policy and Strategy, 2006
Identifying the increasing trend of youth involvement on drugs addiction, use of multi drugs, injecting drugs and also increasing trend of STI including HIV and crime rate, Nepal Narcotic Drugs Control Policy and strategy, was also formulated in 2006 with a vision of “narcotic drugs user free healthy and prosperous society”. This policy has adopted various strategies like supply control, demand reduction, treatment & rehabilitation, harm reduction, research & development and collaboration, partnership & resource mobilization etc. It also establishes various entities like High-level Drug Control National Guidance and Coordination Committee, Drug Control Executive Committee to implement the policy.

Nepal has no legislation to regulate safety and quality of blood transfusion although blood transfusion services started in Nepal from 2021 BS (1966 AD). The first national blood policy was formulated in 2050 BS (1993 AD) and amended in 2006 AD. The Government of Nepal/Ministry of Health & Population recently announced a new and revised policy called the “National Blood Transfusion Policy, 2071 (2014 AD)”. It contains provisions for Transfusion Transmissible Infections (TTI) screening which covers testing of HIV, Hepatitis B (HBsAg), Hepatitis C (HCV) and syphilis (VDRL), and external quality assurance system (EQAS) for TTI tests. The policy has a clear bio-safety guideline to minimize injuries, infections, harmful toxins, and flow chart for PEP. The policy is silent

28 Related to HIV AIDS and World of Work Recommendation 2010 (number 200);Recommendation 3.d & 10, P3-4 (available in Nepali, translated version)
29 Peoples Forum (2069 BS), Foreign Employment related Information booklet, p6
30 National Drug Control Policy 2063 BS (2006 AD)
31 National Policy and strategy on Narcotic Drugs Control, 2006
32 National Blood Transfusion Policy, 2014; objective-6, P10-11
about the rights of patients, in case of HIV infection, HBsAg, HCV or other blood-borne diseases from a blood transfusion.

### 3.2.2 National Strategies and Plans


Third National Health Sector Programme for the period 2015-2020 (NHSP-III) builds on the progress over the last two decades in establishing the health system and in health outcomes for the population. The country has made great strides towards achieving its targets for the Millennium Development Goals (MDGs), substantial reductions in maternal and child mortality and also in reversing the trend of infection of HIV, TB and Malaria. At the same time progress has been made in the area of family planning and this is having the effect of bringing the country closer to a stable population size. NHSP-III builds on the National Health Policy 2014 (NHP). HIV and AIDS services are one of the elements in the basic health service package.34


The National HIV AIDS Strategy (2011-2016) has been developed based on the achievements, lessons learned and experiences gained from the implementation of previous HIV AIDS strategy (2006-2011).35 The overall goal of the strategy is to achieve Universal Access to HIV prevention, treatment, care and support in direct alignment with the Government’s Poverty Reduction Strategy Paper (PRSP) and the Millennium Development Goals (MDGs). Its programmatic objectives are set with the following targets:

- Reduce new HIV infections by 50% by 2016 (compared to 2010).
- Reduce new HIV infections in children by 90% by 2016 (compared to 2010).
- Reduce HIV related death by 25% by 2016 through universal access to treatment and care services (compared to 2010).

The HIV and STI preventive messages have been incorporated by the Ministry of Education in the secondary level curriculum, as per the policy guidance. However, issues such as appropriate training for teachers for delivering related messages to students remain. Other challenges include mainstreaming HIV issues into sectorial ministries, creating an enabling environment for needle syringe exchange programmes, and providing for the distribution of condoms.


To implement the National Drug Control Policy, the Ministry of Home Affairs has developed the National Drug Control Strategy, 2066 BS (2010 AD), which envisions a healthy and prosperous society, free of drug abuse. Programmes to control and reduce the transmission of HIV, Hepatitis B/C, and STI among drug users and their families/communities are proposed under this strategy. Through this strategy, the MoHA has allowed Opioid Substitution Therapy (OST) services and other harm reduction programmes to scale up.

**d. Nepal HIV Investment Plan 2014-2016**

Built on the principles of UNAIDS’ Investment Framework, the National Strategy Plan 2011-2016 and the recommendations from the comprehensive national review (2013), the Nepal HIV Investment

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34 National Health Sector Programme III (2015 – 2020), Ministry of Health and Population
Plan of 2014-2016 advocates for strategic investments in the country’s response to HIV, such as public-private partnerships, evidence-based policies, or the rapid scale up of HIV testing and Antiretroviral Therapy (ART). The plan introduces Nepal’s ‘Test, Treat and Retain’ paradigm and focuses on the elimination of vertical transmission of HIV (eVT), so that no child is born with HIV in Nepal and that mothers are kept alive and well.

4. PLHIV, Key Populations, Programmes, Practice, and Rights

4.1 People Living with HIV (ART, eVT, CABA)

Prejudice, fear and violations of human rights against people living with HIV (PLHIV) can discourage people from accessing and utilizing HIV prevention services, getting tested and seeking treatment. Attitudes of service providers do not encourage access to treatment; on the contrary, they reinforce stigma and discrimination36. Therefore, protective laws and policy responses are important to limit the cases of discrimination from health personnel or disclosing of HIV status without prior consent. Although Article 18(2) in the Constitution of Nepal 2015 clearly speaks that there shall be no discrimination on the ground of health status, the criminalization of HIV transmission is there in the proposed draft of the Penal code, inconsistent with the recommendations of UNAIDS and the Global Commission on HIV and the Law, which must be corrected.

Anti-Retroviral Treatment (ART)

Nepal has seen gradual increase in the number of people who are on ART every year during the last decades. By July 2015, there were 11,089 people receiving ART from 61 ART sites throughout the country. Out of this total of 11,089 who are on ART, 5,652 are male, 5,406 are female and 31 are transgender and 8% are children of under -15 years.37 The recent cohort analysis shows that around 83.7% of people who started ART in last 12 months and 78% who stated in last 24 months are still alive and on treatment.

Through the NHIP 2014-2016, the country widened the eligibility criteria for ART enrolment based on the WHO Treatment Guidelines 2013, relaxing it from CD4 count of 350 to \( \leq 500 \), and also scale up HIV Testing through the roll out of the ‘Community Test and Treat Competence (CTTC)’ model, driven by community-led HIV testing and counselling. In the light of adoption of the new criteria of CD4 \( \leq 500 \) from 2015, it is estimated that around 32,000 PLHIV will need ART in 2015. Comprehensive guidance is now provided on how to use ARV drugs across age groups and populations groups (adults, pregnant and breastfeeding women, adolescents, children and key populations). Bidirectional referral linkages between Community Care Centres (CCCs), Community Home-Based Care (CHBC) System and ART sites have facilitated the quality of ART services, and adherence to ART treatment.

Elimination of Vertical Transmission of HIV (eVT)

In recent years, Nepal has scaled up elimination of Vertical Transmission ‘eVT’ services, based on the National Guideline on eVT (PMTCT). The number of sites offering ‘eVT’ services has gone up to 98

36 UNAIDS, Gender Audit of the Response to HIV in Nepal 2010.
37 NCASC. HIV Factsheets Summary-2015
across 55 districts in July 2015, compared to 65 sites in 33 districts in 2013. As a result of this scale up, the number of women attending ANC who were tested increased from 142,043 in 2013 to 158,146 in 2014 (NCASC Programme Data 2014). Likewise, with 162 pregnant women receiving ARV prophylaxis out of 498 pregnant women needing eVT services, the eVT coverage in 2014 has reached to 32.5%, an increase from 20.9% in 2013. As of the July 2015, there were 9 sites providing early infant diagnosis (EID) service in Nepal\textsuperscript{18}. Option B+ (Lifelong ART) for pregnant women living with HIV has been formalized in the National Consolidated Guidelines for Treating and Preventing HIV in Nepal, which recommends that all HIV-infected pregnant women immediately start life-long ART regardless of WHO clinical stage and CD4 cell count.

The eVT service is free of charge, but most of the eVT sites are located at district headquarters in government hospitals, and are not easily accessible to all. Community-based eVT programmes are implemented in six districts (Achham, Kailali, Sunsari, Saptari, Baitadi and Bajhang), where HIV prevalence is higher among seasonal labour migrants to India and their families. A DNA testing facility has also been set up at the National Public Health Laboratory in Kathmandu for the purpose of Early Infant Diagnosis (EID).

Pregnant women living with HIV often face difficult choices regarding ARV treatment to reduce the risks of transmitting HIV to their child. According to the Stigma Index report of 2011, one in three women (32%) reported being advised against having children at least once by healthcare providers and 2% of the respondents (2% female and 1.3% male respondents) stated that they were coerced into being sterilized. Thorough systematic gender analysis was not done during planning processes; therefore interventions are not necessarily responsive to the needs on the ground. Discrimination against women and girls persists and particularly for WLHIV experience multiple challenges related to poverty.\textsuperscript{39}

**Children Affected By AIDS (CABA)**

Since April 2014, Nepal has launched a cash transfer programme targeting Children Affected by AIDS (CABA), based on the endorsed CABA Operating Guideline 2070 under which 1,090 children living with HIV (CLHIVs) aged between 0-18 years, across 45 districts, are getting a monthly amount of NRs 1,000 (roughly US 10$) as the educational and nutritional support. At present, this cash transfer programme is being implemented by Save the Children with financial support from GFATM. However, the Government of Nepal is to takeover in near future. The draft Civil Code of Nepal under Provision concerning Parental Authority mentions that the parent shall have to take special care of and provide special treatment and protection to a child living with HIV or Hepatitis\textsuperscript{40}.

4.2 Sex Workers (Female, Male and TG)

**Female Sex Workers**

\textsuperscript{38} NCASC. HIV Factsheets Summary-2015
\textsuperscript{39} Gender Audit of the Response to HIV in Nepal
\textsuperscript{40} The Draft of Civil Code, Civil Procedures Code and Report 2010; Government of Nepal, Ministry of Law and Justice.
As of 2010, it was estimated that there were about 26,504 female sex workers in Nepal, with 40% operating from establishments and homes (HSCB/NCASC, 2011) and 20% being street-based. Since 2004, the Integrated Biological and Behavioural Surveillance (IBBS) Surveys studies conducted among FSWs in Kathmandu, Pokhara and other cities (22 Terai districts) suggest that the country has successfully stabilized the HIV prevalence under 2%. However HIV prevalence among street-based FSWs in Kathmandu valley is in increasing trend; from 2% in 2006, to 3.5% in 2008, 4.2% in 2011 and still 4% in 2015.

**Male Sex Worker and Transgender sex workers**

The estimated size of MSW ranges between 10,450 to 12,300 and between 7,706 to 9,221 for Transgender. An assessment of risk and vulnerability of transgender people in Nepal shows that around 60% of transgender are selling sex. According to the 2015 IBBS, HIV prevalence among MSM in Kathmandu Valley was estimated at 2.4% whereas prevalence among MSWs/TG-SWs was at 6.8%. Due to cultural constraints in village settings, most of the MSWs are concentrated in the cities where they feel more comfortable with their sexual orientation. It is estimated that 20% of the MSM community have not been HIV tested yet. With the support of Global Fund and Pooled fund, over 50 LGBT organizations in 40 districts are working on interventions for MSM & MSW.

“Constitution of Nepal, 2015” has granted constitutional rights to sexual and gender minority community (lesbian, gay, bisexual, transgender and intersex/ LGBTI). Under the principle of “Inclusion”, the new Constitution of Nepal has acknowledged “gender and sexual minorities” communities in Article 18 (Right to Equality) & Article 42 (Right to Social Justice). However, it did not go so far as to include a specific prohibition against discrimination on the grounds of gender or sexual orientation. The use of gender neutral language in article 12 (regarding Citizenship ID) has ensured the fundamental rights of sexual and gender minorities.

Sex workers tend to experience physical, sexual, emotional and economic violence at work, in their homes and neighbourhoods, as well as in health care and custodial settings. The kind of violence they are subjected to at the hands of clients, pimps, and law enforcement is a direct deterrent to positive health-seeking behaviour. Sex workers are being arrested and prosecuted by police and Chief District Offices under the pretence of disturbing peace or demonstrating obscenity under the Some Public (Offence and Punishment) Act. Reported cases include possession of condoms being taken as evidence of sex work and peer educators and outreach workers being harassed/arrested by police on the basis of carrying condoms.

According to the Constitution of Nepal, 2015, individuals are free to practice any profession, occupation, industry and trade. On the same grounds, the Supreme Court of Nepal has decided in a

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43 UNAIDS, Assessment of Risk and Vulnerabilities of Transgender People in Nepal -2011
45 UNAIDS, UNFPA, UNDP: SEX WORK AND THE LAW IN ASIA AND THE PACIFIC
46 The Rights Evidence: Sexwork, Violence and HIV in Asia 2015; A multi-country qualitative study; UNDP, UNFPA, APNSW, SANGRAM
case that prostitution is also a kind of profession and everyone has a right to choose his/her profession. Therefore, the law is silent on sex work as an occupation while clients of sex workers are criminalized. According to the Human Trafficking and Transportation (Control) Act 2007, it is an offence to engage the services of a sex worker. It is further expressed that any house, land, vehicle used for such work shall be seized. The act has provisioned penalties to clients of sex workers of both imprisonment (ranging from one to three months) and paying a fine. While documents such as the NSP and documents from the UN, government agencies and NGOs talk of rights-based approaches, stakeholders consulted from among FSWs, IDUs, sexual minorities, WLHIV and others claimed not to be aware of their rights. Indeed, it is important to be aware of one’s rights in order to be able to assert the same.

NCASC has developed standard operating procedure (SoP) to conduct HIV targeted intervention programmes for FSWs. Behaviour change intervention programmes for FSW have been implemented along the east west highways, link highways, Pokhara, and Kathmandu valleys. They are focused on the prevention package of behaviour change communication, condom distribution, HTC and STIs services. The service sites are operating in strategic locations for FSWs and their male clients.

4.3 People Who Inject Drugs (PWID)

The survey conducted by Central Bureau of Statistics in 2013 estimated that there were around 52,000 PWID in the country of which females account for 7% of the total PWID of Nepal. The study also identified that most drug users start before the age of 20, that injecting is the main mode of drug administration, and that drug mobility is the highest along the Indian border.

Despite a sharp decline of HIV prevalence observed among PWID of Kathmandu valley from 68% in 2002 to 6.4% in 2015, the HIV epidemic in Nepal has consistently been over 5% among PWID, with 8.3% in the Eastern Terai and 5% in the Western Terai (IBBS 2012). Another issue is the high rate of co-infections such as Hepatitis C, which has a prevalence of 22%, 13.1% and 47.5% in among PWID in Kathmandu Valley, Pokhara Valley and Eastern Terai Highway.

Females account for 7% of the total PWID of Nepal (CBS 2012). It has been estimated that there are 4,453 female IDUs (NCASC, 2013) and the HIV prevalence among was reported at 4% in 2010 (UNODC, 2011), of which 15% of women were also co-infected with Hepatitis C. Female sex workers who inject drugs are found particularly vulnerable. However, little is known about or focused on female IDUs.

Harm reduction programmes have been continuously implemented by NGOs since 1990s and the integration of treatment for Hep B and Hep C into these programmes has been planned.

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47 Purna Shrestha, Prostitution and Public Health: Various Forms of Regulating Methods - An Analysis of Current Legal Responses to Prostitution in Nepal
48 Gender Audit of the Response to HIV in Nepal 2011
50 NCASC, IBBS among the drug users
51 NCASC, IBBS among the Injecting Drug Users in Kathmandu Valley 2015; in Pokhara Valley 2015; in Eastern Terai Highway 2015
52 UNODC. Profile, Drug Use Pattern, Risk Behavior and Selected Bio-markers of women drug users in seven sites in Nepal
Under the current HIV and STI policy and strategy, as a key components of the harm reduction, clean
needle/syringe exchange programmes (NSEP) for PWID are being implemented by the NGO sectors
since 1990, whereas Opiate Substitution Therapy (OST) service sites are in operation at the
government hospitals. Government of Nepal, Ministry of Health and population, Department of Drug
Administration DDA has identified Methadone Buprenorphine (Narcotics and Psychotropic
Substances) for import and use and listed under essential drug list.

Although no laws restrict the act of distributing and keeping clean needles or syringes, PWIDs have
been arrested and tortured under accusations of drug peddling/trafficking, rather than under the
drug use offense. The country has committed to the UN and regional assemblies to revise its current
Drug Control Act to align it with its commitments and conventions’ ratifications for the prevention
and control of drug abuse. In addition to ensuring enabling legal environments for the
implementation of the full package of harm reduction services endorsed by the United Nations,
UNAIDS and the World Health Organisation recommend decriminalisation of drug use as one of the
measures for effective HIV responses. Due to the lack of clarity amongst the governmental officials
about the linkages between the harm reduction approach and HIV prevention to drug users,
expansion of harm reduction programs especially oral substitution therapy is not moving smoothly.
Drug users are strictly considered as “criminals” rather than a “victim” by our judiciary. Even though
law allowed judges to divert drug users from criminal justice system and lead them towards
treatment and rehabilitation, this benefit is rarely been applied by the Supreme Court of Nepal.
Moreover, in few of the cases, while using their discretionary powers, the Court has penalized drug
users with the strict maximum penalties.53

4.4 Men who have sex with men (MSM) and Transgender

Men who have sex with men in Nepal comprised of the following sub-populations: a) Male Sex
Workers (MSW) (estimated population size of 12,639), b) transgender people and transgender sex
workers (TGSW) (estimated population size of 9,474) and c) Men Who Have Sex with Men (MSM)
with the population size estimated at 196,270 (NHIP, 2014). Data from Kathmandu Valley shows that
overall HIV prevalence among MSM has not changed much and remains around 3.8% up to 2012 and
decline to 2.6% in 2015. However, the prevalence among MSW has increased from 4.8% in 2004 to
6.8% in 2012 and in 2015. (Source: IBBS Study among MSM and TG in Kathmandu Valley 2015)

The Blue Diamond Society (BDS) is a prominent advocacy group for the rights of LGBTI Nepalese that
has been reporting incidences of prejudice and violence related to sexual orientation and HIV
infection (Bhattarai, 2012).54 Numerous cases of police abuse against MSM and TG have been
recorded including harassment, beatings, torture and arbitrary arrests without a hearing under the
public nuisance law.55 BDS conducts services of peer outreach, condom distribution, training on safe
sex and HIV, community sensitization and awareness, and support services for MSM and transgender
people living with HIV. Through MSM and other key affected populations networks such as BDS,

http://www.globalpressinstitute.org/global-news/asia/nepal/sexual-and-genderminorities-hiv-face-
doublestigma-nepal-ixzz1c73RYZND
55 APCOM, UNDP; Legal environments, human rights and HIV responses among men who have sex with men
and transgender people in Asia and the Pacific, An agenda for action, July 2010
MSM and TG have been involved in Nepal’s Country Coordinating Mechanism (CCM) and other technical working groups related to HIV prevention and treatment.

In 2007, the Supreme Court decriminalized homosexuality and recognized a third gender identity in the *Sunil Babu Pant and Others Vs. Government of Nepal and Others* (writ no 917 of Year 2007) Case. The Supreme Court also provided protective and anti-discriminatory provisions for PLHIV and people with diverse sexual orientation and gender identity. However, the necessary measures for the implementation of these directives are still not in effect. For instance, the chapter on Bestiality of the Country Code about “unnatural sex” could be used to prosecute people who have homosexual intercourse and the proposed Penal Code still envisions that marriage is to be solemnized only between a man and a woman.

### 4.5 Migrant Labour and Mobile Populations

Migration is becoming an important facet in the population dynamics of Nepal. Increasing number of youths are emigrating abroad. The absentee population of Nepal in 2011 was 1,921,494 as compared to 762,181 in 2001. There is also an increasing trend in internal migration. In 2011, 2.6 million inter-district migrants were reported to be lifetime migrants, compared to 1.5 million in 1981.

Vulnerability of migrants to certain health risks, poses an additional challenge for the government to address. For example, “the highest percentage of total cases of HIV in Nepal is contributed by seasonal labour migrant workers (46%)”

Male labour migrants, particularly those going to India for work and who visit female sex workers there are acting as bridging population that transfer infections from high risk groups to low risk populations. The size of these returnee male labour migrants were estimated to number around 505,728 in 2011 (CBS, 2011 and NDHS, 2011).

Many of the Nepalese people from West, Mid-West, and Far West migrate to Mumbai and Delhi for work. Both are categorized as high-risk destinations due to the higher HIV prevalence among sex workers there compared to other parts of India (UNAIDS, 2011). The migration for foreign employment has also been rapidly increasing to areas in the gulf, Malaysia and Korea.

The Government and its partners through the pool fund mechanism, Save the Children, and FHI Saath-Saath project are implementing Targeted Intervention (TI) through NGOs among migrants and their spouses. The TI programme for migrants covered 58 districts during July 2013 – July 2014. However, very few interventions try to track migrants at source, during transit, and to their destination.

The IBBS of 2012 recorded that 87.5% of Western and 77.8% of Mid and Far Western region migrants have consistently used condoms, which indicates that most migrants use condoms (made available from health post/health centres) during their stay in India. HIV prevalence among India’s returned migrants of the Mid and Far West Regions is approximately 1.4% and 1.1% respectively.

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56 Arjun Aryal, YN Yogi, and H Ghimire, "Vulnerability to Unsafe Sex and HIV Infection among Wives of Migrant Workers in Far Western Nepal," *Journal of Chitwan Medical College* 3, no. 3 (2013)
HTC services have been found to have an unsatisfactory reach, with only 9.5% in the Western and 21% in the Mid to Far Western region\textsuperscript{57} of the migrant populations accessing those services. Stronger referral mechanisms across health services, cross border initiatives, and a rapid scale-up of HTC and STI services in Nepal are required to improve the quality and accessibility of these services, which constitute the entry point to the HIV ‘treatment cascade’.

4.6 Prisoners

In April 2015, there were 17,678 prisoners in 74 prisons throughout Nepal, of which 16,406 were men and 1,272 women; and 192 juvenile and 98 dependent children\textsuperscript{58}. There are 100 reported cases of HIV in 16 prisons. The National HIV AIDS Strategy (2011-2016) explicitly encourages human rights dialogues between prison inmates and the authorities, health service providers, and other stakeholders in order to encourage mutual respect and protection, including from discrimination. It provides for a wide range of services including condom distribution, harm reduction programmes, Hep B, Hep C, and HIV testing, counselling, provision of ART, treatment of STI, and discrimination reduction activities. It also aims to ensure the continuity of HIV care for prison inmates after their release from prison. However, prison departments do not always allow for condom distribution or other harm reduction services inside prisons, and the prison act is silent in the matter of providing these services.

4.7 Young People

Young people (aged 15-24) constitute about 20% of the population in Nepal. Findings show that young people bear 4.6% of the HIV epidemic burden in Nepal. National Youth Policy, 2066 aims to eliminate sexual violence and HIV infection among young people\textsuperscript{59}.

Considering that the median age of female sex workers’ first sexual intercourse is 16 years of age and 17 for MSM/MSW (IBBS survey, NCASC, 2012), young people can start to engage in risky behaviours from the age of 15-19 years old and so it is important that their needs, vulnerabilities and realities are addressed. An important barrier for the young people below the age of 18 years to access HTC services without a guardian. Similarly, young people who use drugs or people who sell sex under the age of 18 are not addressed by rights-based policies.

There are no HIV specific programmes targeting for young people in Nepal. However, with the support of Youth Lead based on Bangkok, a group of Young Key Affected Population (YKAP) comprised of the youth aged (15-27 ) from MSM and TG, FSW, PWID and People living with HIV communities is active in empowering young KAP to guard themselves against human rights violations, ensure their health is a responsibility they feel confident managing, and link them to the existing networks of peers so that their needs can be registered by multinational organizations and governments. National Federation of Women Living with HIV is the secretariat of YKAP.

4.8 Uniform Services

There are approximately 67,000 Nepal Police, 160,000 Armed Police Force and 180,000 Nepal Army personnel in Nepal. Although Nepal Police has developed its HIV and AIDS Strategy in 2004 and the HIV prevention education was integrated in the training of the personnel’s at different level, its continuity is questioned and in other two groups of US (armed Police and Nepal Army), very less has

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\textsuperscript{57} NCASC (2015), IBBS Survey among Male Labor Migrant in Western and Mid to Far Western region of Nepal, Round V-2015

\textsuperscript{58} Monthly Pay roll, April 2015, Department of Drug Administration, Kathmandu, Nepal

\textsuperscript{59} National Youth Policy Nepal 2010.
been done in terms of preventing them from HIV and also for creating an enabling environment for the HIV and AIDS programming. However HIV testing service has been integrated into the hospital of Nepal Police and Nepal Army. A total of 12,420 including 8,243 army personnel and 4,177 police personnel have been tested for HIV during the period of 16 Dec 2013 to 15 Dec 2014 (Source: Save the Children/ GFATM Programme 2014). Uniform services represent one of the Clients group of FSW and incident of harassment and violence to the PLHIV and the KP from the uniformed personnel is very common in Nepal as reflected in various studies; IBBS studies among the Sex workers, Injecting drug users and Men having sex with men; The Rights Evidence: Sexwork, Violence and HIV in Asia 2015; Sex work and the Law in Asia and the Pacific; APCOM, UNDP, Legal environments, human rights and HIV responses among men who have sex with men and transgender people in Asia and the Pacific, An agenda for action, July 2010 etc.).

C. FINDINGS AND RECOMMENDATIONS

The analysis of the existing documents reveal many supportive efforts initiated from both state and non-state sectors which has resulted in gradual improvements in the lives of PLHIV and key populations. Family and social acceptance towards PLHIV has been improving. Social media also seems supportive in producing enabling news. Advocacy conducted at national, regional, and local levels have been eye openers for local leaders, government authorities, law enforcement, and political leaders. Nepal has a commendable history where legal and justice systems have played constructive roles in responding to HIV, by respecting, protecting and fulfilling human rights, in the absence of appropriate laws and acts. Policies and programs for the mobilization of these groups for the effective prevention and treatment interventions are in place though the implementation is not optimum.

Following are the key recommendations to improve the legal and policy environment in response to HIV in Nepal, derived based on the desk review of the available literature/documents, small thematic groups consultations conducted with PLHIV and KP networks and as validated with the key partners including Government, EDPs, PLHIV and KPs:

1. Formulation of Supportive Laws

a. Further dialogue with stakeholders is required to determine the implications of Article 18 (2) and next steps in terms of implementation.

b. To clearly state laws (as suggested in the pending HIV Bill) that prevent and prohibit discrimination and prejudice against people living with HIV/AIDS and other key populations; based on non-discrimination provisions in the Constitution and international human rights instruments.

c. To specify that HIV as a non-communicable disease in all legal provisions such as the Infectious Diseases Control Act 2020 (1963), so that personnel have no ground for the segregation or discrimination of people living with HIV or the disclosure of their status.

d. To systematically apply the Universal Precaution and Infection Control (UPIC) in all HIV and AIDS related health practice, under legal provisions, including measures for the examination of blood, blood-related substances, tissues organs, Siemen and transplants.

e. To enact and enforce a law explicitly requiring informed consent before testing for HIV, as well as pre- and post-test counselling in relation to the HIV test.
National laws and guidelines related to drug use and HCT need to be revised jointly by Ministry of Health and Population and Ministry of Home Affairs to enable independent consent to access HIV testing and services, including harm reduction, for people under 18.

f. Laws to enforce the implementation of National Policy on Workplace and HIV (2007) and ILO World of Work Recommendation.

g. Criminalisation of HIV transmission, exposure or non-disclosure of HIV status, which are Counterproductive, should be removed in the proposed Penal Code draft.

h. To adapt the Drug Control Act and policies to explicitly allow OST and NSP and other amendments necessary to allow for smooth implementation of clean needle and syringe exchange programmes and other community based services including harm reduction for PWID, in collaboration with the MoHA and MoHP.

i. To revise the Drug Control Act and other relevant laws/codes to decriminalise possession of drugs/drug paraphernalia for personal use or public health measures such as harm reduction.

j. Amend the proposed draft of the Penal code to decriminalize sex work and sex between consenting adults. The Penal Code should explicitly prohibit use of possession of condoms as evidence for arrest/charge or prosecution.

k. The Human Trafficking and Transportation (Control) Act, 2007 should be revised to distinguish between human trafficking and voluntary sex work and any other necessary provisions to ensure that sex workers and clients are not charged with human trafficking and transportation punishments or suffer rights violations as a result of anti-trafficking efforts.

l. Ensure legal provisions to control the transmission of blood borne diseases during blood transfusions and the measures to take in case a patient gets infected with HIV, Hep B or Hep C from a blood transfusion.

m. Review and amend the proposed HIV Bill in the context of the new Constitution and in line with the recommendations to ensure that it ensure the protection and promotion of the human rights of PLHIV and key populations, and push for the endorsement/enactment, as soon as possible.

2. Improving Policies and Programmes in Response to HIV

a. Reactivate NAC to translate high-level commitments into meaningful action and to guide the national response to HIV.

b. Functionnalise the HIV/AIDS and STI Control Board, in line with the National AIDS Policy, as a coordinating body to coordinate various ministries and partners for the sectoral response to HIV with HIV focal points, or to identify an optional coordinating mechanism similar to the National Planning Commission, which also performed this coordinating role in the past.

c. Involve PLHIV and key affected population in the planning, programming, implementing, monitoring, and evaluation processes in initiatives and programs that impact these populations.

d. Revise and amend the national mechanism for providing social security/protection to ensure all women and children infected or affected by HIV can access relevant allowances and necessary supports.

e. Review contents of HIV component in formal and non-formal education curriculums to ensure it reflects human rights principles and meet the international standards and current science regarding HIV and AIDS. Incorporate HIV-related contents in teachers training curriculum so that the teacher can deliver accurate HIV-related information to students.
f. Expand HIV work place policies and programmes designed to prevent HIV infection among workers and to protect them from discrimination and losing their employment.

g. Update the National Consolidated Guideline for Treating and Preventing HIV in Nepal, 2014 in line with the WHO Consolidated Guidelines on HIV Testing Services, July 2015 to include community-led testing and services.

h. Develop and update SoPs/guidelines of HIV targeted intervention programs as needed and take steps to ensure the effective implementation for the standardization of the HIV interventions among the Key Populations.

i. Allocate resources for rehabilitation and livelihoods support for people who use drugs, based on the Nepal HIV AIDS Policy of 2011 and international human rights standards.

j. Develop a guideline for partnerships between State and non-state sectors in their response to HIV AIDS, especially to manage the HIV Targeted Intervention Program.

k. Ensure legal literacy and legal aid services for PLHIV and key populations as an important part of the HIV AIDS response.

l. Continue to expand health facilities in terms of human resources, infrastructure, and logistics to scale up the HIV-related treatment, care and support services, as envisioned in the National Health Policy of MoHP, 2014.

m. Clarify the role and accountability of MoHA and MoHP for coordinating harm reduction (needle syringe exchange and oral substitution therapy) and HIV prevention package in prison through Harm Reduction Strategy. Elaborate a clear legal policy on providing condoms and other harm reduction tools as per the newly recommended standard operating procedures inside prisons.

n. Clarify policy that the young people under 18 (who are drug users or sex workers), should have proper access to HIV prevention services including HIV testing, NSEP and condoms.

o. Coordinate with Ministry of Education, which collects children data biannually, for CABA related data for better programming.

p. Government and other partners to collaborate to ensure CABA are included as a disadvantaged community in the Education Policy which is currently being amended.

q. Implement coherent strategy to address the prejudice and discrimination towards the PLHIV and KP in health care settings, including community rights, literacy, routine monitoring, education programmes for health workers, health sector vs community feedback mechanisms, and access to justice for rights violations.

r. Ministry of Labour and Employment to strictly implement policies and orientation programmes on HIV for migrants going to work in other countries to ensure their right to information and health.

s. National policies and programmes on gender based violence must have specific approaches to make the GVB services accessible to the KP women groups, who face the multi-faceted violence, at the health care, from the law enforcement people, at the society and at the family level.

t. National response to HIV must be assessed and analysed to see the gender gaps in the programme.
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Annex II : Validation Workshop Report

An Assessment of Legal and Policy Environment in Response to HIV in Nepal

VALIDATION WORSHOP REPORT

26 January, 2015

Organized by:
National Centre for AIDS and STD Control
(Supported by UNAIDS)
As decided at the Asia-Pacific High-Level Intergovernmental Meeting held between 6-8 February 2012 in Bangkok, Nepal as a member country of the Asia-Pacific region have adopted a regional framework for action called the “ESCAP roadmap to 2015”.

National Centre for AIDS and STD Control (NCASC) with the technical support of UNAIDS conducted a national review relating to the legal and policy barriers towards the elimination of HIV related stigma, discrimination and violence. While conducting the review, the recommendation of the Global Commission on HIV and Law was followed. Being a signatory country to the ESCAP Resolutions 66/10 and 67/9 pertaining to the removal of legal and political barriers to universal access, the assessment assessed the country’s Legal and Policy environment in response to HIV AIDS.

The review process started in November 2014 and completed in January, 2015. The following process was adapted while conducting the national assessment of legal and policy environment in response to HIV in Nepal.

- The National Centre for AIDS and STD Control (NCASC) convened a Steering Committee (SC) to guide, support, and oversaw the work of the legal environment assessment, and of the national consultation. The members came from sectors that included the relevant ministries, key affected communities, UN agencies and National Human Rights Commissions (NHRC).
- A desk review was conducted on the national Constitution (Interim Constitution of 2007 and the 2015 Constitution), laws, acts, policies, strategies, plans, and guidelines to be proposed during the drafting of the Civil and Criminal codes, in line with the International Guidelines on HIV reduction and Human Rights.
- Separate consultative meetings with PLHIV and key population networks were conducted to collect further information on the practical implication of existing laws, policies, and guidelines and the impact they have on the access to HIV services.

After completing the desk review and consultation meeting with thematic groups, a one day validation workshop was conducted on 26 January 2015. NCASC invited all participants in the workshop. The key line ministries, NGOs, Nepal Human rights Commission, development partners, law enforcement authorities, parliamentarians, people living with HIV and other key affected populations attended the meeting.

The report was revised by the Steering Committee in November-December 2015 to incorporate appropriate references and implications of the Nepal Constitution 2015.

I. Purpose of the workshop:

To validate and refine the draft findings, and the recommendations of the assessment

II. Schedule of the validation workshop:

A. Opening session
   - Registration
   - Welcome and objectives of the meeting
   - Introduction of the participants
• Sharing of country situation in terms of HIV AIDS in Nepal
• Remarks from Constitution Assembly members
• Remarks from Country Coordinator, UNAIDS

B. Presentation
• Key findings of legal/law environment in response to HIV in Nepal
• Key finding of policy environment in response to HIV in Nepal
• Conclusion and recommendations

C. Discussion and documentation
• Discussion on key findings and recommendation
• Documentation of the recommendation

D. Closing
• Vote of Thanks from UNAIDS and NCASC

III. Validation Workshop process in detail
NCASC organized a Steering Committee meeting before the validation meeting. As decided in the meeting the validation workshop was held. NCASC as the leading entity of the assessment, sent invitation (see the annex 1) and there was representation from the following key organizations:

• Ministries (Home Affairs; Health and Populations; Education; Youth and Sports; Law enforcement authorities,
• Community Social Organization (CSO)/NGOs,
• Development partners including USAID, Family Health International, Save the Children
• Networks leaders and members from the National Association of People living with HIV and the National Federation of Women Living with HIV; Blue Diamond society working with LGBTI communities; Recovering Nepal, network of people who inject drugs; Jagriti Mahila Mahasangh (Federation of female sex workers in Nepal), Dristi Nepal, NGO working with the female drug users.
• Constitution Assembly Members (CA Members).
• National Human Right Commission

The detail participants list (attendance sheet) is attached here as annex 2.

Opening session
The opening session proceeded with the registration in an informal way. Dr. Dipendra Raman Singh, Director of NCASC welcomed to all participants in the workshop and shared the key objectives of the assessment and the validation workshop. Dr. Singh requested all to contribute in the discussion and validate the key finding and recommendation with additional inputs to finalize the report.

Then, the quick introduction of all participants was conducted.
Dr. Ruben del Prado, Country Director, UNAIDS during his remarks emphasized that the laws and policies should be equal to all, no laws and policies should be barrier in accessing services and treatment from the people living with HIV and key population at risk. He highlighted the importance of Health system and community system working together for making the prevention, treatment and care services accessible and affordable to all.

Mr Rajiv Bikram Shah and Ms. Om Devi Malla, the honourable members of Constitution Assembly praised the initiation of conducting the assessment of legal and policy environment in response to HIV in Nepal. Hon. Shah shared that most of the parliamentarian are unaware of the HIV situation in the country and also about the violation and discrimination that the PLHIV and Key population are exposed to in their day to day life. In this context civil society role is very crucial to make the CA members aware of the issues so that favourable laws and policies could be in place to ensure their rights to services. Honourable Ms. Malla suggested organising orientations, interactions meeting with CA members on such critical issues to build the positive mass to influence the legislative reforms, as the country is in the process of drafting the constitution and the penal and civil codes. She committed her time and effort in organizing such meetings in coordination with the civil societies.

Mr. Shambhu Kafle, the Senior Public Health Officer of NCASC highlighted the country situation in terms of HIV response. He further highlighted that the assessment of legal and policy environment is also one of the milestone in response to HIV in ensuring the rights of the key affected population.

Sharing the Assessment findings and the recommendations

The presentation of the key findings and recommendation were divided into following three parts.

- HIV AIDS Situation
- Laws and Acts
- Policies, strategies, Plans and Guidelines

Mr. Lok Nath Kandel was hired as a consultant for the assessment. He was supported by Mr. Prem Bahadur Thapa, a lawyer by profession in conducting the desk review of the existing legal and policy environment in response to HIV in Nepal. Mr. Thapa reviewed the legal part and Mr. Kandel assessed the existing policies, strategies, plans and guidelines. The assessment was conduct on the following areas:

- International Human Rights Instruments:
- Global Commission, HIV and the Laws, 2012
- Nepal Interim Constitution, 2007
- National Relevant Laws/Acts
- Nepal- HIV AIDS Epidemic Facts
- Other Relevant documents (reports, surveys, factsheets....)
• National Policies, strategies, plans and guidelines

• Proposed Civil and Penal Code specially related to:
  ➢ Criminalization of HIV Transmission under Chapter 5 Offences against Public Interest, Health, Safety and Facilities and Morals (Article 103: Prohibition of HIV Transmission)
  ➢ Criminalisation of same sex relationship as unnatural
  ➢ Marriage legal only between man and women
  ➢ Rape of women is punishable

Mr. Kandel highlighted HIV situation and available services in the country.

Then Mr. Thapa, the legal consultant, presented the findings and recommendation of legal part. The summary of key findings and recommendation shared were as follows:

Recommendations for Formulating Supportive Laws:

1. HIV is taken as one of the communicable disease in National Health Implementation Plan. On this ground there is high chance of segregation of people living with HIV or the disclosure of their status, under Infectious Diseases Control Act 2020 (1963). To avoid this, HIV should be specifically mentioned as a special case and no need of segregation.

2. To systematically follow the Universal Precaution and Infection Control (UPIC) in all HIV AIDS related health practice, under legal provisions. Including measures for the examination of blood, blood-related substances, tissues organs, semen, and transplants.

3. To enact and enforce a law explicitly requiring informed consent before testing for HIV as well as pre-, as well as post-test counselling in relation to the HIV test.

4. Law to be in place protecting the rights of people living with HIV and other key population at workplace in line with work place policy 2007 and World of Work Recommendation.

5. The criminalisation of HIV transmission in the proposed Penal Code should be removed.

6. To adapt the Drug Control Act and policies to allow smooth implementation of clean needle and syringe exchange programmes for PWID, in collaboration with the Ministry of Home Affairs and Ministry of Health and Population including categorizing punishments differently, based on the impact of drug use.

7. Amend the proposed draft of the penal code in order to decriminalize sex work and the sex between consenting adults. In the event that any aspect of sex work remains in the penal code, the Penal Code should explicitly provide that possession of condom should not be used as evidence for arrest/charge or prosecution.

8. The Human trafficking and Transportation (Control) Act, 2007 should distinguish between human trafficking and voluntary sex work. For sex workers and clients not to be charged with human trafficking and transportation punishments.
9. To review and amend the proposed HIV Bill to ensure it provides for protection and promotion of PLHIV and key populations human rights, and push for endorsement/enactment of this Bill as soon as possible.

Then Mr. Kandel presented the key finding and recommendation of policies, strategies, plans and guidelines as follows:

1. National AIDS Council need to be functional to translate high level commitments into meaningful action, and to guide the national response to HIV, as per the National AIDS Policy 2011.

2. As HIV, STI Control Board (HSCB) is almost non-existent, either it should be revitalized in line with the National AIDS Policy 2011 or a strong coordinating mechanism needs to be in place for the coordination of national response to HIV, at least to coordinate key ministries like Home, Health, Education, Social Welfare, Labour, Law and Justice, Federal Affairs and Local Development with the HIV focal points. National Planning Commission could play this role.

3. Enhance the meaningful participation of PLHIV and key affected population in the planning, programming, implementing, monitoring, and evaluation processes that concern them.

4. Establish a national mechanism for support to infected/affected children and women under social security/protection.

5. Content about HIV in formal and non-formal education curricula should be reviewed to ensure it meets international standards and current evidence and science regarding HIV and AIDS.

6. Expansion of HIV work place programmes to prevent HIV infection among workers, and to protect them from discrimination, and losing their employment.

7. SoPs/guidelines of HIV TI program, and SRH guideline, should be developed and updated as needed.

8. National laws and guidelines need to be revisited to enable independent consent to access HIV testing and services for people under 18.

9. Based on the HIV & STI Policy, 2011, the state is to allocate resources for rehabilitation and livelihoods support for drug users.

10. Legal provisions to control the transmission of blood borne diseases during blood transfusions and the measures to take in case of patient gets infected with HIV, Hep B or C from a blood transfusion.

11. Develop a guideline for partnerships between State and non-state sectors in their response to HIV AIDS, especially to manage the HIV Targeted Intervention Program.

12. Legal literacy and legal aid services for PLHIV and key populations needs to be ensured as an important part of HIV AIDS response, for accessing the services as their rights.

13. Programmes to address the prejudice and discrimination towards the PLHIV and KPs in health care settings, with the law enforcement entities and the judiciaries.

E. Discussion and feedbacks
After the presentation, the floor was open for the discussion, where participants shared their opinion for and against the key findings and recommendations. Ms Binna Pokharel from UNAIDS facilitated the discussion. Mr. Amrit Rai had documented the participant’s opinion. The meeting validated the findings and recommendation shared by the consultants, with few suggestions to be incorporated in the assessment report. Following suggestions were expressed by the participants:

**From the representative of Ministry of Law and Justice**

- Sex Work is neither legal nor illegal, not clearly defined. Sex workers are being harassed on that ground. Sex work related laws to be formulated.
- The matters of confidential issues should be resolved by the respective ministries

He clarified the participants about the positive aspect of the proposed civil code submitted to the parliament by the Ministry of Law and Justice that consensual sex between two adult is not criminalized.

**From JMMS, Federation of Female Sex Workers**

Amend the proposed draft of the Penal code to decriminalize sex work and the sex between consenting adults. Possession of condom should not be used as evidence for criminalization.

**From the representative of Ministry of Education:**

- There is possibility to include HIV in the curriculum of Teachers Training as the training curricula are under revision, should be included as the recommendation.
- As schools take updated record of the children of the community in every six month, School/district education office can be taken as point of contact for CABA children’s record. Recommend accordingly.

**From UNODC:**

Issues of reaching PWID and Sex Workers under 18 years with the HIV services should be reflected accordingly.

**From Migrants Network:**

Migrants workers working in gulf and other countries (besides India) to be reached with HIV interventions.

**From KP Networks: JMMS, BDS and RN**

- As the harassment and violence towards KPs from the uniform personnel is very common, which needs to be addressed urgently. Building US personnel’s understanding on HIV AIDS and human right; protecting the rights of female sex workers, injecting drug users and MSN and TG and PLHIV through the HIV Bill which is pending since long, are some of the important approaches.
– Ensure that the new constitution guarantees the rights of PLHIV and KP including sexual and gender minorities.

**From NAPN:**

CABA cash Transfer programmes needs to be institutionalizing within the Govt. system.

**From NFWLHIV:**

- Laws (as suggested in the pending HIV Bill) to be in place, to prevent discrimination and prejudice against people living with HIV/AIDS and other key populations; based on non-discrimination provisions from the Constitution, and human rights instruments.
- Criminalization of HIV transmission increases the discrimination of PLHIV face. The criminalisation of HIV transmission in the proposed Penal Code should be amended.
- Lobby to include CABA as disadvantaged community in the education policy as Education Policy is currently being amended.

Plenary discussion was then held on the way forward, led by Mr. Shambhu Kafle. Following were the agreed way forward to finalize the draft report and its further use in regard to the national response to HIV:

- The Steering Committee will work for the updating/revision of the propose draft report in line with the recommendations provided by the participants.
- UNAIDS to support in the printing and dissemination of the report.
- With the final report, NCASC will take lead in revisiting/updating of the pending draft of HIV Bill in line with the recommendations of the review report.
- NCASC and UNAIDS jointly organise a meeting with the CA members to share the Legal review report and the updated draft of HIV Bill with the CA members and advocate for the endorsement of HIV Bill.

**G. Closing:**

Finally the validation workshop was closed with the remarks from UNAIDS and NCASC, with the vote of thanks for all for their contribution in validating the assessment report with additional suggestions/recommendations.
### Annex III: List of National Policies, Strategies and Guidelines related to HIV

#### National Policies:

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<thead>
<tr>
<th>Year</th>
<th>Policy</th>
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<tbody>
<tr>
<td>1988</td>
<td>First National AIDS Prevention and Control Program</td>
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<tr>
<td>1993</td>
<td>National Blood Policy</td>
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<tr>
<td>1995</td>
<td>National AIDS Policy</td>
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<tr>
<td>2007</td>
<td>National Policy on AIDS in Workplace</td>
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#### National Strategies:

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<th>Year</th>
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<tr>
<td>2002-2006</td>
<td>National HIV AIDS Strategy</td>
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<tr>
<td>2007-2011</td>
<td>National HIV AIDS Strategy</td>
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<tr>
<td>2011-2016</td>
<td>National HIV AIDS Strategy</td>
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#### National Plans:

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<tr>
<th>Year</th>
<th>Plan</th>
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<tr>
<td>1990-1992</td>
<td>Medium Term Plan</td>
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<tr>
<td>1993-1997</td>
<td>Second Medium Term Plan</td>
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<td>1997-2001</td>
<td>National HIV AIDS Strategic Plan</td>
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<td>2008-2011</td>
<td>National Action Plan</td>
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<tr>
<td>2008-2011</td>
<td>National Advocacy Plan</td>
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<tr>
<td>2014-2016</td>
<td>Nepal HIV Investment Plan</td>
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#### National Guidelines:

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<tr>
<th>Years</th>
<th>Guideline</th>
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<tbody>
<tr>
<td>2004</td>
<td>National ART Guideline (Revised on 2012)</td>
</tr>
<tr>
<td>2005</td>
<td>National Guideline on Universal Precautions Waste Disposal and Post Exposure Management</td>
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<tr>
<td>2008</td>
<td>Policy and Strategy Guideline on Collaborative TB/HIV control</td>
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<tr>
<td>2009</td>
<td>DACC Operating Guidelines (Revised on 2012)</td>
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<td>2010</td>
<td>National Targeted Intervention Guidelines/Standard Operating Procedure (SoPs) for MARPs</td>
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<td>2011</td>
<td>Guideline for Operating Rehabilitation Centre for PWID</td>
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<td>2011</td>
<td>National Guideline/SoP of Community Care Centre for PLHIV</td>
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<tr>
<td>2012</td>
<td>National Guidelines for Early Infant Diagnosis</td>
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<tr>
<td>2014</td>
<td>National Consolidated Guideline for Treating and Preventing HIV in Nepal</td>
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